

**Competing interests and change within the pharmacy
education system in South Africa**

Thesis

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Abstract

This thesis provides a historical account of the emergence of the pharmacy education system in South Africa, and an analysis of the influence of competing interest groups over the pharmacy education curriculum. It provides a critical evaluation of structural-consensus and micro-interpretive approaches to medical and pharmacy education, and sets out a macro-interpretive account of pharmacy education in South Africa. Following Margaret Archer (1979) it analyzes three forms of negotiation between competing interest groups in their efforts to change the pharmacy curriculum; these are political manipulation, external transaction and internal initiation.

The thesis argues that whilst the private sector interest group (comprising of retail, wholesale and manufacturing pharmacy) dominated the pharmacy education system until 1994, since then a newly emerged government interest group has begun to compete for educational control. The priorities pursued by this interest group have consistently reflected the objectives set out in the ANC National Health Plan of 1994. The thesis maintains that given its frustration over the non-implementation of the ANC's health policy objectives, the government interest group is likely to resort to direct political manipulation by passing legislation to alter the content of the current pharmacy curriculum. Such changes would seek to ensure that the syllabus more accurately reflects the ANC Plan's community health and primary health care objectives.

The thesis asserts that such an outcome (of direct political manipulation of the curriculum) is not inevitable, and can be avoided through a process of internally initiated change. It presents the findings of an interpretive case study into how the Rhodes University Community Experience Programme (CEP) influenced final year pharmacy students' perceptions of the role of the pharmacist. The students' comments were collected by means of focus group interviews, participant observation and documentary analysis. Whilst the CEP did not successfully transform their concept of the pharmacist's role, it did succeed in influencing students' understanding of the notions of community pharmacy and primary health care in line with the government interest group's health objectives.

This thesis concludes that internally initiated change within the pharmacy education system, would be preferable to that imposed through external political manipulation, as such change would be more likely to preserve the independent professional interests of pharmacy academics.

Contents

<i>Acknowledgements</i>	viii
Chapter 1: Introduction	1
1.1. A macro-interpretive approach to pharmacy education.....	1
1.2. The Rhodes University Community Experience Programme.....	4
1.3. Structure of the thesis.....	5
Chapter 2: Research Methodology	7
2.1. Research paradigms	7
2.1.1. Positivism.....	10
2.1.2. Interpretivism.....	12
2.1.3. My research orientation.....	16
2.2. Research methods and techniques	16
2.2.1. Case study method.....	18
2.2.2. Focus group interviews.....	20
2.2.3. Participant observation.....	23
2.2.4. Documentary research.....	24
2.3. Analysing, interpreting and presenting the data	26
2.3.1. Analysis.....	26
2.3.2. Interpretation.....	29
2.3.3. The role of the researcher.....	31
2.3.4. Presentation of research data.....	32
2.4. Some key issues in research	33
2.4.1. Research validity.....	33
2.4.1.1. Reliability / dependability.....	34
2.4.1.2. Internal validity / credibility.....	35
2.4.1.3. External validity / transferability.....	37
2.4.1.4. Objectivity / confirmability.....	38

2.4.2. Research ethics.....	39
2.4.2.1. Informed consent of research participants.....	41
2.4.2.2. Addressing power relations between researcher and participants.....	45

Chapter 3: A theoretical framework for the research..... 47

3.1. Structural-consensus theory.....	49
3.1.1. Emile Durkheim.....	49
3.1.2. Talcott Parsons.....	52
3.1.3. Robert Merton.....	56
3.1.4. A functionalist analysis of pharmacy education.....	57
3.1.5. A critique of the functionalist account of pharmacy education.....	58
3.2. Micro-interpretivism.....	60
3.2.1. Alfred Schutz.....	61
3.2.2. Harold Garfinkel and ethnomethodology.....	62
3.2.3. Ethnomethodology in its application to medical education.....	67
3.2.4. A critique of the micro-interpretive approach.....	69
3.3. The neo-Weberian perspective.....	70
3.3.1. Margaret Archer.....	73
3.3.1.1. The educational system.....	75

Chapter 4: The pharmacy education system in South Africa..... 81

4.1. Pharmacy education as a social system.....	81
4.1.1. The emergence of the pharmacy profession in South Africa (1880-1928).....	82
4.1.2. Competition for educational control within pharmacy (1885-1928)...	83
4.1.3. Consolidation of the private sector interest group within the pharmacy profession (1928-1995).....	87

4.1.4. The influence of the private sector interest group on the pharmacy curriculum (1928-1993).....	89
4.1.4.1. Pharmacy education at Rhodes University.....	92
4.1.5. Challenges to the private sector domination of the South African Pharmacy Council.....	95
4.2. Negotiation within the pharmacy education system.....	98
4.2.1. Skewed resource allocation within the South African public health care system.....	99
4.2.2. Policy interventions and changes to the pharmacy curriculum by the government interest group.....	101
Chapter 5: Research findings and discussion.....	104
5.1. The influence of dominant interest groups on students' perceptions of the role of the pharmacist.....	105
5.1.1. The influence of private sector interests.....	107
5.1.2. Preoccupation with competition between retail pharmacists and medical doctors.....	112
5.1.3. Students' asocial and ahistorical view of the pharmacist's role.....	115
5.1.4. The government interest group's vision of the role of the pharmacist.....	118
5.2. Changes to pharmacy education through internal initiation.....	122
5.2.1. The Rhodes University Community Experience Programme.....	125
5.2.2. The autonomy of academic interests and the CEP.....	127
5.3. Students' perceptions of community pharmacy in post-apartheid South Africa.....	129
5.3.1. The pharmacist's community health role.....	129
5.3.2. The primary health care role of the pharmacist.....	133

Chapter 6: Conclusion.....	138
List of references.....	143
Appendices.....	157
Appendix 1: Interview questions.....	157
Appendix 2: Consent form.....	158

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Chapter 1

INTRODUCTION

The research reported in this thesis analyses the impact on the perceptions of final year undergraduate pharmacy students, of the Community Experience Programme conducted by the Rhodes University Faculty of Pharmacy. This research is situated broadly within the field of the sociology of education, and more narrowly within the field of the sociology of pharmacy and medical education. It employs a qualitative research methodology, in its application of an interpretive case study research method, to explore students' understandings of their future role as practising pharmacists.

The central research question posed within this thesis is: To what extent can internal initiation produce the changes necessary for pharmacy schools (such as the Rhodes University Faculty of Pharmacy) to meet the government's new policy priorities?

1.1 A macro-interpretive approach to pharmacy education in South Africa

In this thesis I adopt a macro-interpretive approach to the study of education, and provide an account of the influence of competing interest groups on the pharmacy curriculum in their efforts to gain control over the pharmacy profession in South Africa in the period since 1880. I provide a historically situated analysis of the influences of these competing interest groups on the pharmacy education system. The analysis provided is informed by Margaret Archer's (1979) theory of educational systems, with a particular focus on developments affecting pharmacy education post-1994. I illustrate how private sector interests (particularly those of the retail pharmacy sector) exerted a dominant influence over the content of the pharmacy curriculum until 1994, whereas after this point a newly established government

interest group has emerged to contest the private sector's control over the pharmacy education system.

In this thesis I detail a number of new policy interventions made by the government interest group after 1994. These interventions aim to bring about a democratic transformation of the health care sector and to eliminate historical inequalities in access to pharmaceutical services within this sector.

Using Archer's theory of education systems, I track the way in which three main forms of negotiation between these competing groups have served to bring about change within the South African pharmacy educational system: political manipulation, which reflects the manner in which interest groups invoke political legislation and regulations to secure changes to the educational curriculum in line with their interests; external transaction, which depicts the way in which interest groups outside of education negotiate with those inside it in order to develop forms of education which meet their specific needs; and finally, internal initiation, which relates to educational change initiated from within the educational system by academics and administrators (Archer 1979: 239 - 244).

My rationale for embarking on this thesis was twofold: firstly, my awareness of ongoing disparities in the distribution of pharmacists and inequalities in access to pharmaceutical health care in South Africa. In 2000, two years prior to when the research for this thesis was conducted, just over 10 percent of registered pharmacists in South Africa were employed in the public health care sector, which is tasked with servicing the health needs of over 80 percent of the country's population (SAPC 2000: 23). Secondly, my personal concern (as a young pharmacy practice lecturer in the Rhodes University Faculty of Pharmacy between 1999 and 2003) for how to extend students' perception of the role of the pharmacist in post-apartheid South Africa to incorporate the health care needs of the majority of the country's citizens. The overwhelming interests of students participating in my own courses

were tied to the narrow pursuit of a career in retail pharmacy¹ and for that reason, in my view, the students were systematically under-prepared for the challenges awaiting them during their community service year.

In this thesis I explore the perception of the government interest group, that pharmacy schools and faculties have shown a lack of responsiveness to the health care needs of disadvantaged citizens and the detailed policy objectives of the new democratic government. In a context of ongoing frustration regarding the implementation of its democratic policy objectives, I postulate the likelihood of increased 'political manipulation' by the government interest group in order to secure the necessary changes to the pharmacy curriculum in its efforts to address current disparities and inequalities.

In this thesis I question whether such political intervention and the external imposition of curriculum change is inevitable. I suggest an alternative to such 'political manipulation' in the form of Archer's concept of 'internal initiation'. I argue that individual pharmacy schools and faculties making up the pharmacy education system are in a position to take steps which would preserve their professional autonomy and preempt increased government regulation. Pharmacy academics may exercise agency and have the ability to initiate educational change which is consistent with their own professional goals, and which also addresses many of the needs of the government interest group.

I present the Rhodes University Community Experience Programme as a case study of such a possibility. In so doing, I explore its development in relation to the professional goals of its initiator, and investigate the resultant influence of this course on students' notion of the concept of 'community pharmacy'. The students' understandings of the concept of 'community', after having completed the course,

¹ More recent research published into the career preferences on pharmacy graduates across South African universities conducted in 2004 (subsequent to the interviews undertaken for this thesis), confirms a generalized preference for retail pharmacy and a lack of interest by pharmacy graduates in entering the public health care sector (Lutchman *et al* 2004).

are largely consistent with the conceptual framework of the government interest group.

1.2 The Rhodes University Community Experience Programme

The Community Experience Programme (CEP) is an experiential, primary health care undergraduate course offered to final year pharmacy students at Rhodes University. It involves taking groups of students to visit public sector patients in their homes in Joza, a poor semi-urban township outside Grahamstown.

The objective of the research reported in this thesis was to explore whether the CEP influenced students' perceptions of the pharmacist's role in post-apartheid South Africa. This involved an analysis of the students' accounts of the practical skills and knowledge required to perform the role of the pharmacist before and after the CEP.

The research took the form of an interpretive case study and relied on the use of focus group interviews with final year pharmacy students at Rhodes University (before and after the CEP) as its primary data collection technique. Additional data collection techniques employed included participant observation of students interacting with one another and the public sector patients (during the course of the CEP) and, an analysis of the students' written work (submitted as a requirement of the CEP) in the form of learning portfolios.

The case study reported in the thesis was conducted over a period of four months, between February and May of 2002, which coincided with the staging of the CEP. Out of 46 final year pharmacy students registered at Rhodes University in 2002, 24 students participated in the first set of interviews in February, which were conducted with three sets of focus groups (each composed of 8 students). During the second round of focus group interviews in May 2002, the number of participants decreased to 19.

1.3 Structure of the thesis

In chapter two of this thesis I provide an overview of the epistemological and ontological issues affecting research into social phenomena. This leads to a discussion of competing research paradigms and the research methods consistent with the interpretivist paradigm. I also provide a detailed account of the interpretive research techniques employed during the course of this research.

IN chapter three I explore the two main theoretical approaches to social theory, namely structural-consensus theory and micro-interpretivist theory, in their application to the study of education. I provide an overview and critical evaluation of these approaches in their application to pharmacy and medical education. In opposition to both approaches, I adopt a macro-interpretive approach to the study of educational systems advanced by Margaret Archer (1979).

I apply Archer's theory of educational systems to the history of pharmacy education in South Africa in chapter four. Here I provide a detailed historical analysis of the emergence of the pharmacy education system and the formation of various interest groups in the pursuit of educational control within this system. I conclude that the dominant interest groups within pharmacy education in post-apartheid South Africa are the private sector pharmacy group and the government interest group (which has consistently articulated the health care objectives set out by the African National Congress in the 1994 National Health Plan).

In chapter five I provide an account of a case study conducted into whether the Rhodes University CEP influenced students' perceptions of the role of the pharmacist in South Africa. I report on the focus group interviews conducted with final year pharmacy students on their perceptions of their future role prior to and after the completion of the CEP. I conclude that the CEP did not change the students' perceptions of the role of the pharmacist, but rather succeeded in introducing new concepts of community health and primary health care. I present evidence of students having adopted these new concepts as a result of their participation in the

programme and maintain that the CEP constitutes a successful instance of 'internal initiation'.

Finally, in chapter six I conclude the arguments advanced during the course of the thesis with a call for concerted collective professional action on the part of pharmacy academics and administrators to embark on the internal initiation of change to the pharmacy curriculum.

Chapter 2

RESEARCH METHODOLOGY

In this chapter I situate my research into pharmaceutical education within an interpretivist paradigm. I provide a discussion of research methodology in its broadest sense including an account of research paradigms, and a discussion of the logical and philosophical principles that underpin the practice of research. This discussion includes a consideration of the fundamental concepts of ontology and epistemology.

On the basis of this discussion I provide an account of the practical methods employed during the research process. This account includes the research techniques used in the data collection process, the analysis and interpretation of research data, and the concepts of validity and research ethics employed.

2.1 Research paradigms

Since the 17th century period of intellectual development, referred to as the Enlightenment, when scholars started moving away from religious explanations of the world in favour of scientific ones, a dispute has raged over the source of scientific knowledge. The epistemological² differences which emerged during the Enlightenment have had a lasting influence on current research paradigms. In particular they have served to shape the methodological differences between the two main approaches to the study of social phenomena: positivism and interpretivism.

Traditionally two competing claims about the source of knowledge dominated epistemological thought during Enlightenment times. These were experience and

² Epistemology can be defined as 'the branch of philosophy concerned with the theory of knowledge. Traditionally, central issues in epistemology are the nature and derivation of knowledge, the scope of knowledge, and the reliability of claims to knowledge' (Flew 1983: 109).

reason. Empiricist philosophers (such as John Locke 1632 - 1704 and David Hume 1711 - 1776³) argued that the only solid basis on which knowledge could be built was sensory experience, whereas rationalist philosophers (such as Rene Descartes 1596 - 1650⁴) argued that the sole criterion for knowledge was reason.

The 18th century philosopher Immanuel Kant (1724 – 1804⁵), frustrated by the limitations of both empiricism and rationalism, embarked on a novel solution to the question of the source of knowledge. His epistemology asserts that knowledge could only be produced on the basis of a combination of reason and experience. Only on the basis of the faculty of understanding (i.e. using transcendental categories) could people make sense of their actual experiences (Benton 1977: 102-104). In this way Kant gave rise to a third perspective within epistemology called idealism. This approach focused on the manner in which people interpret their experiences of the world. Idealism served to shape the foundations of subsequent interpretivist and phenomenological thought.

In the discussion below I hope to demonstrate the way in which this epistemological dispute has helped to shape the key social research paradigms of positivism and interpretivism over the past two hundred years. It is important to recognize that the manner in which various researchers go about conducting their research practice, the ways in which they collect and analyse their research data, and even those things on which they choose to focus their research techniques (the things they view as 'real' and requiring investigation in the first place) are shaped by the network of assumptions that underpin their research paradigm.

A research paradigm includes the set of assumptions that guides and informs a researcher's practical activities. As Bassey (1995) puts it: 'A research paradigm is a

³ Locke, J. (1690). *An Essay Concerning Human Understanding*. In V.G. Potter (1993), *Readings in Epistemology*. New York: Fordham University Press.

Hume, D. (1748). *An Enquiry Concerning Human Understanding*. In V.G. Potter (1993), *Readings in Epistemology*. New York: Fordham University Press.

⁴ Descartes, R. (1637). *A Discourse on Method*. In V.G. Potter (1993), *Readings in Epistemology*. New York: Fordham University Press.

⁵ Kant, I. (1781). *Critique of Pure Reason*. In V.G. Potter (1993), *Readings in Epistemology*. New York: Fordham University Press.

network of coherent ideas about the nature of the world and of the functions of researchers which, adhered to by a group of researchers, conditions the patterns of their thinking and underpins their research actions' (p12).

As indicated, research paradigms do not only inform our views on what constitutes knowledge (epistemology). They also shape our views on what can be said to exist or what is treated as real (ontology) by a researcher. In the words of Terre Blanche and Durrheim (1996):

'Paradigms are all-encompassing systems of interrelated practice and thinking that define for researchers the nature of their enquiry along three dimensions: ontology, epistemology and methodology. Ontology specifies the nature of reality that is to be studied, and what can be known about it. Epistemology specifies the nature of the relationship between the researcher (knower) and what can be known. Methodology specifies how the researcher may go about practically studying whatever he or she believes can be known' (p 6).

More recent writers have argued that we may be influenced by a particular paradigm without being consciously aware of this. The post-structuralist writer, Popkewitz (1984), believes that 'at a deeper layer, we can view inquiry as metalanguage in which the narrative creates a style or a form for thought. The metalanguage maintains assumptions which are unconscious in the formal debates of science but by which the content and procedures of inquiry are made sensible and plausible' (p. 33).

Similarly, the underlying epistemological and ontological assumptions constituting a research paradigm may not be immediately apparent but they serve to shape the customs and conventions of actual research.

In the following section, the two main research paradigms applied to the study of social phenomena will be discussed, with particular reference to some of their underlying ontological, epistemological and methodological assumptions.

2.1.1 Positivism

The positivist paradigm has its roots within the Enlightenment epistemological approach of empiricism. The empiricist philosopher John Locke (1690) asserted that:

‘Our observation, employed either about external sensible objects, or about the internal operations of our minds, perceived and reflected on by ourselves, is that which supplies our understanding with all the materials of thinking’ (p58).

David Hume (1748) took this approach further and applied it to the analysis of causality. He argued that the causes of events were not open to observation. To talk about one thing causing another to happen was simply a ‘habit’ arrived at on the basis of experience. This gave rise to an inductivist approach to scientific method. The basic idea of inductivism is that ‘statements about the world, or some part of it, can be justified or established as true in a direct way by an unprejudiced observer’s use of his [or her] senses’ (Chambers 1982: 2). Inductive or observation statements form the basis from which the laws and theories of science are derived. The laws of science are identified through the process of induction (the collection of observation statements) and these laws can then be used to make predictions about states of affairs or events in the world on the basis of deduction.

The term ‘positivism’ first arose in the 19th century when the philosopher, Auguste Comte (1798 - 1857) extended the empiricist (and inductivist) model of science to the study of society. Comte set out to identify the ‘invariable laws’ of human behaviour (Benton 1977: 18 – 33). Positivist social thought since Comte has concerned itself solely with the observable aspects of human behaviour. It has denied that social theorists should be concerned with the internal motives or feelings of individuals. These mental states of mind cannot be observed and therefore cannot be measured. For this reason they can play no meaningful role within scientific explanation.

Comte and subsequent positivist social thinkers such as Emile Durkheim (1858 - 1917) have argued that the proper subject matter of social research should not be focused on individuals and their concepts and ideas, but rather on collective human behaviour. Durkheim (1938) argued that researchers should 'consider social facts as things' (p14). Consequently, the ontological emphasis within positivism has been focused on social institutions which are believed to have an existence outside of individuals. Institutions exist independently of the ideas and beliefs of the individuals that make them up. People's values and beliefs are impressed on their minds externally by society and its institutions such as schools, the mass media and religion.

The positivist paradigm asserts that it is possible to count sets of observable social facts and in so doing to produce statistics which would help to identify social laws governing human behaviour. For this reason the research method generally employed by positivists has set out to produce statistical correlations as the basis for its explanations of human affairs. 'The aim of such research would be to provide an accurate description of the laws and mechanisms that operate in social life' (Terre Blanche & Durkheim 1999: 6; de Vaus 1986).

The concept of objectivity employed by positivists is grounded in the assertion that science should only concern itself with observation. As Chalmers (1982) puts it: 'Observation statements can be ascertained by any observer by normal use of the senses. No personal, subjective elements should be permitted to intrude. The validity of the observation statements when correctly acquired will not depend on the taste, opinion, hopes or expectations of the observer' (p.10). In this way science is objective and value-free.

Numerous criticisms have been leveled against positivism since the turn of the century. One of the most significant limitations of positivism to which critics have drawn attention is its deterministic view of human beings, as being passively affected by external factors and hence lacking agency or the ability to change their circumstances. Its objectivist approach to facts has also been criticized for being

oblivious to the way in which the assumptions of the researcher and the research framework affect the design and research outcomes.

Positivism as a theoretical framework underpins various theories in both sociology (structural-functionalism) and educational psychology (notably behaviourism) (Janse van Rensburg 2001a).

2.1.2 Interpretivism

As mentioned, interpretivist theories of social action have their origins in Kantian philosophy. Kant agreed with the empiricists (in opposition to rationalists such as Descartes) that there cannot be 'innate' ideas that are produced prior to sense experience. However according to Kant, the possibility of having an experience in the first place depends on the prior existence of transcendental categories in the human mind. The objects of our experiences do not have an existence independently of our thoughts. So the activities of the thinking subject are required in order to make sense of sensory experience (Benton 1977: 102). It is for this reason that Kant is known as the father of German Idealism. In his terms, the ability to experience the external world is dependent on the human mind.

Neo-Kantian thinkers such as Wilhelm Dilthey (1833 – 1911) and Max Weber (1864 – 1920) drew a clear distinction between the natural and social sciences. Positivists had modelled their concept of scientific method on the natural world, which consisted of inanimate objects. By contrast, neo-Kantians pointed out that the subject matter of the social world was reasoning and conscious individuals. Kant's assumption had been that all individuals possess a set of subjective transcendental categories which make their conscious experiences possible. For this reason the neo-Kantian interpretive and phenomenological schools of thought came to prioritise the interpretation of meaning as the basis for explaining social action. According to Dilthey (cited in Hamilton 1974: 91) human history, unlike the objects of the natural world, was made up of meaning complexes.

As a result, the study of society could not be approached using the same methods as natural science, which dealt with generally repeatable law-like phenomena. Neo-Kantians such as Dilthey argued that there is a marked difference between the study of nature and the study of human action. Human action is an expression of 'lived experience' and requires a special method of analysis, called hermeneutics or interpretivism⁶. Human history is characterised by unrepeatable phenomena which cannot be inductively formulated into generalizable social laws (*ibid*).

From an interpretivist point of view, human beings possess powers of consciousness; they have intelligence and attach meanings to what they do. While the statistical processes derived from the deductive methods employed by natural science may tell us what is observable in the first place, they do not explain the meanings and motives for why individuals choose to act in certain ways.

In these terms Max Weber (1864 - 1920) argued that the study of society can still be scientific, although not in the same way as the study of nature. Weber defined the study of society (or sociology) as 'a science which attempts the interpretive understanding of social action in order thereby to arrive at a causal explanation of its course and effects' (1964: 128). Weber's method is one of *Verstehen*. Before the cause of an action can be established we have to understand the meanings and motives attached to the action by the individual actor.

Weber argues that once we have come to understand the subjective meanings attached by individuals to their actions, then we can produce a causal explanation of human behaviour. As long as the researcher follows a rigorous methodological procedure, and eliminates any form of bias, then a scientific method can still be used to study social action (Keat & Urry 1981: 146).

⁶ The differences and similarities between interpretivism and philosophical hermeneutics are discussed in Schwandt (2000). For the purposes of this research project, however, I will treat these terms as being interchangeable. This is because both approaches prioritise the use of *Verstehen* (or interpretive understanding) of social action.

Phenomenological sociology was heavily influenced by the epistemological views of Edmund Husserl's (1859 – 1938) phenomenological philosophy. Husserl's phenomenology is concerned with 'the structures and workings of human consciousness. Its basic though often implicit presupposition is that the world we live in is created in consciousness, in our heads' (Craib 1984:84). The foundation of Husserl's epistemology is the assertion that one can only ever truly know one's own experiences.

Experience in this instance does not mean the act of focusing on the objects of experience, as is the case with traditional empiricist epistemologies (Locke & Hume), which view sensory experience (acquired primarily through observation) as the source of all knowledge. Husserl was concerned with the mental process of experience itself. He hoped to transcend the actual objects of experience in order to focus on the experience itself or the "essences" of the phenomena we perceive (Cuff & Payne 1984). In other words, Husserl focuses on the process by which we come to make sense of our experiences of the world around us, the manner in which we classify and interpret the world.

Husserl did not actually apply his philosophy to the study of social action. This task was undertaken by the 20th century social theorist, Alfred Schutz (1899 – 1959), who combined Husserl's epistemology with Weber's theory of *Verstehen*.

Schutz agreed with Weber that social action is meaningful, yet he argued that Weber had failed to show how action comes to be meaningful and how actors share meanings with each other. Schutz started off by rejecting Weber's use of the term 'subjective meaning'. Weber had defined action as 'all human behaviour when and in so far as the acting individual attaches a subjective meaning to it' (1964: 128). Schutz argued that this definition implied that actions have a single meaning capable of imputing the same subjective understanding of an action to otherwise isolated individuals. In Schutz's terms, Weber had failed to explain inter-subjectivity, that is, the process through which these meanings come to be shared.

According to Schutz, rather than assume that the social world has meaning, researchers should look at the way in which actors construct their ideas about the world.

‘The first task of the methodology of the social sciences should be the exploration of the general principles according to which man in daily life organises his experiences, and especially those of the social world’ (1962: 59).

Schutz (1962: 491) criticizes the positivist’s identification of experience with overt or observable action for excluding several dimensions of social reality from possible inquiry, these include:

- The different meanings attached by the actors to a specific action
- The actions of the observing observer
- Negative actions (i.e. intentionally refraining from action)
- Social reality contains elements of beliefs and convictions which are real because they are so defined by the participants, whether they are observed as such by the observer or not
- Situations in which the observer is unable to observe the actions of individuals.

Despite the subjective nature of the scientific problems found in the social sciences, Schutz still maintained that it was possible to produce a scientific explanation of the social world (Schutz 1962: 498). According to Schutz, the role of the social researcher is to construct a rational and objective account of the social world. This is to be achieved by constructing ‘second-order’ (or scientific) explanations about our ‘first-order’ (common-sense) knowledge of the world. These explanations need to conform to the standards of scientific objectivity (Cuff & Payne 1984: 156).

His criteria for the ‘postulate of adequacy’ of a social theory set out to ensure that researchers’ theoretical constructs of the social world were understandable to the actors in terms of ‘commonsense interpretations of everyday life’ (Schutz 1962: 499). For Schutz, the focus of social research should be on how people ‘make up’ the social world by sharing meanings and how they ‘get on’ with each other (inter-

subjectivity). Since Schutz believed that any attempt to explain the social world beyond people's everyday understanding was unfounded, his criteria for the 'postulate of adequacy' deemed it inappropriate for a researcher to theorize beyond this world of common-sense understandings about social life (May 1993: 29).

2.1.3 My research orientation

I subscribe to a broadly interpretive (neo-Kantian) epistemology where the source of knowledge within the social world is interpretation (of the subjective meanings that individuals attach to their actions). Consequently, this research project does not attempt to lead each individual student back to particular and concrete experiences that would shed light on how they have to come to hold certain shared meanings about the world (as would be the case with a phenomenological study), but is rather concerned with obtaining a consensus view of how groups of students understand their practical experiences of the pharmacy profession before and during the CEP course.

I shall for the purposes of this research study, make extensive use of a macro-interpretive approach to the study of educational systems. I shall refer to my research project as an interpretive study as I believe that both the underlying research paradigm and the practical methods and techniques used in the research process, are consistent with a macro-interpretive analysis of the social world.

2.2 Research methods and techniques

The epistemological and ontological assumptions underpinning the paradigms of positivism and interpretivism/phenomenology have traditionally resulted in the adoption of diametrically opposed research methods⁷ and techniques⁸. This is

⁷ The term research method refers to the different strategies, styles or kinds of research (such as ethnographic research, surveys, case studies, experiments and action research) that are prevalent in the natural and social sciences.

⁸ The term research technique refers to the range of approaches, tools or instruments used to gather data which are then used as a basis for inference and interpretation, for explanation and/or prediction.

because the practical methods and techniques adopted by the researchers working within these paradigms must be consistent with their underlying ontological and epistemological assumptions, if the research findings are to be accepted amongst their peers in the research community.

Consequently, in contrast to the positivist paradigm which aims to measure social behaviour through the collection of quantitative data about social actors, interpretivism aims to understand human actions through the collection of qualitative data. Whereas quantitative research methods attempt to produce quantifiable data that can be analysed using statistical methods, qualitative research methods give rise to narrative-type data (e.g. interview transcripts) or texts in terms of which the research participants' meanings or motives can be analysed.

As indicated above, the interpretive approach adopted within this study is principally concerned with understanding how the pharmacy students interpreted their everyday, inter-subjective practical experiences of the pharmacy profession before and during the CEP. Uncovering how research participants attached particular meanings to their experiences, and the degree to which these meanings could be said to be 'shared', therefore necessitated the careful selection of research methods and techniques. At the outset, for this reason, quantitative research methods and techniques, which often 'begin with a series of predetermined categories, usually embodied in standardized quantitative measures' (Terre Blanche & Durrheim 1999: 42), were deemed unsuitable for the interpretive study of inter-subjective meanings.

Instead, given the interpretive research paradigm underpinning my approach to the subject matter, a number of qualitative research techniques were chosen to collect the research data using a case study method.

2.2.1 Case study method

The purpose of this research project, as indicated, was to analyse fourth year pharmacy students' accounts of their practical experiences of the pharmacy profession before and during the CEP, and to explore how this programme influenced their understanding of the role of the pharmacist in South Africa. A qualitative research method that would not only provide me with a detailed account of the students' experiences, but also an understanding of the extent to which students had developed shared meanings of these experiences, was therefore required. Given this objective, the case study method was eventually chosen because it 'strive[s] to portray what it is like to be in a particular situation, to catch the close-up reality and thick description of participants' lived experiences of, thoughts about and feelings for, a situation' (Cohen *et al* 2000: 182).

The various strategies and approaches to designing case study research have been set out by Yin (1984). As he points out, whether one chooses a multiple- or single-case study approach or an exploratory, descriptive or explanatory strategy depends on the aims and objectives of the specific research study. Since this study only set out to explore a single case, that is the Community Experience Programme at Rhodes University, a single case study method was identified as the most logical research strategy. Similarly, since one of the research aims was to explain how the students had attached particular meanings to their practical experiences of the pharmacy profession, an explanatory strategy was employed.

The case study method appeared most appropriate for my research. Among other things, the case study approach was deemed appropriate for the following reasons:

1. It addresses and/or applies to cases which provide an illustration of some typical phenomena (in this instance, the manner in which students respond to the legislated changes taking place in the pharmacy profession in South Africa).

2. It focuses on *particularities*, including the meanings and beliefs of particular individuals rather than their abstracted roles (this involved a discussion of students' views about their ability to perform their future roles as pharmacists).
3. It sets out to explain case *histories*, recording ongoing processes in the relationship between particular individuals and the interaction between these individuals and particular institutions (in this instance, how the research participants interpreted their new experiences of interacting with patients in their own homes).
4. It is frequently *social-problem orientated*. Case studies often seek to interrogate the processes involved in social problems (in this instance, the problem of producing a new cohort of pharmacists with the skills necessary to address the social needs of communities in post-apartheid South Africa) (Glickman 1987: 5).

The case study took place over a period of four months, between February and May of 2002. This coincided with the same period during which the CEP was presented (it started on 3 March 2002 and ended on 30 April 2002). The settings in which most of the research took place included the Rhodes University Faculty of Pharmacy and the site of the Community Experience Programme (viz. patients' homes in and around Joza).

The 2002 final year pharmacy class at Rhodes University consisted of 46 students. The research participants from this class were selected at the start of the academic year shortly before the CEP had commenced. A presentation was made to all students inviting them to participate in this study. There were initially a total of 24 students who had volunteered to be participants in the study; all of whom were asked to sign consent forms (refer to section 2.4.2.1 for more information on the consent forms).

The focus of the research set out to go beyond a simple description of the Rhodes University final year pharmacy students' practical experiences of the pharmacy profession before and during the CEP. Rather the intention was to explore 'the

question of what specially can be learned from [this] single case' (Stake 2000: 435). In particular, I set out to reflect on the relevance of students' meanings of their experiences of the CEP to the implementation of newly introduced educational policy and the ongoing process of transforming the role of pharmacy professionals in South Africa.

Since the in-depth investigation of the students' shared meanings was the central focus of this research project, I chose to use the focus group interview as the main research technique to collect the research data.

2.2.2 Focus group interviews

Morgan (1988:18) believes that the focus group interview⁹ offers the unique advantage of providing the researcher with access to interactions *within* a group context (that is, the participants interact with each other rather than with the interviewer). Given the fact that the students' experiences of the CEP occurred largely in groups (e.g. visits to patients' homes; tutorials with the general practitioner) it was deemed appropriate to investigate how the students collectively interpreted these shared experiences. For this reason, use was made of the focus group interview technique as a way of uncovering some of the students' discussions and debates in an attempt to understand these shared experiences, and to explore some of the differences in the ways in which these experiences had been understood.

It is only recently that the focus group interview has been accepted as an appropriate qualitative research technique within social science research (Morgan 1988; Kitzinger and Barbour 1999). Historically, it has largely been associated with marketing research and the perspective of the research participant as consumer (Cunningham-Burley *et al* 1999). Vaughn *et al* (1996) believe that focus group interviews are well suited for empirical research in the fields of education and

⁹ I have chosen to use the term focus group interview, as opposed to focus group or focus group discussion, as I feel that it is important to acknowledge the pivotal role that the interviewer plays in shaping the discussions and debates (e.g. by establishing pre-determined research questions) that take place between the participants.

psychology. Similarly, it has been argued (Hassell and Hibbert 1996; Smith 2001) that focus group interviews comprise a vital data collection technique within the pharmacy practice research arena.

According to Kelly (1999a: 388) a focus group interview is a general term given to research conducted with a group of people who share a similar type of experience. It is important to note that, whilst conventional interviews strive to collect data on the subjective experiences of individual participants, focus group interviews focus on accessing inter-subjective experiences shared within a given group of participants (*ibid*).

It is this focus on the inter-subjective experiences of the participants that makes this research technique well suited to the objectives of this case study. As a technique, the focus group interview emphasizes the need for participants to continue discussing a subject until their points of agreement and disagreement become apparent. This often means that participants become consciously aware of their own perspectives when confronted with an active disagreement or an explicit attempt to reach consensus (Morgan 1988: 29).

I identified the focus group interview as the preferred technique to elicit students' perceptions because I felt that it would be the least threatening interview environment for the students, as they would be in the company of their peers (Madriz 2000: 835). I had hoped that the focus group interview technique would be effective in facilitating debate amongst the students and deterring them from misrepresenting their knowledge and views in front of their peers. This view is shared by Green and Hart (1999) who, in the context of researching children, believe that research 'participants in a group setting obtain immediate feedback on their views and constructions of reality, as their stories are challenged, corroborated or marginalized by their peers' (p24).

The first set of focus group interviews took place between 15 and 18 February 2002 (before the commencement of the CEP), and the second set took place between 21

and 24 May (shortly after the CEP course had ended). The 24 participants were divided into three focus groups¹⁰, each consisting of eight¹¹ students, with the anticipation of a 10-20% drop out rate as indicated in the literature¹². However, all the participants arrived for the first round of interviews. The number of participants then dropped to 19 in the second round of interviews. This was considered to be an adequate sample size, not to generalise, but to obtain a sufficiently comprehensive picture of the diverse experiences that the students may have had. Note that the students chose which groups they wanted to join, hence the formation of peer discussion groups.

The focus group interviews followed a semi-structured format and consisted of four main questions (See appendix 1 for a list of questions). I then tape recorded the students' responses and transcribed them in full.

A major criticism that has been leveled against the focus group interview is that the research context in which it takes place is a 'fundamentally unnatural social setting' (Morgan 1988:16). The research context (in this case, the University) is often far removed from the original setting in which the initial sets of experiences took place (viz, a suburban retail pharmacy or in Joza and surrounding areas). The research setting is not only deliberately created by the interventions of the researcher, but the researcher actively participates in and directs the interview process. Furthermore, Green & Hart (1999) warn against discounting the effect that such an unnatural context has on the production of data, and urge researchers to take steps to ensure that different contexts and compositions of research participants are used to 'tap different repertoires of knowledge' (p34) of their lived experiences.

As a means of overcoming this limitation (i.e. the dependence on an unnatural research setting) it has been suggested that observation be used in conjunction with

¹⁰ According to Calder (1977 in Morgan 1988: 42) if the researcher can clearly anticipate what will be said next in the group, then enough groups have been formulated, this usually takes about 3 to 4 groups.

¹¹ Most focus groups are composed of between six and twelve people (Kelly 1999a: 389; Morgan 1988: 43).

¹² Morgan (1988: 44) suggests the need to over-recruit by as much as 20%.

focus group interviews, as it strives to overcome this problem by studying research participants in their natural social settings.

2.2.3 Participant Observation

Since I was fully involved in one of the practice settings being studied (that is, as the CEP course co-ordinator I accompanied the students on their visits to the patients' homes), I was provided with a unique opportunity not only to participate in the course but also to observe the students' experiences of the course in its natural setting. This enabled me to capture a number of observations about students' interactions amongst themselves and with the patients, in a research journal. The data generated from these encounters were recorded in the form of field notes, and consisted of observations made during students' interactions with patients in their homes, as well as their discussions after their interviews in the university vehicle driving in and around Joza, from one patient's home to the next. Consequently, my research role was that of the *participant-as-observer* (Cohen *et al* 2000:305) or *complete-member researcher* (Adler & Adler 1994 in Angrosino & Mays de Pérez 2000: 677).

The main rationale for documenting the observations made during the course of the CEP, was to provide me with the much-needed contextual information that could then be used to interpret the data generated from the focus group interviews. From my interpretivist viewpoint, meanings are deemed to be socially constructed, and I therefore felt that it was important to access the context in which those meanings were generated. The observations therefore took on an unstructured format, as I was chiefly concerned with getting an overall picture of how the students interacted with one another, the patients, and their surrounding environment. Using a pre-determined structured observation schedule could have had the unintended effect of neglecting vital information that would later prove to be essential. However, it is important to recognize that what I observed was nonetheless determined by my prior experiences and cannot claim to be atheoretical (Chalmers 1982).

As a participant observer I was also very aware that my participation was inevitably affecting the very social process which I was studying, and consequently, the observations that I was making (Babbie *et al* 2001:296). It is important to acknowledge that my dual role as course co-ordinator and researcher may at times have been confusing to the students. Hence, another important limitation of the use of the above research technique arose and should be addressed: My presence 'might well stimulate a very different set of interactions, and a different set of observations leading to a different set of conclusions' (Angrosino & Mays de Perez 2000: 689) throughout the course.

In an effort to address this additional limitation, I decided to use documents alongside observational data to allow for comparisons to be made between the observer's interpretations of events and those recorded in relevant documents (May 1993: 133). It should be pointed out, that, as part of the CEP course requirement, each student was required to draw up a portfolio in which they were to track their reflections on the course. An effort was made to triangulate the reflections contained in the portfolios with the results of the focus group interviews and my own observations, to overcome the above limitation.

2.2.4 Documentary Research

Documentary research has gained favour amongst researchers throughout the years as an unobtrusive research technique. The positivist approach has traditionally been that of content analysis, which is typically quantitative and often includes counting the frequency with which certain themes or words appear (May 1993: 145). This approach was considered inappropriate for this research project given that it fails to take into account the deeper layers of meaning within the text. Within the interpretive tradition, the emphasis is on the subjective, socially-constructed nature of the document. The context in which the text was produced is of paramount importance in interpreting the meanings attached to the words appearing in the text or document.

The student portfolios can be broadly classified as documents, and their analysis as such requires that the rigour of documentary research be adhered to. These portfolios can further be classified as primary sources of documentary evidence, since 'they were written by those who actually witnessed the events which they describe' (May 1993: 136) and it is therefore 'assume[d] that they are more likely to be an accurate representation of occurrences in terms of both the memory of the author[s] and their proximity to the event' (*ibid*).

The students' portfolios provided a rich source of information about how each student had understood, or came to make sense of, his/her experiences during the CEP. They did not, however, provide information about how the students had collectively interpreted their shared experiences. As a result of this limitation, the purpose of using this research technique was to verify the interpretations derived from the focus group interview data and/or the observational data, and not to provide a standalone account as evidence of students' shared understandings.

The student portfolios were due for submission one month after the completion of the course, such that the students had enough time to critically reflect on their experiences. Although all students were encouraged, throughout the course, to record their immediate experiences and resultant thoughts and feelings, few students took up the recommendation. Platt (1981a) suggests that the inability of the author to 'record his [*sic*] observations immediately in a full and unambiguous system of notation' is one 'possible source of distortion which might affect one's general or particular confidence in an author' (p42). Most of the portfolios focus on the students' most vivid and lasting memories of their experiences, and concentrate on aspects of the students' experiences that they wished to recall. This raises yet another potential limitation on the research technique employed: these documents only provide the reader with the carefully selected highlights of the students' experiences, they do not provide a description of the students' (sometimes mundane, sometimes repetitive) daily experiences and how they shaped the students' understanding of their experiences.

A further limitation extends from the purpose for which the portfolios were written. According to May (1993: 139), 'documents do not independently report social reality, they are located within a wider social and political context. It is therefore important to examine the factors surrounding the process of its production, as well as the social context'. It should be noted that the student portfolios were produced as a course requirement for the purposes of summative assessment, and it would therefore be safe to assume the students' primary concern was that of meeting the assessment criteria against which their portfolio would be judged. In this context, when analyzing a student portfolio it is important to acknowledge that 'the author was seeking some practical advantage to himself [sic]' when writing the portfolio, and that this represents yet another 'possible source of distortion which might affect one's general or particular confidence in an author' (Platt 1981a: 42). It stands to reason then that the purposes for which the portfolios were written differs substantially from the purposes for which they were being analysed in this research project. Whilst the students were concerned with demonstrating that they had met the course requirements, I was concerned with trying to develop a deeper understanding of the students' experiences during the course.

2.3 Analysing, interpreting and presenting the data

After the research data has been collected the next step in the research process is the analysis and interpretation of that data. According to Stake (2000: 448) the modes of case study analysis, interpretation and presentation of data are no different than those of other qualitative research methods.

2.3.1 Analysis

Whereas in positivist research one can rely on tried and tested research instruments to collect data, and on proven statistical techniques to analyse the data, in interpretive research it is the researcher who is the primary instrument for both collecting and analyzing the data (Terre Blanche & Kelly 1999: 126). For this reason,

the interpretive researcher needs to justify and explain the methods of analysis employed in the interpretation of the research data.

As discussed above, the research data was collected using three different research techniques (viz. focus group interviews, participant observation and documentary research). The differences in the contexts and features characterizing these techniques necessitated the adoption of different methods of analysis.

In dealing with the focus group interview, particular attention needs to be paid to its central distinguishing feature, that is, the interaction between participants. In analyzing the patterns of interaction between the research participants, the researcher needs to be cognizant of the strong possibility that a participant's contributions were made in the context of an existing discussion or debate amongst a number of participants. Thus, for example, 'the emergence of a majority view will be, to some extent, a result of participants' reflections on the thoughts of others' (Smith 1999: 195). The different *types* of interactions between the participants – such as the types of questions they asked each other, or the occasions when participants deferred to the opinions of others or changed their minds (Kitzinger 1994: 114) – also require particular attention.

For the focus group interviews, the method of analysis advocated by Vaughn *et al* (1996: 103 - 113) was followed. This consisted of studying the interview transcript data until a series of conceptual categories emerged. This process was aided by the formation of data displays – a 'condensed mode' of the "full" data set – which help to focus the interrogation (Huberman & Miles 1994: 432). These categories were then further developed into theoretically informed themes. In other words, the data categories were compared with the concepts and theories that underpinned the study, allowing for the corresponding data to be used as empirical evidence to confirm or refute these concepts and theories. These themes were then in turn verified against the analyses generated from the participant observation and the documentary research techniques. Finally, the relationships between the revised themes were explored, and an attempt was made to create a coherent picture of these relationships.

Participant observation was used to access the context in which the students' meaningful experiences took place, by observing the students' interactions in their natural setting. It therefore seemed appropriate to use a method of analysis which would provide a 'thorough description of the characteristics, processes, transactions and contexts that constitute the phenomenon being studied, couched in language not alien to the phenomenon, as well as an account of the researcher's role in constructing this description' (Terre Blanche & Kelly 1999: 139). In other words, a theoretically informed method of analysis was called for, one which could produce a description of the real-life events and phenomena from a particular perspective.

The analysis of the documents referred to in the previous section focused on the subjective, socially-constructed nature of these documents. I deemed the method for the evaluation of historical data and information known as historical criticism, as suggested by Cohen *et al* (2000), as most appropriate. Historical criticism consists of two processes, namely external criticism and internal criticism. The former process sets out to appraise the relative 'authenticity or genuineness' of the document itself 'rather than the statements it contains' (Cohen *et al* 2000: 162). It is safe to assume, given the reflective nature of the contents of the students' portfolios, that it is highly unlikely that any of the documents were frauds, forgeries or hoaxes. Though the issue of plagiarism is an important one, an in-depth investigation into its frequency and effects are beyond the scope of this research project. The latter process, internal criticism, goes on to evaluate 'the accuracy and worth of the data contained' within the documents, suggesting that 'while [the documents] may be genuine, they may not necessarily disclose the most faithful picture' (*ibid*).

This second process speaks to some of the concerns discussed in section 2.2.4, viz. the selectivity of the accounts written were the result, in part, of the length of time that passed between when the experiences occurred and when they were recorded in the portfolios. The process of production was also heavily influenced by the purposes for which the portfolios were intended, viz. summative assessment. The ability to engage in internal criticism is, to some extent, affected by the quality of the data produced in the form of student portfolios. The varying quality of the data,

specifically with respect to the students' writing skills and their ability to critically reflect on their experiences, had a bearing not only on the selection of portfolios for analysis, but also on the specific aspects (of the students' recorded experiences) chosen for analysis.

As with the participant observations, the main purpose for analyzing the student portfolios was limited to the verification of the interpretations derived from the focus group interview data.

2.3.2 Interpretation

Positivist research tends to take the interpretation process for granted. It assumes that what has been objectively observed (using reliable research techniques) and analysed (using statistical processes) represents a true and valid reflection of reality, and should be reported as such. By contrast, interpretive research acknowledges the pivotal role that interpretation plays in the research process, and strives to make explicit the taken-for-granted processes that shape the understanding of a given phenomenon.

Ricoeur (1981 *cited in* Kelly 1999b) suggests that the understanding of a phenomenon needs to be developed both from the perspective of being in the context (in which a given phenomenon takes place) and from the perspective of 'distanciation'. The term distanciation is defined as 'the process of understanding a context from outside of that context' (p400). Thus, the process of understanding goes beyond the immediate context in which the research takes place (in this case, the university) to include broader social and political issues that have a bearing on the context of the phenomenon being investigated.

The process of developing an understanding of a phenomenon, from the perspective of being *in* the context, suggests a call for subjective (or inter-subjective) understanding. As discussed in section 2.1.2, this perspective was first advanced by the German sociologist Max Weber. He believed that social action should be

explained by means of the *interpretive understanding* of the actor's motives (Weber 1964: 128), and that interpretive understanding was composed of both observational understanding and explanatory understanding. Whilst observational understanding of the subjective meaning of a given act could be illustrated by watching a person, explanatory understanding provides the researcher with the knowledge of the actor's 'motives' for acting in particular way (Keat & Urry 1981:145 & 146). A motive, in turn, is described by Weber as a 'complex of subjective meaning which seems to the actor himself or to the observer an adequate ground for the conduct in question' (Weber 1964: 132).

Understanding a given phenomenon from *outside* of its context, can be said to involve the dual investigation of the context within which the research was conducted, and the context within which the phenomenon took place. The context of the research setting will have a direct bearing on the data generated. For example, the focus group interviews took place in a university lecturer's office as opposed to what could be categorized as a more student-friendly environment, such as a student residence or dining hall. This may have had the unintended effect of inhibiting some students from sharing their views, and/or inhibiting certain views from being shared, for fear of later being penalized by the lecturer, or faculty, for holding such views. Another example, involves the possible social relations inherent within pre-existing groups (Kitzinger & Barbour 1999: 9). The discussions taking place within such groups are likely to consist of numerous taken-for-granted assumptions that may be inaccessible to the 'outsider', that is, the researcher (Hassel & Hibbert 1996: 172), such as the significance of prior experiences in shaping the participants identity as final year undergraduate pharmacy students at Rhodes University.

As mentioned earlier, the context in which the research phenomenon took place relates to the broader historical, political and social issues concerning pharmacy education in post-apartheid South Africa, and an in-depth discussion of these issues can be found in chapter 3.

Though Ricoeur's method of interpretation is a particularly compelling way of approaching qualitative research, I would argue that it does not adequately account for one of the most critical components of the interpretation process, that is, the role of the researcher. It does not account for the fact that two researchers studying the same phenomenon, are likely to develop different interpretations, despite both using the method advocated by Ricoeur. I would argue further that the differences in interpretation are mainly due to the strong influence of the individual researcher's values, goals, concepts and theoretical framework on the entire interpretation process.

2.3.3 The role of the researcher

Huberman and Miles (1994) stress that qualitative researchers need to understand just how they are construing "theory" during the analysis and interpretation process. This theoretical construction will – consciously or not – inevitably influence and constrain data collection procedures, and the drawing and verification of conclusions (p434). Thus, the concepts and theories held by the researcher determine not only how the data are interpreted, but also the whole research process: starting with the subject matter, the topic and research questions chosen, and ending with the way in which the research is written up.

In the case of this research project, my experiences as the lecturer/course co-ordinator for the CEP over a period of three years had a profound effect on my decision to undertake the study. Similarly, my experiences as a practicing pharmacist in post-apartheid South Africa, alerted me to the complexities of the pharmacist role in society and some of the challenges facing the transformation of the profession. Both of these work-related experiences later gave rise to my contention that a potential relationship between the CEP and the changing pharmacy policy landscape existed, and that it needed to be explored from the students' perspective.

My participation in the didactic component of the Post-Graduate Diploma in Higher Education and Training course (PGDHET), presented by the Rhodes University Academic Development Centre (during 2000 and 2001), also affected the research process. The decision to focus on the educational aspects of the students' experience of the CEP was directly related to the concepts acquired whilst participating in the PGDHET. As chapter 3 will show, the PGDHET also served as a springboard for the subsequent development of my ideas concerning the existence of reality, knowledge, society and education. Once these ideas took shape, the ways in which the research data should be presented was considered.

2.3.4 Presentation of research data

Once the research data have been analysed and interpreted, the researcher is tasked with the responsibility of adequately justifying his/her interpretations to the larger research community. The problem, however, lies in demonstrating how the data supports the interpretations without overwhelming the reader by 'using extraordinary lengthy, crude and cumbersome means of presentation', yet providing 'the reader insufficient material with which to evaluate results' is equally problematic (Platt 1981b: 60).

I have chosen to present the data in a style which proceeds by way of illustrations chosen 'on principles which make them qualitatively representative of the whole body of data' (Platt 1981b: 61). These illustrations are in fact examples that cover both the range of meanings conveyed and their relative weight (in relation to the range of meanings). One of the disadvantages of using such an approach to represent the data is that its credibility relies all too heavily on 'an appeal to [the researcher's] authority or to the reader's trust in the author' (*ibid*), thereby lending credence to any suspicion that the author may have decided to 'embark on a self-fulfilling quest' where the evidence was selected purely on the basis of it conforming to his/her pre-formed ideas (Kelly 1999c: 424).

Representation of data generated from the focus group interviews has one added dimension that bears mentioning. Kitzinger (1994) has criticized a number of qualitative research studies using the focus group interview technique, for relying too heavily on isolated quotations from individual participants, and neglecting the central importance of using the interaction between research participants as part of the research data (p104). As a way of overcoming this criticism, Hassell & Hibbert (1996) suggest that extracts need to be of 'reasonable length to give some flavour of the group interaction' (p169), if they are to convey the inter-subjective context within which the participants' contributions are made.

2.4 Some key issues in research

The assertion that qualitative research offers knowledge about the social world which is not necessarily available by other means, involves making a privileged claim about the reliability of such research work. Actual research then becomes more than the simple replication of our opinions and prejudices: it either substantiates, refutes, organizes or generates our theories and produces evidence which may challenge not only our own beliefs, but also those of society in general (May 1993: 4). However, if such knowledge claims are going to have their desired effect, the research process needs to conform to certain conventions and rules that have been approved by the research community. These rules and conventions are sometimes referred to as research issues, and they include validity and research ethics.

2.4.1 Research validity

As discussed in section 2.1.1, interpretive and phenomenological thought emerged in opposition to positivism's preoccupation with social facts and institutions, and its exclusive reliance on empiricist epistemology. Interpretive researchers' rejection of positivist notions of what constitutes reliable and valid research must therefore be situated within the broader epistemological and ontological differences between these two scientific paradigms. It stands to reason then, that within each scientific

paradigm there are separate rules and criteria for ensuring research quality. Whilst positivists emphasize the criteria of reliability, internal validity, external validity and objectivity; interpretivists emphasize the need for the dependability, credibility, transferability and confirmability of research findings.

2.4.1.1 Reliability / dependability

Within the positivist paradigm, the concepts of reliability and validity are central to the establishment of the truthfulness and credibility of research findings. According to Neuman (2000: 164) reliability in essence means 'consistency'. Applied to qualitative research, it refers to the ability of a research technique (when used by two different researchers or one researcher on different occasions) to consistently yield the same findings under an identical set of conditions. Provided that the researcher plays the role of the objective, neutral observer, the research technique can be designed to reliably yield the same findings under the same set of conditions. If different findings emerge, then the problem lies with the way in which the research technique was designed.

Such a concept of reliability, however, is clearly premised on the experimental research techniques applied within natural science. It presupposes that social reality is somehow fixed and unchanging, and thus conducive to the replication of investigations into a given social phenomenon. Interpretative researchers find the very idea of replication within the social world, problematic (Marshall and Rossman 1989 *in* Silverman 1993: 146). Human history is composed of unrepeatable phenomena (Hamilton 1974: 91), and individuals are expected to act differently and attach different meanings to their actions, in diverse contexts. It is thus inconceivable that a set of conditions could remain constant over time.

Interpretive researchers also differ in their understanding of the role of the researcher in the research process. It is considered misleading to claim that the researcher has no influence on the construction of his/her research findings (for a more in-depth discussion refer to section 2.3.3). As a result, it is highly improbable

that any two researchers using the same research technique could produce the same findings. These two reasons (namely, the problematic idea of the replication of phenomena within the social world; and the existence of the objective, dispassionate researcher) render the concept of reliability meaningless within the interpretive paradigm.

Instead, interpretive researchers use the concept of dependability as a criterion for ensuring consistency within the research (Janse van Rensburg 2001b: 9).

Dependability refers to 'the degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did' (Durrheim & Wassenaar 1999: 54). It is achieved through rich and detailed descriptions that show how certain actions and opinions are rooted in, and developed out of, contextual interaction (*ibid*). Chapters 3,4 and 5 within this dissertation are dedicated to demonstrating how an acceptable standard of dependability has been applied to this research project.

2.4.1.2 Internal validity / credibility

Validity, within the positivist paradigm, refers to the degree of fit between reality and research conclusions (Janse van Rensburg 2001b: 7). The underlying ontological assumption is that through scientific scrutiny researchers have direct access to a single immutable reality. Research conclusions can, and therefore must, provide a true reflection of this stable, external reality.

There are a number of ways in which validity can be expressed within positivist research (Neuman 2000 & Cohen *et al* 2000). However, for the sake of simplicity I have chosen to concentrate on the most commonly used validity checks within qualitative research, which I consider to be internal validity and external validity.

Internal validity checks the internal consistency of the research project (Janse van Rensburg 2001b: 6), and is closely related to another type of validity known as construct validity. A construct refers to the way a researcher conceptualizes an idea in a conceptual definition (Neuman 2000: 164), and how well it matches 'actual

reality' is an indication of its truthfulness, or validity. A research project in which there is a good fit between the constructs a researcher uses to describe, theorize, or analyze the social world, and what actually occurs in the social world, is considered highly credible (*ibid*). Again this approach is premised on the predictive techniques associated with natural science experimentation, and is extremely problematic in its application to the world of social interaction.

By way of illustration, if this research project were to employ the concept of internal validity, one of its checks would consist of an assessment of whether the research techniques did in fact "measure" the students' understanding of the changing role of the pharmacist in South Africa. If the research technique in fact measured the students' intention to please their lecturer - in an effort to obtain good marks at the end of the course - then the research project would be said to have low internal validity, and its findings would lack credibility. However, since this research does not set out to measure students' perceptions, nor to treat these perceptions as truth statements about the students' experiences, establishing high internal validity as a measure of research quality or credibility is not necessary for the purposes of my research.

Though interpretive researchers may reject the positivist concept of internal validity and the underlying assumption that it measures the truth-value of research findings, they are nonetheless committed to establishing the credibility of their findings. Silverman (1993) has suggested two specific strategies for ensuring the internal consistency and credibility of research findings, which he deems particularly appropriate for the logic of qualitative research. These are triangulation and respondent validation (p156).

Triangulation can be defined 'as the use of two or more [techniques] of data collection in the study of some aspect of human behaviour' (Cohen et al 2000: 112). Sections 2.2.2 to 2.2.4 above provide a detailed account of how different research techniques were used to collect the data. It has been acknowledged in the literature (Huberman & Miles 1994) that the idea of several research techniques converging

unproblematically to provide a more comprehensive and credible picture of a phenomenon, is difficult to emulate in practice. The focus group interview data presented in this research do not merge seamlessly with participant observations nor with the written records. Silverman (1993: 158) suggests that this is a function of trying to counterpose different contexts, and ignoring the context-bound and skilful character of social interaction. Consequently, triangulation should be viewed as a mode of inquiry. 'By self-consciously setting out to collect and double-check findings, using multiple sources and modes of evidence, the researcher will build the triangulation process into ongoing data collection' (Huberman & Miles 1994: 438).

Respondent validation¹³ is a process whereby the researcher reports back on findings to the research participants. If the participants verify these findings then the researcher can be more confident in their validity (Silverman 1993: 156). This process was applied during the course of this research approximately three months after the data was initially collected, at which point the students expressed satisfaction with my interpretations of their responses.

2.4.1.3 External validity / transferability

The concept of external validity has been used by positivists to refer to the ability to generalize from a research project to a wider population (Janse van Rensburg 2000b: 7). Since positivist researchers are chiefly concerned with the establishment of universal social laws about human affairs, the ability to apply the research findings to a broad range of settings and people is considered another important criterion for establishing quality.

Interpretive researchers, on the other hand, believe that meanings are highly variable across contexts of human interaction, and thus do not seek to generalize their findings. Instead they argue that research findings should be *transferable* from one context to another (*ibid*: 9). Transferability is achieved by providing detailed and rich descriptions of contexts. These descriptions serve to illuminate certain

¹³ Also referred to as member checks.

understandings about the structures of meaning which develop in a specific context, and such understandings can be transferred to new contexts in other studies (Durrheim & Wassenaar 1999: 63). Refer to chapters 3 and 4 for a detailed description of the contexts encircling this research project.

2.4.1.4 Objectivity / confirmability

As discussed earlier, 20th century positivists believed that science should concern itself with discovering the truth about the social world via untainted observations. In order to access this truth, social scientists should approach the subject matter in an objective, neutral manner – free from the influence of values, commitments, theoretical perspectives, or worldviews (Taylor & Bogdan 1998: 161). This view is premised on the belief that the discovery of the ‘truth’ is only possible on the basis of the principle of value freedom.

A value is a belief that something is good and desirable. It defines what is important, worthwhile and worth striving for. Values also concern what we would like our experiences to be (May 1993: 34). Value freedom, by contrast, refers to the ability to make judgements about a particular state of affairs without the influence of personal beliefs and associated experiences. Objectivity, as defined by positivists, therefore involves the suspension of a researcher’s personal belief system such that the facts under investigation can be uncovered.

Interpretivists have rejected this empiricist model of objectivity. They assert that the equating of objectivity with value freedom is mistaken. Amongst other things, this approach fails to acknowledge the theory-laden nature of the process of making observations in the first place (Chalmers 1982). Interpretivists believe that ‘both the selection of a subject matter to study and the choice of a theoretical perspective to direct its investigation inevitably depend upon value-judgements’ (Jones 1991: 109). From this point of view, value-judgements affect every aspect of the research process.

Nevertheless, this does not mean that objectivity is impossible. Objectivity is still possible if researchers openly acknowledge the values and theoretical assumptions that direct their research. This allows the reader to judge a researcher's choices from the point of view of the reader's own values and theoretical assumptions (*ibid*). Consequently, within interpretivist research the focus (of efforts made to ensure the validity of research findings) has shifted towards the establishment of confirmability. This is defined as 'the degree to which the [research] findings are the product of the focus of the inquiry and not the biases of the researcher' (Babbie *et al* 2001: 278).

Some of the strategies for ensuring confirmability within qualitative research include the devices of reflexivity and triangulation (Janse van Rensburg 2001b: 9). Reflexivity suggests that researchers should acknowledge and disclose their own selves in the research (Cohen *et al* 2000: 141), viz. their interests and their values; whereas triangulation refers to the combination of two or more data collection techniques to ensure the credibility of qualitative research findings. The reader should refer to section 2.3.3 for an account of how my experiences helped to shape this research project. Section 2.4.1.2 provides a discussion on how triangulation was used in this research project.

2.4.2 Research ethics

In its broadest sense, the term ethics suggests 'a set of standards by which a particular group or community decides to regulate its behaviour – to distinguish what is legitimate or acceptable in pursuit of their aims from what is not' (Flew 1984: 112). Within social research such legitimate or acceptable behaviour is not limited to the execution of specific activities. Instead, a social researcher can be said to have acted ethically during the course of a research project when research decisions have consistently been based on ethical principles rather than expedience (May 1993: 42). It must be noted, however, that ethical principles to a large extent reflect the values of a given society at a particular point in time. One such value concerns the principle of sensitivity to the rights of others. When applied to research, this principle requires that the ethical researcher safeguards research participants' rights to privacy and

dignity throughout the research process. However, this principle has often resulted in tension with the Enlightenment scientific value of the pursuit of truth.

Ethical researchers have to constantly balance the conflicting ethical values of free scientific inquiry in pursuit of truth and knowledge; and the dignity of individuals (Cohen *et al* 2001: 58). This has resulted in an ongoing debate about whether scientific discoveries resulting from free scientific inquiry justify the harmful and detrimental treatment of research participants.

Ultimately there is no agreed theory of research ethics (Bulmer 1987: 21).

Researchers' responses to ethical issues spread across a continuum, the poles of which can be categorized into two dichotomous approaches – the absolutist and the relativist position (Cohen *et al* 2001: 58). The approaches are closely aligned with the ontological assumptions underpinning various research paradigms (see section 2.1).

The absolutist view holds that clear, set principles should guide researchers in their work and that these should determine what ought and what ought not to be done (*ibid*). Such a view is based on the premise that research ethics should take on a universal form, and that a set of universally applicable principles should be followed regardless of the place and circumstances in which the researchers find themselves (May 1993: 42). This view of research ethics is consistent with the positivist epistemology which regards the pursuit of knowledge, and ethical conduct during the research process, as synonymous. Both depend on the researcher's objective observation of external facts as part of a process of uncovering the 'laws' of nature and society. In positivist terms, the idea of research ethics is equated with the principle of research objectivity (see section 2.4.1.4 for a discussion of objectivity).

By contrast, the relativist position holds that there can be no inviolate ethical rules that apply universally. Proponents of this approach believe that such rules do not take into account the specific research context, and may result in undue restrictions on the researcher's activities and creativity. Instead researchers should be guided by the situation in which they find themselves, and their ethical decisions should be

guided by the consequences of their actions (*ibid*: 42 & 43). This approach underpins the interpretivist perspective, which holds that human history is characterised by unrepeatable phenomena which cannot be inductively formulated into generalizable social laws (Hamilton 1974: 91). Since each research context contains peculiarities and sets of meaning-complexes that are unique to that context, ethical decisions should remain within the subjective domain of the researcher's own value judgements.

The relativist position is not without its critics, who have maintained that a 'loose and flexible system of "anything goes" ethics can so easily open the door to the unscrupulous' (May 1993: 43).

As mentioned, these two positions represent the two extremes on the continuum of views on how researchers should respond to ethical dilemmas. My sympathies lie with those commentators who have advocated a more measured approach where ethical principles are used to guide, but not constrain, the researcher's conduct. For proponents of this approach, ethical decision making in research is a matter of both individual judgement and professional guidance (Bulmer 1987: 21). Individual judgements should not go unchecked, and should be subjected to reflexivity (discussed in section 2.4.1.4). In particular they should be informed by a clear set of institutional/professional ethical standards (such as the Rhodes University Ethical Guidelines 2005).

2.4.2.1 Informed consent of research participants

Each stage in the research process presents a potential source of ethical problems (Cohen *et al* 2001: 49). This is particularly the case at the start of the process when the researcher tries to ensure access to, and participation by, research participants. Frequently, researchers must gain access through a 'gatekeeper' (Terre Blanche & Kelly 1999: 136), or obtain permission from some other authority, with a vested interest in the outcome of the study. This raises a major ethical dilemma for the researcher who has to weigh up the need to satisfy the requests of gatekeeper (in

order to access the participants, and ultimately conduct the study) and the need to freely pursue the study devoid of 'internal politics' and interference. Since I was a lecturer in the Faculty of Pharmacy, and was the course co-ordinator for the CEP, I had direct access to the students (who would later become research participants) on a regular basis. For this reason, obtaining access to the students in order to request that they participate in the research study was not problematic.

The general ethical dilemma normally encountered at the recruitment and participation stage of a social science research project relates to the tension between the participants' rights to freedom and self-determination, and the researchers' interest in access to personal information that may form the basis for their scientific investigation. With few exceptions, it is generally considered unethical for a researcher to make it compulsory for individuals to participate in a research project. Such an action would constitute an infringement of their rights to freedom and self-determination. In addition, it is considered equally unethical for the researcher to withhold any information that could have a bearing on whether or not an individual may choose to participate in a research project.

The Rhodes University Ethical Guidelines (Rhodes University 2005) set out very clear recommendations for ensuring that the abovementioned rights are protected. The guidelines recommend that all potential research participants should be provided with adequate information about the study, as well as the risks and benefits associated with participating in the study. This ensures that they are 'fully informed' of what their participation entails when they consent to participate in the research study. Furthermore, the guidelines stipulate that the participants' rights to privacy should be realized by guaranteeing the anonymity and confidentiality of information provided by the participants. Undertakings in respect of all of the above, should be verbally communicated to all the potential research participants, and presented in writing as part of the consent form.

Informed consent has been defined by Diener and Crandall (1978 *in* Cohen *et al* 2001) as 'the procedures in which individuals choose whether to participate in an

investigation after being informed of facts that would be likely to influence their decision' (p51). This definition encompasses the principle of voluntary participation in which 'participants can freely choose to take part (or not) in the research and guarantees that exposure to risks is undertaken knowingly and voluntarily' (*ibid*). The ethical norm of 'no harm to participants' is also formalized in the concept of informed consent (Babbie *et al* 2001: 522), and this ensures that no information that would embarrass or endanger the participants is revealed.

In line with the Rhodes University Ethical Guidelines outlined above, I made a presentation to the entire fourth year pharmacy class prior the commencement of the CEP course. The presentation consisted of a brief explanation of the intended research project and the need for a consent form. Every effort was made to ensure that those students who later volunteered to take part in the project, were sufficiently versed in the purpose and aims of the project to provide fully informed consent. It was also made clear during the course of this presentation that the students did not have to participate if they did not wish to do so, and that non-participation would not prejudice them in any way. I informed the students that the information they provided would be treated in the strictest of confidence, and their anonymity would be guaranteed in the publication of the research findings.

The students who had agreed to participate in the research project were then asked to fill in a written consent form (see Appendix 2). This form consisted of a brief account of the purpose of the research, an explanation of the extent of the students' participation, and a brief description of what the findings would be used for. It went on to explain that the research findings would first be presented to the participants for comment, before being published; and that the students were free to withdraw their participation at any point during the research process.

The consent form can in most instances be viewed as a contractual obligation by the researcher to demonstrate sensitivity to participants' right to privacy with regard to the information being given, and the manner in which such information is disseminated. The greater the sensitivity of the information (whether real or

perceived), the more safeguards are required in order to protect the privacy of the research participants. Ensuring participants' right to privacy when it comes to the dissemination of information, involves rendering it virtually impossible for the reader to match personal information with the identity of the research participants (Cohen *et al* 2001: 61). Anonymity and confidentiality are two widely accepted methods of ensuring participants' rights to privacy.

A participant may be considered anonymous when the researcher cannot identify a given response with a given participant (Babbie *et al* 2001: 523). In effect, this means that a focus group interview participant can never be considered anonymous, since the interviewer collects the information from an identifiable participant. However, anonymity of information must be ensured once the findings are published.

In this research project, anonymity of information was achieved by removing all identifying information (such as students' names and registration numbers) from the research data during the analysis and interpretation phase of the research process, and replacing it with the researcher's own identifying information (such as 'student number one'). A master identification file that linked the numbers to the names was stored in a locked cupboard for safekeeping. Except for this master identification file, all potentially identifying information was removed from all text-based documents. Only the voice recordings on the focus group interview cassette tapes remained, and these tapes were locked away together with the master identification file.

As suggested above, confidentiality is another way of protecting a participant's right to privacy. Here the researcher is aware of which participant has provided the information, but undertakes not to publicly reveal the participant's identity (Cohen *et al* 2001: 62). With regards to this research project, confidentiality was pledged at the start of the project – during the recruitment process – and again at the start of the focus group interview.

During the report back session (discussed in section 2.4.1.2), which took place three months after the data were initially collected, the participants were presented with

the preliminary research findings and an explanation of how the data had been represented in an effort to safeguard their confidentiality.

2.4.2.2 Addressing power relations between researcher and participants

Discussions of the ethical issues that may arise within social research frequently lead to a consideration of the power structure within which the research process operates (Bulmer 1987: 19). The existence of power relations between the students (research participants) and myself (the researcher) were apparent throughout the research process.

During the data collection phase I remained acutely aware of the power that I held, in relation to the students, not only as a researcher but also as the students' lecturer, course co-ordinator, and assessor. Consequently, I constantly reflected on questions such as: Were the students' interactions tailored according to their perceptions of what was considered appropriate behaviour for assessment purposes? Did the students take their roles more seriously once they discovered that their interactions formed part of a research project? How critical could the students be of the course if the researcher was in a position of power?

These concerns also informed my approach to the students during the focus group interviews, where the roles of researcher and participant appeared to be more formal. Upon reflection, the research setting in which the interviews were being conducted, viz. my office in the Faculty building, must have served to reinforce those power relations. However, Kitzinger and Barbour (1999) have suggested that focus group interviews may in fact have the effect of reducing the power differential between the researcher and participants. They believe that focus group interviews offer the possibility of fostering a sense of 'collective identity' amongst the research participants in 'opposition to the researcher' (p14). In contrast to one-to-one interviews, focus group interviews harness the interactive potential amongst participants and as such have the potential to 'shift the balance of power in favour of the participants' (*ibid*: p19).

I would argue that it is unrealistic to believe that one can completely eliminate the power relations that exist in any given research setting. However, during the course of the research every effort was made to acknowledge this power relation with research participants, and to safeguard their rights to privacy (and to avoid any form of detriment) in the manner detailed above. This included obtaining their informed consent to participate in the research process, and providing the students with a written undertaking to ensure the confidentiality of their identities and the anonymity of their remarks.

Having explicated the philosophical assumptions underpinning the research described in this thesis and the practical methods employed in the research process, the next chapter will provide a theoretical framework for the research.

Chapter 3

A THEORETICAL FRAMEWORK FOR THE RESEARCH

In the previous chapter I set out a number of philosophical divisions around the relationship between ontology (what exists), epistemology (how we obtain knowledge) and research methodology. In this chapter I set out to illustrate how these same ontological and epistemological disputes have shaped divisions between social theorists about how to explain social phenomena and about what the proper unit of social analysis should be.

This chapter offers an illustration and critique of the two main theoretical approaches to social theory, namely structural-consensus theory (informed by positivist assumptions) and micro-interpretivist theories (informed by neo-Kantian assumptions). It also provides a critical evaluation of the application of each of these theories to the broad social phenomenon of education and to the specific fields of medical and pharmacy education. The chapter proceeds to offer an alternative account of social theory to that offered by either structural-consensus or micro-interpretive approaches. I adopt a neo-Weberian approach to the study of educational systems advanced by English social theorist (and educational theorist) Margaret Archer¹⁴.

The chapter starts off with an account of the influence of positivist philosophical assumptions on the structural-consensus social theorists, and the resultant efforts of theorists associated with this approach to explain education (including Emile Durkheim, Talcott Parsons and Robert Merton). Since positivists believe that the only source of knowledge is experience, they assume that only those things that are open to direct observation in society are real. This excludes the motivations and beliefs of individuals in favour of a focus on observable patterns of social behaviour, which

¹⁴ This chapter draws heavily on Archer's earlier work within the field of the sociology of education between the period 1971 and 1981. Archer's subsequent work in the area of general sociology - for example, her book entitled *Culture and Agency* first published in 1988 - follows a critical realist perspective. Her later ideas have not been used in this thesis.

take the form of social institutions. An account of the role of the social institution of education, in particular the function it plays in socializing students into their future professional roles, is illustrated with reference to medical and pharmacy education and critically evaluated.

The chapter then provides an alternative account of the social phenomenon of education from the point of view of micro-interpretive social theory. This perspective is informed by neo-Kantian assumptions which emphasize subjective experience as the source of knowledge. For this reason only individuals and their subjective meanings and motivations are deemed to be real. Social phenomena, such as educational institutions, are reducible to the individuals and the beliefs of these individuals which make up the educational system. The views of theorists associated with this perspective (including Alfred Schutz and Harold Garfinkel) are illustrated in their application to medical education and critically evaluated.

In opposition to both of these approaches, the chapter then provides an account of the neo-Weberian approach to social theory advanced by Margaret Archer. Archer believes that it is equally important to stress the purposeful action of human beings (the motivations of individuals for acting or behaving as they do) as well as the social and historical contexts of their actions.

From this perspective an adequate explanation of the social phenomenon of education must explain the macro-element of the structural conditioning of educational interaction and the micro-element of the influence of individual action on bringing about changes in educational systems (viz. structural elaboration or morphogenesis).

This theoretical framework provides the basis for an examination of the pharmacy education system in South Africa using Archer's approach in the next chapter.

3.1 Structural-consensus theory

Structural-consensus theory is founded on the assumption that peoples' actions are structured by their social environment. The values and attitudes that people hold, and the activities and relationships they produce, are seen to be the result of, or at least to be greatly influenced by, the organization and structure of the society in which they live (Cuff & Payne 1984: 24). Furthermore, it is assumed that there is agreement between people in society – or a *consensus* – about what constitutes appropriate behaviour and beliefs (Jones 1991:7). Without such a consensus human society would not survive, social order would disintegrate and chaos would prevail. In these terms, proponents of this theory are more concerned with the organization and structure of society than with individuals and their subjective meanings and experiences. Moreover, structural-consensus theorists are particularly interested in uncovering how social institutions (such as the family, religion, education, economics and politics) serve to maintain shared values and beliefs within society.

For structural-consensus theorists then, people do not choose to believe the things they believe or choose to act in the way they act. They learn to think and engage in action as a result of the influence of external social institutions. Pre-existing cultural rules shape their ideas and behaviour through socialization. Thus, in the same way as natural phenomena are the products of the external laws of nature to which they are subject, so peoples' ideas and actions are caused by the external social institutions to which society is subject. Because of this similarity between the two kinds of subject matter (viz. nature and society) structural-consensus theorists argue that the means by which they should be investigated should also be similar, i.e. observation of external facts, and the deductive explanation of such facts.

3.1.1 Emile Durkheim

This connection between structural-consensus theory and positivist method was most powerfully articulated by the classic consensus theorist, Emile Durkheim (1858 – 1917) (Jones 1991: 83). I have already indicated in Chapter 2 how Durkheim's

positivist injunction to treat 'social facts as things' resulted in his ontological focus on social institutions.

In his work entitled *The Rules of Sociological Method* (1938), Durkheim rejected the suggestion that the social world could be investigated by reference to non-observable phenomena (such as an actor's internal motives and feelings). For Durkheim, societies constituted their own reality which could not simply be reduced to the action and motives of individuals. In Durkheim's terms 'whenever certain elements combine, and thereby produce, by the fact of their combination, new phenomena, it is plain that these new phenomena reside not in the original elements, but in the totality formed by the union' (Durkheim 1938: xlvii). Since societies, or rather social institutions, have an existence independent from the individuals that constitute them, social theory should not concern itself with individual human motivations. Individuals are moulded and constrained by their social contexts.

Durkheim used education as an example of how social institutions shape individuals' actions:

'all education is a continuous effort to impose on a child ways of seeing, feeling and acting which he could not have arrived at spontaneously. From the very first hours of his life, we compel him [*sic*] to eat, drink, and sleep at regular hours; we constrain him to cleanliness, calmness and obedience; later we exert pressure upon him in order that he may learn proper considerations for others, respect for customs and conventions, the need for work, etc. If, in time, this constraint ceases to be felt, it is because it gradually gives rise to habits and to internal tendencies that render constraint unnecessary; but nevertheless it is not abolished, for it is still the source from which these habits were derived... What makes these facts particularly instructive is that the aim of education is, precisely, the socialization of the human being; the process of education, therefore, gives us in a nutshell the historical fashion in which the social being is constituted. This unremitting pressure to which the child is subjected is the very pressure of the social milieu which tends to

fashion him in its own image, and of which parents and teachers are merely the representatives and intermediaries' (Durkheim 1938: 6).

For this reason, Durkheim asserts that social researchers should focus their attention on 'social facts' such as the moral systems, social institutions, customs and popular opinions that prevail within society, rather than on the subjective meanings of individuals. Although these facts consist of shared values, they are observable through their influence on peoples' behaviour. Once identified, social facts should then be treated like 'things in nature' (Durkheim 1938: 1-13).

In explaining social facts investigators should first find their *causes* and then attempt to ascertain their *functions*, that is, the part they play in helping to maintain consensus and an orderly society. In their search for these causes, researchers should look for those social facts which precede and seem to produce the particular social facts under investigation. In this regard, Durkheim can be seen to employ the same concept of causality as David Hume (1748). Causes are interpreted as 'habits' arrived at on the basis of experience which are open to empirical investigation. For example, the existence of the Church (a social institution, and therefore a social fact) could be said to precede and produce the Christian beliefs (another social fact) held by individual members of society. In the search for functions, the researcher should look to the general needs of society (Cuff & Payne 1984: 36).

In an attempt to illustrate how consensus within society is maintained, Durkheim drew on the social institution of education. Since the content of education varies from society to society, and from time to time, Durkheim concluded that it was impossible, by the use of reason alone, to specify what the content of education ought to be. Researchers should investigate the structure and needs of society through established empirical research techniques (such as the use of structured surveys to produce statistical correlations) which serve to illustrate the role education plays in maintaining society's value consensus. This would demonstrate that education (an antecedent social fact) is a means to an end. But the end is pre-determined by society, not by the individuals being educated or by the teachers and educational

administrators. The prime function of education is not to develop the individual's abilities and potentialities for their own sake. Rather it is to develop those abilities and capabilities required by society. For this reason, according to Durkheim, it was not important in earlier educational systems to promote scientific or rational thinking; but, as such thinking is essential in modern society, it is now developed in pupils in schools (Blackledge & Hunt 1985: 13).

In summary, the characteristic features of Durkheim's functionalist analysis are therefore:

1. An interest in the *effect* of an activity or belief (viz. a social fact) rather than its constituent *ingredients*, i.e. what it *does* rather than what it *is*
2. A stress on the need to often go beyond peoples' own explanations for their activities in order to reveal the true functional significance of institutionalized behaviour and belief (Jones 1991: 28).

3.1.2 Talcott Parsons

Functionalist analysis as a form of sociological explanation was further developed by the 20th century sociologist and American functionalist Talcott Parsons (1902 – 1979). Parsons produced a theory of society in which culture, social structure and personality are linked together into a logical system (Blackledge & Hunt 1985: 67). He believed that society as a whole could be viewed as a system, much like a biological organism. If the human body is used as an example of a system, it can be seen as having certain needs, for example food, and a number of inter-related parts (the digestive system, the endocrine system, the circulatory system, etc) which function to meet those needs. Much like Durkheim, Parsons sees a social system as having needs which must be met if it is to survive in an orderly fashion, and a number of parts which function to meet those needs (Craib 1984: 39).

Parsons went on to differentiate between three systems of society, which he called cultural, social and personality systems. The broad values shared by the members of

society constitute the most important part of the cultural system. The social system, by contrast, is a structure made up of social roles (such as wife, student, pharmacist, etc). Lastly, Parsons viewed the personality system as composed of the individual's motives and needs (Blackledge & Hunt 1985: 71). He believed that these shared values served to unite society and maintain social order, and that the behaviour of the actors of social roles was the direct result of a consensus around these values. This in turn led to cooperation and stability within society (Romm & Sarakinsky 1994: 197).

Parsons argued that there was a hierarchy of control between these systems, that is, the cultural system controls the social system which in turn controls the personality system. In other words, culture determines the nature of the social structure, and individual personalities are shaped in accordance with the demands of their culture and of their social roles. More specifically, the broad values of society define the roles the individual has to play. The problems and choices faced by an individual during his/her life are solved by reference to the moral standards of the cultural system. What individuals are expected to do in their positions in society – their role-expectations – is defined by society's moral standards (Blackledge & Hunt 1985: 72). It is through the process of socialization that individuals internalize the social values of the cultural system and expectations regarding their specific roles (Romm & Sarakinsky 1994: 204).

In order for society to remain in a state of equilibrium, Parsons identified four functional pre-requisites that need to be met on an ongoing basis. These are: adaptation (meeting the physical needs of its members), goal attainment (directing its members toward meeting common goals), integration (establishing mechanisms to reduce and manage conflict) and pattern maintenance (institutionalizing the basic patterns of values in a society) (Craib 1984: 39).

Parsons suggests that a distinction can be drawn between the fundamental value system characterising modern industrialized society and that which prevailed in traditional societies. These value systems shape the norms, tasks, roles and

institutions of the society and ensure its cultural integration and stability. He refers to these systems as pattern variable 'A' and pattern variable 'B'. The former is primarily concerned with expressive values and norms emphasizing 'emotional' satisfaction, while the latter is concerned with 'instrumental' values and norms emphasizing the achievement of goals and accomplishment of tasks.

The difference in value orientation between these pattern variables (i.e. pattern variable 'A' versus pattern variable 'B') can be summarized in the following opposing values: ascription (personal characteristics – such as status or role) versus achievement (based on merit); diffuseness (broad relationships or obligations – such as that between mother and child) versus specificity (specific obligations such as those between pharmacist and patient); particularism (criteria for evaluation particular to certain groups) versus universalism (generally applicable principles – such as equality before the law); affectivity (immediate emotional gratification) versus affective neutrality (deferred gratification); and, collective orientation (pursuing communal interests) versus self-orientation (emphasizing individualism) (Cuff & Payne 1984: 51).

Parsons saw education, along with the family and religion, as a major socializing agency. He believed that education's primary function was to develop in individuals the commitments and capacities deemed essential for their future role-performance. Education must develop within individuals a commitment to society's broad values and to the performance of a specific type of role conducive to maintaining the needs of society (Parsons 1961: 435).

Social institutions such as the educational system serve to maintain the integration of society by ensuring the socialization of its members into values associated with pattern variable 'B'. This differs from the socialization role of the family, which emphasizes values associated with pattern variable 'A'.

Although there is no reference to Parson's social theory being applied to the professional role of the pharmacist in society, he did apply his views more broadly to

the medical profession. Parsons (1972) sees medical institutions as providing a key illustration of how the harmonious interrelationship of the social roles of doctor and patient contributes to the effective functioning of social institutions.

Parsons' functionalist approach infuses his very definition of health and illness, and shapes his account of the role played by medical professionals. He defines health as the capacity of an individual to effectively perform 'the roles and tasks for which he [*sic*] has been socialized', whereas he defines illness as the inability or 'disturbance of the capacity' of the individual to perform this role (Parsons 1972: 107). In his functionalist terms, illness is deemed to be 'undesirable' and is stigmatized such that the 'sick person is prevented from setting an example which others might be tempted to follow' (*ibid*: 108).

Parsons' account of the role of the health professional (particularly the medical doctor) is defined in response to - or out of the need to - contain, control and manage the 'sick role'. He offers five criteria for defining the sick role. These are: a disturbance in the capacity to fulfill social role expectations; an exemption from role-obligations; a judgment that the patient is 'not responsible for his [*sic*] state'; a conditional legitimation of this state; an 'acceptance of the need for help' by the sick person and 'of the obligation to cooperate with the source of help' (*ibid*: 112).

In these terms the role of "illness" places patients in a passive position of dependency on persons who are not sick. By contrast, the medical practitioner performs the socially powerful role of employing the empirical conventions of medical science in order to 'legitimize' the patient's exemption from their social role performance. For Parsons 'where scientific evidence is not available' (*ibid*: 113) it is the role of the medical professional to expose the supposed illness of 'malingerers' and other anti-social individuals as illegitimate. In this manner health professionals perform an important role in maintaining social order and control.

3.1.3 Robert Merton

Whilst the significance of educational socialization in ensuring the reproduction of the role played by medical professionals remained largely implicit in the work of Parsons, this socialization process was explicitly addressed in the work of Robert Merton, America's second most prominent structural-functionalist. In a book on the sociology of medical education, Merton defines socialization as a 'process by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short, the culture – current in the groups of which they are, or seek to become a member' (Merton *et al* 1957 in Hammer *et al* 2003: 9). Merton applies this definition to the medical profession and uses the term 'professional socialization' to describe the transformation of medical students to physicians.

According to Merton the medical profession has its own 'normative subculture'. It has a body of shared ideas, values and standards 'toward which members of the profession are expected to orient their behaviour'. These norms and standards indicate what is 'prescribed, preferred, permitted, or proscribed' by the medical profession. The function of the medical school is 'to transmit this subculture' to successive generations of medical students (Merton 1976: 65).

Medical education enables student physicians to 'blend' seemingly incompatible norms into functional and 'stable patterns of professional behaviour'. Amongst the norms and values governing the medical professional's self-image and relationship to patients, Merton includes: a disciplined approach to the scientific appraisal of evidence; detailed knowledge requiring specialized education; a strong moral character; a commitment to advance medical knowledge; and, an emotionally detached attitude. At the same time, however, medical professionals are also expected to come to know their patients as persons and to give 'substantial attention to their psychological and social circumstances' and to participate in communal life. It is the 'function' of the medical school to socialize medical students and provide them with the ability 'to blend these potential opposites into a stable pattern of professional behaviour' (*ibid*: 68 & 69).

This functionalist and positivist approach to medical education, with its emphasis on the impartiality and scientific objectivity of the dispassionate professional, has dominated the teaching and training of doctors and pharmacists since the 1950s.

3.1.4 A functionalist analysis of pharmacy education

From the point of view of those applying a positivist and structural-consensus approach, socialization in pharmacy schools concerns the transformation of students into pharmacists through a process of learning to abandon old roles and self-conceptions in the process of acquiring new scientific (i.e. empiricist) ones. Despite being challenged by interpretive approaches to pharmacy education (such as Shuval 1981 and Rothmann *et al* 1998), the influence of the positivist and functionalist approach over the education of young pharmacy 'professionals' remains strong. In a recent call to action by Hammer *et al* (2003), pharmacy administrators and faculty practitioners in American universities are enjoined to improve student professionalism by resuscitating Merton's concept of professional socialization. In these terms, pharmacy socialization is seen to involve:

'the transformation of individuals from students to professionals who understand the values, attitudes, and behaviours of the profession deep in their soul. It is an active process that must be nurtured throughout the professional's/ student's development. In pharmacy the socialization process begins the moment a student (or potential student) observes or interacts with pharmacists, evaluates what they do, or actively seeks information about the profession. Beliefs, attitudes, and behaviours begin to develop with regard to pharmacists' roles' (Hammer *et al* 2003: 9).

From this point of the view, the process of professional socialization is seen as relatively smooth and orderly, and the role of the student in the process is viewed as being the passive recipient of external norms and values. During their years in pharmacy school, students gradually learn a common body of professional ideas and standards that are internalized "thoroughly" so as to continue in the future to regulate

a stable pattern of behaviour, thus ensuring conformity to professional norms during later practice (Shuval 1981: 30).

Contemporary advocates of the functionalist approach to pharmacy education, such as Hammer *et al*, assert that the pharmacy profession is characterized by the following traits:

- It provides socially necessary and important functions
- It encompasses a body of specialized knowledge and skills requiring advanced theoretical training
- It renders an individualized, unstandardized service directly to clients/ patients
- It provides autonomy for the definition, organization and performance of work
- It internally controls the behaviour of its practitioners
- It has formal organizations, code of ethics, and licensure requirements (2003: 4).

For Hammer *et al* what defines pharmacy as a profession is 'the specialized knowledge that pharmacists must attain as it relates to medicines and their use, along with the mission to assure the safe and effective use of them in patients' (*ibid*: 5).

The structural-functionalist analysis of pharmacy education is thus primarily concerned with explaining the ways in which the shared values of the cultural system (viz. value consensus within the entire pharmacy profession, including the education sector) and the norms associated with the role-expectations (viz. the attitudes and behaviours of practising pharmacists) are transferred to, and internalized by, subsequent generations of pharmacy students.

3.1.5 A critique of the functionalist account of pharmacy education

The basic assumption underpinning functionalist theory is that society is held together by 'value consensus' which is transmitted by culture. Without shared values and beliefs society would lapse into a state of anomie or chaos. The common thread

running through Durkheim, Parsons and Merton's work is the assertion that order and stability in society, are brought about by the transmission of collective values through institutions such as the educational system. These institutions prepare individuals for increasingly differentiated and specialized roles and set the guidelines for acceptable social behaviour.

One of the most significant criticisms of this approach is that it rests on an empiricist concept of social actors which reduces them to being the passive receivers of external stimuli. The individuals making up educational institutions, medical and pharmacy schools and the patients attending doctors' rooms and pharmacies, are viewed as little more than automatons, stripped of the capacity to think for themselves. Functionalism thus fails to consider the subjective meaning that actors place upon their experiences within the social system, and thereby omits a consideration of how actors themselves interpret and respond to their environment (Keat & Urry: 137).

This basic flaw in the positivist methodology can be held responsible for a number of common criticisms directed against functionalism. A detailed account of all such criticisms is beyond the scope of this thesis; I shall therefore focus on three of the most relevant criticisms. Firstly, the assumption of a shared value system within contemporary societies (such as South Africa) is incapable of explaining the existence of a range of competing value systems (Blackledge & Hunt 1985: 100).

When applied to pharmacy education, the functionalist emphasis on socialization assumes there is a common core of relatively homogenous professional values, norms and role definitions¹⁵. This perspective assumes that the objects of socialization (viz. the pharmacy students) receive consistent messages from educators and practitioners regarding the profession's ideology and the philosophy, values and attitudes of being a practitioner. It further implies that socialization

¹⁵ Merton, given his acknowledgement of opposing values, may appear to be an exception. Yet, his contention that it is the role of the medical education system to 'blend' these opposing values together indicates his acceptance of the view that there is a common core of professional values. It is the values themselves rather than their individual holders (actors) which are in opposition to each other.

proceeds linearly and smoothly, that all agents of socialization contribute in a positive reinforcing way and, consequently, students passively are moulded into future practitioners (Chalmers *et al* 1995: 86).

Secondly, the assumption of value consensus fails to explain conflict within societies and instances of the manipulation of social beliefs by one group of social actors over another. Such criticism is frequently extended to argue that the theory has an in-built conservative bias: inequalities of wealth and the differences in the distribution of power within society are seen as functional for achieving the system's goals (Craib 1984: 50).

A third criticism of the functionalist emphasis on value consensus is its resultant inability to explain social change. If the role of social institutions is simply to reproduce society as a stable entity, and institutions such as education function to continuously socialize people into their social roles, how is it that society, its institutions and peoples' social roles have changed so dramatically over the past hundreds of years? Where do the new ideas come from that bring about this change if they are not initiated internally (which assumes some form of conflict or competition over ideas and is theoretically precluded)? If changes are the result of the influence of other parts of the system (for instance the influence of the economy over the education system) this is at odds with the basic assumption of social stability (Gouldner 1970: 351-354).

3.2 Micro-Interpretivism

In contrast to the functionalist focus on the deterministic effects of social institutions (also referred to as the macro-level of analysis), most interpretivist theories of society tend to focus on the micro-level of interaction between actors. As mentioned earlier, the micro-interpretivist theories of society originate from very different ontological and epistemological assumptions to that of Durkheim and the functionalists, Parson and Merton. Micro-interpretivist theories adopt the philosophical assumptions of the

interpretivist paradigm (discussed in Chapter 2), and are based on a neo-Kantian perspective of the social world, with a focus on the subjective meanings and motives in terms of which individual actors choose to engage in social action. This has led to a focus on how everyday activities and interactions between people occur.

Unlike structural-consensus theorists who believe that people are constrained to act in particular ways by their specific roles within society as well as society's moral values, micro-interpretivist theorists view people as exercising autonomy and freedom in their daily activities. Where structural-consensus theorists believe that meanings are imposed by culture or society, micro-interpretivist theorists hold that meanings are created by individuals during the course of their unique interactions. Subjective meanings are used to make sense of interactions between people and to interpret the behaviour of others.

The interpretivist paradigm, with its focus on the understanding of social actors, includes a number of separate perspectives on how to explain what motivates actors to behave in the ways in which they do. These perspectives include symbolic interactionism, phenomenology and existentialism. For the purposes of this thesis, however, I will concentrate on the micro-interpretivist approach of phenomenology and its extension to society, ethnomethodology.

3.2.1 Alfred Schutz

Following Husserl's ontology (see section 2.1.2), Schutz only recognizes the existence of individuals and their individual streams of experience. For this reason he argues that the focus of social inquiry should be directed toward the ways in which actors continually construct the notion of a shared social world (Craib 1984: 87 & Jones 1992: 76).

Schutz rejects positivist approaches to the explanation of social action, which treat people as the passive transmitters of ideas imposed on them by social institutions. He asserts that social actors only see the world as 'structured' (into institutions such

as schools and churches, for instance) because of the kinds of common-sense knowledge that they possess. Schutz's phenomenological analysis is principally concerned with understanding how the everyday, inter-subjective world (the life world, or *Lebenswelt*) is constituted (Gubrium & Holstein 2000: 489).

Although individuals have different personal biographies and different experiences and interests, they still see this shared life-world as a 'factual reality'. Unless there is some reason for believing otherwise, social actors commonly assume that events and actions in the social world are understandable to others in the same way that they are understandable to themselves. This is what Schutz terms 'the reciprocity of perspectives' (Schutz 1962: 497).

Through language, social actors acquire an enormous amount of knowledge about the world, only a small part of which they have actually experienced. The rest of this knowledge consists of taken-for-granted assumptions that are shared with other social actors. Actors build up 'meaning contexts' or sets of criteria by means of which they organize their sense experience into a meaningful world. These are organized through a process of 'typification' into what Schutz calls 'stocks of knowledge' which come to make up our shared 'life world' (Schutz 1962: 492 – 497).

The concepts which make up this common-sense knowledge or what Schutz refers to as 'typifications', enable actors to experience objects, events and actions. Actors continually construct and change their 'life world' in the course of their interaction and pass on their common sense ideas through language from one generation to the next (through the process of socialization). Society is an ongoing accomplishment according to Schutz.

3.2.2 Harold Garfinkel and ethnomethodology

These ideas were closely analysed and refined by the American social theorist, Harold Garfinkel. He sought to show how theoretical notions (about the inter-subjective character of the social world and the nature of common-sense knowledge)

derived from the work of Schutz could open up the world of everyday life to sociological investigation (Cuff & Payne 1984: 157).

Instead of referring to people as social actors, in the way that Schutz does, Garfinkel refers to them as 'members'. For Garfinkel this term refers to the membership of a social collectivity, which implies possession of a shared stock of knowledge about the world. Following Schutz's lead, Garfinkel maintains that members accomplish their activities in and through the use of common-sense knowledge (*ibid*: 161 & 162).

Garfinkel, in common with the phenomenologists, reverses the Durkheimian maxim 'treat social facts as things'. Rather, he argues that social facts should be treated as 'interactional accomplishments'. Garfinkel coined the term 'ethnomethodology' to describe his alternative account of how the 'members' of society construct the world around them and how they have to continuously work to make sense of their own activities and those of others. The term ethnomethodology literally mean: the study of people's methods. In Garfinkel's words:

'I use the term "ethnomethodology" to refer to the investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of the organized artful practices of everyday life' (Garfinkel 1967: 478).

Garfinkel maintains that the members of a society have to accomplish or achieve their social world on an ongoing basis. His primary concern is not to provide a scientific explanation of society but rather to produce an understanding of the methods that ordinary people use to make sense of the world around them. He sets out to 'rediscover' this common-sense world of everyday life and specifically rejects the positivist assumption that members of society are 'cultural' and 'judgmental' dopes. Garfinkel criticizes positivists and structuralists for treating the members of society as 'cultural dopes' by assuming that they act in compliance with pre-established 'common culture' (Garfinkel 1964: 244). This not only excludes 'the

persons own lived inner states' but also the micro-contextual factors with which members continuously engage in the course of re-creating social reality (*ibid*: 247).

Among the methods that ordinary members of society use to make sense of the world, according to Garfinkel, is the 'documentary method of interpretation'. This method allows members of society to interpret the mass of other members' utterances and actions by virtue of the 'indexicality' of their speech and action. Put simply, 'indexicality' means that all actions and utterances depend for their meaning on the context in which they occur. For Garfinkel, to understand a conversation the participant has to fill in a set of background assumptions that are unique to the micro-context of that specific conversational interaction. This includes an analysis of who the speaker is, what the relationship between the speaker and listener is, and what the purpose of his/her utterances is (Cuff & Payne 1984: 161).

To make sense of utterances members produce a description of the occasion and 'document' its significance by using shorthand terms such as 'a meeting', 'an investigation' or 'an arrest'. In this way members of society are able to impose a pattern on the social world around them and to see this world as 'out there', 'given' and 'objective'. Similarly, the ethnomethodologist is also obliged to make use of the documentary method of interpretation. The difference with ordinary members is that this method is applied to an examination of the methods of sense-making which members use to provide an unproblematic sense or orderliness of everyday life (*ibid*).

Ethnomethodologists following Garfinkel have criticized the positivist and normative model of social action for treating social rules, actors and situations as independent entities. By contrast, the ethnomethodological model views persons as involved in a ceaseless, ongoing process of *creating* social situations and rules. In these terms, as Hugh Mehan and Houston Wood (1975) put it, people are viewed as 'human reality constructors' (p322).

Mehan and Wood, by drawing on the work of Garfinkel and other ethnomethodologists, identify the following two key methods employed by human 'reality constructors': Firstly, the application of social knowledge; and secondly, the use of interpretive procedures to operate on that social knowledge.

Social knowledge is viewed as having the following features: it provides a practical interest in the world – as opposed to being concerned about scientific claims, semantics or formal logic; it is socially distributed – actors assume that not everybody knows everything and that some people, like medical doctors and pharmacists, have specialized knowledge; it is tacit – there is more to understanding the meanings in any given conversation than is actually said; it takes the world for granted – actors simply assume that objects within the world are real (Mehan & Wood 1975: 323-325).

Three key interpretive procedures are identified by Mehan and Wood as being employed by actors as reality constructors: searching for a normal form – which enables actors to normalize discrepancies and overlook ambiguities in the course of conversations and interactions; participating in a reciprocity of perspectives – where actors assume that they would have the same experiences if they changed places with other actors; and, employing the *et cetera* principle – where unclear information is allowed to pass and vague utterances are left unchallenged (1975: 325 & 326).

Garfinkel developed a number of novel techniques for demonstrating the above features of social knowledge and interpretative procedures. These involved conducting experiments to breach social order. These techniques consist of a social application of Husserl's phenomenological method of 'bracketing out' or suspending a belief in the social order for purposes of discovering the manner in which this order is produced. In order to demonstrate the practical nature of everyday knowledge, Garfinkel asked his students to suspend this assumption and adopt a theoretical interest in their daily conversations.

Garfinkel encouraged his students to challenge the taken for granted nature of social reality by instructing them to conduct themselves as if they were boarders in their own homes. One student provides the following report:

'A short, stout man entered the house, kissed me on the cheek and asked, "How was school?" I answered politely. He walked into the kitchen, kissed the younger of two women, and said hello to the other. The younger woman asked me "What do you want for dinner, honey?" I answered, "Nothing." She shrugged her shoulders and said no more. The older woman shuffled around the kitchen muttering. The man washed his hands, sat down at the table, and picked up the paper' (Garfinkel 1964: 230).

To demonstrate the use of the interpretive procedures listed above, Garfinkel asked his students to insist on clarifying the sense of all commonplace remarks during the course of their conversations. He recounts the following typical response (S = subject, E = experimenter):

- S: Hi, Ray. How is your girl friend feeling?
E: What do mean, how is she feeling? Do you mean physical or mental?
S: I mean how is she feeling? What's the matter with you? (He looked peeved.)
E: Nothing. Just explain a little clearer what do you mean?
S: Skip it. How are your Med School applications coming?
E: What do you mean, 'How are they?'
S: You know what I mean.
E: I really don't.
S: What's the matter with you? Are you sick? (*Ibid*).

3.2.3 Ethnomethodology in its application to medical education

The English social theorist, Paul Atkinson, has applied an ethnomethodological approach to the study of teaching of medicine in British hospitals. He seeks to apply the same principles of reality construction outlined by Garfinkel (and summarized by Mehan and Wood above) to the training of medical students in clinical skills within an Edinburgh teaching hospital. The title of his book illustrates this ethnomethodological approach – *Clinical Experience: The construction and reconstruction of medical reality*. In it, Atkinson criticizes the disappointing lack of interest by sociologists of health and illness in ‘the processes of knowledge production and reproduction through medical curriculum and pedagogy’. He also criticizes the sociology of education for not straying ‘beyond the bounds of schooling’. He asserts that ‘the reproduction of professional knowledge, including the practice of medical education, remains beyond the pale of the sociology of education’ (1997: 14).

Atkinson recounts the range of experiences and interactions that medical students engage in during the process of acquiring clinical skills. These include attendance at post-mortem examinations, visiting outpatient clinics where they sit in on consultations between medical doctors and patients, observing surgeons in the operating theatre and most importantly, conducting bedside visits to patients with qualified medical consultants during their ward rounds. As Atkinson puts it, during this learning process ‘emphasis is placed on students’ acquisition of methods and routines of clinical inquiry’ (1997: 20). As with other forms of social knowledge, the information gathered here provides the students with a *practical interest* in the world and is socially distributed. During their clinical training, students move away from the academic, theoretical and scientific aspects of their course and shift towards the work of medicine. For Atkinson, this marks the students’ ‘first sustained contact with practicing doctors and their patients in the milieu of “real” medical work’ (1997: 23).

In this context, the clinician responsible for teaching the student ‘portrays himself [*sic*] as a pragmatist’. It is not that the clinician’s knowledge is portrayed as crude or unsophisticated; rather this knowledge is portrayed as ‘grounded in painstakingly

accumulated personal experience' (Atkinson 1997: 25). Atkinson recounts the following exchange between a consultant surgeon and his students:

- Dr: So there's an example of course of a goitre in a patient of thirty six – of long standing, eighteen years. So you are in a little difficulty if it isn't nodular. You've finished with thyroid pathology?
- St: Yes
- Dr: So what is it?
- St: If it isn't nodular, it might be adenoma of the thyroid.
- Dr: Hmm I sometimes think that pathologists have a distorted view of thyroid pathology. By adenoma I suppose you mean a simple tumour?
- St: Yes
- Dr: Simple tumours of the thyroid are very rare.

The consultant then went on to ask the students about the age of the onset of goiter:

- St: Onset of puberty.
- Dr: You're quite right that the text books talk about adolescent goitre, *but...* (*Ibid*).

For Atkinson, what examples such as the above demonstrate is the manner in which the clinician reinforces the primacy of clinical knowledge (acquired through years of personal experience) over 'theory'. Examples such as the above, according to Atkinson, illustrate how medical reality is 'artfully stage managed'. The medical reality students are exposed to 'is constructed so as to reproduce particular *versions* of medical work and a particular form of medical culture' (Atkinson 1997: 29).

This version of medical work, according to Atkinson, is primarily informed by positivist assumptions. He criticizes 'cold medicine' as a rational and methodic 'retrieval of facts', because it overlooks the relationship between facts and the 'socially legitimated methods of their discovery and testing'. Like other phenomenologists, Atkinson argues that the discovery of the facts is dependent on the particular methods of inquiry employed in the discovery procedure, and therefore

the medical students' line of inquiry (in the form of history-taking and physical examination) must be sufficiently managed by the clinician such that appropriate facts are discovered. In Atkinson's view 'the methodic nature of their production is a warrant for the correctness of the facts of the case' (*ibid*: 195).

Following Garfinkel, Atkinson argues that the factual accounts of medical conditions (produced during a clinical diagnosis) are themselves constitutive of the states of affairs they describe:

'rules... are only established as such by their ability to organize the settings of practical, everyday, commonsense actions – an ability which is proven in organizing these actions' (Filmer 1972 *in* Atkinson 1997: 195).

This illustrates the extreme relativism of the ethnomethodological perspective. There are no rules of society, social facts or institutions which exist independently (in the ontological sense) of the humans who produce them, and which can be explained through the application of a single scientific method. For Atkinson, medical students need to be taught how to become competent 'investigators of facts'. They require practical training by the 'old hands' of the profession, the clinicians, in 'the correct application of the rules of investigative procedure'. Whether these rules, or the methods of medical science are true or false, or whether they correctly explain the medical conditions of patients, is irrelevant. In Atkinson's words:

'In the medical context... the facts of a diagnosis are guaranteed by the rules and procedures of clinical inquiry which establish them: by the same token, these procedures are validated insofar as they generate reproducible and reportable diagnoses' (Atkinson 1997: 195).

3.2.4 A critique of the micro-interpretive approach

A number of criticisms have been directed against the ethnomethodological account of society. Alvin Gouldner criticizes Garfinkel's social world for being ahistorical – it is

a world outside of time. He asserts that Garfinkel is incapable of explaining why one definition of social reality becomes prevalent in one time or place, or why one group's definition of social reality becomes established in a particular time and place, and not another. He criticizes Garfinkel for excluding the 'process of struggle among competing groups' who seek to impose their common sense definitions on the world (Gouldner 1970: 391).

Similarly, Anthony Giddens observes that ethnomethodological writings 'have a peculiarly empty character': conversations are disembodied and 'not described in relation to the goals or motives of speakers' (1977: 176). It also excludes any element of power from everyday conversations, whereas participants in interaction always bring differential resources to this interaction. These power differences, as Giddens points out, may reflect 'much more generalized imbalances (e.g. class relations) structured into society as a totality' (*ibid*).

3.3 The neo-Weberian perspective

The previous two sections of this chapter focused on structural-consensus theory and micro-interpretivism, and their ontological and epistemological origins. The structural-consensus tradition, with its macro focus on the structures within society (such as social institutions) was criticized for reifying society and belittling individuals in the process. From this perspective, people are thought of as programmed puppets with no creativity or free will, and who lack the capacity to change society. By contrast, micro-interpretivism, with its micro focus on the interactions between social actors and their goals, tended to celebrate human creativity and freedom. Yet in the process it lapsed into extreme relativism¹⁶ and failed to take sufficient account of the fact that action is constrained by the situation in which it takes place.

¹⁶ A theory is said to be relativistic when it cannot provide criteria of truth independent and outside of itself. Beliefs, theories, or values are claimed to relative to the age or society that produced them and not valid outside those circumstances (Abercrombie *et al* 1984: 206).

The interpretivist social theorist Ronald King (1980) believes that these limitations can be overcome by using Weber's theory of social action, since:

'the study of education using the methods of Weber enables explanations to be made which combine the voluntarism of phenomenology and its important stress on the subjective meaning of social action, with the structural constraints on social action which are emphasized in functionalism' (p7).

Within the field of education there have been a number of neo-Weberian social theorists that have attempted to analyse both the micro- and macro-aspects of education. These include Ronald King, Randall Collins and Margaret Archer (Blackledge & Hunt 1985: 318 – 335).

Section 2.1.2 presented Weber's definition of the study of society, and his focus on the interpretive understanding of social action – that is, his focus on the micro-element of social reality. His method of *Verstehen* proposed adopting the subjectively intended meaning of the social actor as a basis for a causal explanation of his/her actions. Weber was primarily concerned with *social* action and believed that 'action is social in so far as, by virtue of the subjective meaning attached to it by the acting individual (or individuals), it takes account of the behaviour of others and is thereby orientated in its course' (Weber 1964: 128). Margaret Archer, however, is critical of sociologists of education who only exploit Weber's 'microscopic discussions of meanings' while they neglect his 'large-scale work on culture' (Archer 1981: 278).

Weber was also devoted to the large-scale comparative study of social systems (such as rise of capitalism, the relationship between world religions and rationality, and process of bureaucratization). He was concerned with the historical dynamics of social structures and institutions, which formed the cornerstone of the macro-element of his analysis of the social world (Archer 1981: 276).

He believed, however, that explanations of patterns of social action - or social structure - must be made through the understanding of the subjective meanings of

those whose actions create the pattern or structure. For example, the social structure of education consists of the ways teachers, pupils and others repetitively behave towards one another (King 1980: 11). In this way, Weber advocated for the combination of both a micro-element (i.e. interpretation of subjective meanings of social actors) and a macro-element (i.e. historical and comparative analysis of social structures and institutions) of analysis in the explanation of patterns of social action.

The neo-Weberian perspective is thus a form of interpretive social theory which is concerned with both micro and macro social processes. It seeks to 'interpret' the behaviour of individual human beings, to understand the subjective meanings of their actions. But it also attempts to locate individual conduct in its social context. All action takes place within a social and economic structure which, to some extent, limits what the individual can do. This structure is, of course, as Margaret Archer points out, the result of past action. It has been constructed by innumerable men and women throughout history. Nevertheless, for each individual it is experienced as an 'objective reality'. Furthermore, the social system of which we are a part shapes our ideas, beliefs and values as well as at times placing limits on our actions. Our conception of the world and of ourselves is influenced by it (Blackledge & Hunt 1985: 335).

Weber explained aspects of the structure of specific historical societies by studying the relevant social relationships using a number of interrelated ideal types¹⁷: power, authority, bureaucracy, class, status and party. These ideal types are concerned with the structure of relationships as well as the subjective meanings of those whose actions create these relationships and are constrained by them (King 1980: 11). Since economic, status and power resources are finite within any given society, there is competition for their maintenance and improvement. This competition, argued Weber, is between individuals but also between groups consisting of individuals who share common interests – that is, interest groups. Individuals and

¹⁷ Weber defines an ideal type as 'a conceptual pattern which brings together certain relationships and events of historical life into a complex, which is conceived as an internally consistent system' (Weber 1949: 63).

groups may therefore create structures in the pursuit of a number of different interests (*ibid*: 14).

In neo-Weberian terms it is necessary to study the patterns of behaviour of teachers, pupils and students which constitute the structure of education, in terms of their meanings in pursuit of economic, status and power interests, and of the resources available to them, without reducing these processes to consequences of external structures or regarding them as totally independent of them (King 1980: 17).

Unlike the other two aforementioned neo-Weberian theorists, Margaret Archer's theory of educational systems is primarily concerned with explaining how educational change comes about. It is this focus on educational change which, in my opinion, makes it the most suitable neo-Weberian theory of education for the purposes of analyzing the Rhodes University Community Experience Programme.

3.3.1 Margaret Archer

Margaret Archer sets out to develop a sociology of educational systems. To do so she draws on Weber, whom she asserts was orientated towards an analysis of education as a macro-phenomenon. According to Archer, Weber's analysis of education included the following key characteristics:

- He treated education as 'a macroscopic social institution rather than a bunch of organizations (schools, colleges, universities), a set of collectivities (teachers, pupils, principles) or a bundle of separate properties (inputs, processes, outputs)'
- He placed education as an institution firmly in the wider social structure (i.e. amongst other social institutions)
- He believed that it was this position in the social structure and the relationship to other institutions that explained educational change (Archer 1981: 262).

Following Weber then, Archer suggests an analytical distinction between theorizing education as a 'social institution' and as a 'social system'.

In contrast to Weber's classical approach to the study of education, by the mid-twentieth century, Archer maintains that 'methodological empiricism' had come to dominate educational theory. She characterizes this approach as having an atomistic orientation and as being atheoretical and ahistorical. On the one hand she criticizes functionalists for assuming that education is a completely permeable social institution which is eternally open to, and reflective of, the broader social structure. Consequently, the educational system is treated as an unproblematic and 'timeless' given, and dealt with simply as an administrative framework. On the other, she is equally critical of the ethnomethodological rejection of objective structures, which is based on the argument that the contingent nature of social reality means that the 'system' has no ontological basis external to interpersonally negotiated meanings (*ibid*: 262 & 263).

Archer asserts that the form taken by education in any society is actively shaped by the views and interests of some group(s) in opposition to the interests of other groups and classes. She advocates a definition of education which

'allows for the fact that the goals which can be entertained by social groups are infinitely varied and that therefore the institutions and activities which are deemed "educational" will be of a variety which defies essentialist¹⁸ definitions. [Such a definition also] acknowledges that these educational institutions and activities are the products of complex processes of social interaction which cannot be captured by a simple notion like "reflection" [where education simply reflects the needs or functional requirements of a given society]' (Archer 1980: 180).

It follows that the role of the social scientist is to uncover which processes of social interaction moulded and institutionalized particular definitions of education at different points in history. Unless we come to understand how social groups interacted, which ones were most successful in imposing their definitions and which

¹⁸ For Archer, the essentialist perspective assumes that there is 'an underlying element, common to education everywhere, and that this similarity outweighs differences in form and content' (1980: 180).

were not, when, where and why, it is not possible to explain the historical emergence of any given kind of education because both its structure and its contents are shaped by these broad social processes. The task of the macro-interpretive sociology of education should therefore involve an examination of 'on the one hand, complex kinds of social interaction whose result is the emergence of particular forms of education: on the other, complex types of social and educational structures which shape the context in which interaction and change occur' (Archer 1979:4).

3.3.1.1 The educational system

Archer's approach to explaining the emergence and change of educational systems involves an acknowledgement of both the impact of social structure and the subjective meanings motivating social actors. She argues that the

[educational] system in operation today was structured yesterday; the patterns of governance and accountability now observed were shaped by past struggles for control and shape future processes of change; the educational interests which are currently defended were distributed earlier in time' (1981: 280).

Archer pictures the development of the educational system over time as a series of what she refers to as morphogenetic cycles. In each cycle the initial educational structure conditions educational interaction, whilst the independent influences of competing interest groups affecting interaction, eventually bring about changes in the educational structure. In contrast to the timeless and ahistorical character of the structural-functionalist and ethnomethodological approaches, Archer's successive cycles of 'structural conditioning → interaction → structural elaboration continue to unite "historical" origins with current operations' (*ibid*).

Whilst Archer's approach explicitly allows for structural influences over social interactions 'it insists that these are conditional and not deterministic'. Similarly, it accords equal importance to agency and structure. Whilst it 'allows for the

independent effects of social action on changing the systemic structure' it 'denies the complete plasticity of institutional structures' (Archer 1981: 281). Archer's morphogenic approach accords time a central role in theorizing educational systems, and enables her to effectively explain change within these systems.

Archer's work in the field of education focuses on the state educational system which she defines as 'a nationwide and differentiated collection of institutions devoted to formal education, whose overall control and supervision is at least partly governmental, and whose component parts and processes are related to one another' (Archer 1979: 54).

She argues that the educational system plays a vital role in mediating between society and schools, by selectively filtering the demands, groups and interests that affect education (Archer 1981: 266). And as a result, a study of the sociology of education must incorporate an examination of the educational systems within broader society.

Archer accuses sympathizers of both the functionalist and the micro-interpretive perspectives of neglecting the political aspects of education. She defines educational politics as

'the attempts of different social groups to influence the inputs, processes and outputs of education, whether by legislation, pressure group and union activities, experimental, traditional or sectional movements, private or collective investment, propaganda or public debate (Archer 1981: 267).

This definition of the politics of education allows for the fact that the balance of educational power at any time (because of compromises or concessions and degrees of success or failure) is not necessarily in complete alignment with the balance of power in society.

In her book, entitled *Social Origins of Educational Systems*, Archer examines the origins and operations of educational systems. Archer is primarily concerned with investigating how educational systems develop and how they change, and asks the question: 'why does education have the particular inputs, processes and outputs which characterize it at any given time?' (1979: 2). Her short answer to this question is: 'because of the goals pursued by those who control it'. The reason for why these characteristics change over time is that 'new educational goals are pursued by those who have the power to modify previous practices...Education is fundamentally about what people have wanted of it and have been able to do with it' (*ibid*).

Archer attempts to explain change within educational systems by making reference to three broad analytic phases: (a) the existence of a pre-existing structure or structural conditioning, (b) social interaction, and (c) structural change or elaboration. This theoretical framework, in turn, is based on an analysis of two major cycles, the historical build-up to state control of education - within four European countries, namely England, Denmark, France and Russia - and system developments since that time. As a result of examining the historical emergence of state educational systems within these four countries, Archer differentiates between centralized and decentralized educational systems. The former has a tightly integrated internal structure as its emergence was orchestrated by the political elite.

'The various parts of the educational system were co-ordinated from the start to protect its own educational requirements from interference by other services... Because such elites sought a system which would be uniquely responsive to their changing needs, the administrative frameworks were expressly designed as the leading part of each such system. Through them educational change could be filtered and monitored so that it never escaped the control of the governing elite (1979: 254).

The decentralized educational system, by contrast, is much more loosely structured. There is considerable local autonomy and little central control. Such a system is

characterized by a lack of strong hierarchical authority and the lack of a unified or systematized quality.

As educational systems develop, change within these systems is increasingly brought about by a process of negotiation rather than open conflict between competing interest groups. According to Archer, negotiation is the most important process of educational change and is far more complex in nature than conflict (which was the principal means by which interest groups attempted to gain control over the educational system prior to the interventions by the state).

Archer identifies three main types of negotiation, and thus three new sources of educational change. First there is *internal initiation* which means that educational change can be initiated from within the educational system by teachers and administrators. According to Archer, 'this source of change is the school, the college, and the university. It can be brought about on a small scale by independent initiative in a particular establishment, and on a much larger scale by collective professional action' (1979: 240).

Secondly, there is *external transaction*, that is the way in which interest groups outside of education negotiate with those inside it in order to develop forms of education which meet their specific needs. The external agency 'will try to buy the educational changes it wants' through various means.

'For example, a particular local firm may offer equipment and facilities for a college to lay on a specialized form of training, the armed services may provide scholarships and a subvention in return for the enrolment of their cadets, the police, farmers and various professional groups may sponsor or support specialized establishments and industry may negotiate applied research in return for grants, professorships, laboratories, etc' (*ibid*: 241).

Archer is quick to point out that the above illustration does not suggest that any outside party can negotiate anything it wants provided it has the necessary

resources. The educational profession itself has power to veto and need not accept all propositions put to it. Like other groups external to the educational system, teachers and administrators are motivated by vested interests of their own, and if the services sought by outside agencies are deemed to be professionally degrading (e.g. being asked to train rather than educate) or to adversely affect working conditions (e.g. longer working hours, increasing pupil numbers), the terms may be rejected.

The third type of negotiation advanced by Archer is *political manipulation*. Archer views this form of negotiation as 'the principle resort of those who have no other means of gaining satisfaction for their educational demands' (1979: 242). Political manipulation arises because education now receives most of its funds from public resources. In turn, a whole series of groups acquire formal influence over the shaping of public educational policy. In the endless quest for support and party votes, competing interest groups focus much of the public dialogue about instruction on popular or democratic themes.

Whilst these three types of negotiation are of roughly equal importance in decentralized systems, in centralized systems, political manipulation is crucial. This is because of the tight control exercised by the political centre over the parts of the educational system. Individual institutions or sets of institutions possess very little autonomy and are thus unable to proceed with internal initiation or external transaction. The demands of various interest groups become channeled through the political system. For this reason educational change within centralized systems is largely the story of educational politics, in which 'interaction... is centripetal in nature, for the negotiation of change depends upon the aggregation of grievances, the acquisition of political sponsorship, and the percolation of these demands into the central decision-making arena' (Archer 1979: 271).

In decentralized systems, the different types of negotiation proceed simultaneously and have consequences which affect one another. With regard to political manipulation, the teaching profession negotiates directly with the polity on an

organized basis and, in so doing, affects policy formation (Blackledge & Hunt 1985: 332).

In addition to examining the different types of negotiation in state educational systems, Archer believes that it is equally important to take into account the negotiating strength of the opposing interest groups. In decentralized systems such strength will depend upon the possession of wealth, power and expertise, whereas in centralized systems it is the distribution of political power alone which is crucial.

Finally, Archer turns to a discussion of the outcomes of negotiation (structural elaboration). Firstly, she points out that a different pattern of change occurs in centralized and decentralized systems. In centralized systems, there is a 'stop-go', jerky pattern of change in education. In decentralized systems, on the other hand, change is never ending, incremental and characterized by the absence of sharp breaks since such systems can more easily adapt or resist what seems inimical to their goals.

With regard to the decentralized education system, the importance of internal initiation and external transaction mean that small, local changes frequently accumulate to produce a significant scale of change. The considerable autonomy of educational institutions in such a system imposes constraints on political intervention and limits its scale. Any attempt to introduce new legislation must take existing practices into account. In addition, she notes that new central directives are often modified by action at a local and institutional level. In effect, centrally directed change in a decentralized system is limited by what exists at a local and institutional level, and the degree to which this is defended (Blackledge & Hunt 1985: 335). In the following chapter I provide an application of Archer's neo-Weberian framework to the emergence of pharmacy education a social system in South Africa.

Chapter 4

THE PHARMACY EDUCATION SYSTEM IN SOUTH AFRICA

The previous chapter set out to explore the two main theoretical approaches to social theory, namely structural-consensus theory and micro-interpretivist theory, in its application to the study of education. In opposition to both of these approaches, the chapter then provided an account of the macro-interpretive approach to the study of educational systems advanced by Margaret Archer.

This chapter provides an application of Margaret Archer's theory of educational change to pharmacy education in South Africa. By drawing on Archer's theoretical approach I provide a historical account of the influences exerted on the system of pharmacy education by key interest groups – medical doctors, private sector pharmacists, and the government – during the colonial, apartheid and post-apartheid eras in South Africa. This account will be used to explain the findings resulting from my research into the Rhodes University Community Experience Programme presented in the next chapter.

4.1 Pharmacy education as a social system

For Archer, an explanation of how certain views 'come to constitute educational knowledge and how these are subsequently translated into syllabuses, set books and examination questions' requires an analysis of educational politics and historical investigation (Archer 1981: 280). In the following section I attempt to provide a brief account of the influences exerted by various interest groups in shaping the curriculum of pharmacy education in South Africa.

4.1.1 The emergence of the pharmacy profession in South Africa (1880 – 1928)

Since the very outset of the practice of pharmacy the role of the pharmacist in South Africa has been the subject of competition, conflict and negotiation between various interest groups. In the mid-1880s chemists and druggists (as pharmacists were then called) located in the Cape found their material interests threatened from a number of quarters. Firstly, their interests were threatened by medical doctors who dispensed their own medicines and who dominated their ability to register and practice via the Colonial Medical Committee. This Committee, consisting of seven doctors and one pharmacist, was responsible for examining and licensing pharmacists after their completion of a four-year apprenticeship (Ryan 1986: 2).

Secondly, their interests were threatened by shopkeepers who 'sold vast quantities of patent medicines and who also traded in poisons', a monopoly sought by pharmacists. Shopkeepers could often sell patent medicines at cheaper prices than chemists' mixtures, because these could be bought in bulk (*ibid*: 9). Similarly, pharmacists in the rural areas of the Eastern Cape were unable to match shopkeepers' supply of poisons such as strychnine and arsenic (used daily in the area as wolf poison and sheep-wash respectively) and were threatened with great financial loss (*ibid*: 13).

As Ryan points out, despite the lack of evidence of a serious poisoning case, pharmacists in the Eastern Cape led a call in 1885 for the Colonial Government to 'control and regulate the sale of Patent Medicines and Homeopathic globules [as well as poisons] if the Public will continue to imperil their health with them' (*ibid*: 13). This was followed by a call to establish a separate pharmacy act and led to the initial formation of a series of voluntary pharmacy associations, established first in the Cape Province (1887) and Natal (1892) – both under British control – and later in the Boer republics of the Transvaal (1894) and the Orange Free State (1903).

After several attempts at creating a national body to further the interests of pharmacists, and after the Act of Union in 1910 (when the British colonies and Boer republics were merged into a single unified state), a loose federation called the Associated Pharmaceutical Societies of South Africa (APS) was eventually formed in 1923. The APS (which was later renamed the Pharmaceutical Society of South Africa) itself was established in response to the introduction of a medicine stamp tax by the Smuts government in mid-1923. The tax applied to all medicines that carried a patent or were marketed to contain a secret formula containing special curative powers.

4.1.2 Competition for educational control within pharmacy (1885 – 1928)

According to Archer, educational change is produced by shifts in the negotiating strengths and strategies of different social groups vis-à-vis one another (1981: 275).

From the above discussion it can be established that the two main groups with an interest in the education and training of pharmacists in South Africa prior to 1928, were an emerging group of pharmacists (who had begun to organize themselves in order to assert their professional status) and a powerful lobby of medical doctors, who had historically dominated the licensing and registration of these pharmacists. The extent of this domination is illustrated by the fact that pharmaceutical training in the Cape Colony during the mid-1800s consisted of a four-year period of apprenticeship followed by an examination set by the Colonial Medical Committee.

At times this domination by medical doctors appeared to occur on an *ad hoc* basis. For instance, the Medical Committee's syllabus for its 'Examination in Pharmacy' in 1887 contained separate papers on Prescriptions, Pharmacy, *Materia Medica*, Botany and Chemistry. Although the competencies identified by the Committee were for the most part perceived to be consistent with the practical skills used by pharmacists (such as: 'the detection of errors and the discovery of unusual doses' within the Prescriptions paper; 'identifying properties of active ingredients' within the

Pharmacy paper; 'recognizing the ordinary chemicals used in medicine' within the Chemistry paper), some of these were perceived to be entirely irrelevant for the purposes of practising as a pharmacist. A key example of this is the inclusion of the following competence within the Prescriptions paper: 'To render in good Latin prescriptions written in English' (See copy of exam syllabus contained in an appendix to Ryan 1986: 117).

As Ryan notes, most of those who failed the examination to qualify as pharmacists during this period, did so because of the Latin requirements. This led to considerable dissatisfaction amongst pharmacists, many of whom complained that having to read and write Latin was no longer fashionable or practical. Notwithstanding these protests the Medical Committee looked upon the use of Latin 'as a test of general education' (*ibid*: 33).

In addition, in opposition to the Medical Committee which was responsible for introducing a syllabus which focused on Latin, chemistry, botany and the compounding of medicines, the pharmaceutical society advocated for the integration of more business-related subjects into the curriculum.

The newly established Pharmaceutical Associations alleged that the doctors on the Medical Committee were 'inadequate to test the capabilities of the candidates in the theoretical and more especially the practical part of the business...' and they demanded that pharmacists be represented on the Committee (*ibid*).

The Medical Committee refused to include more pharmacists within its governing board and it was only after several years of intense lobbying by the Pharmaceutical Associations, that a separate Pharmacy Board was established in the Cape in 1892 to take over the supervision of the training, registration and examination of pharmacists. Similar Pharmacy Boards were established between 1892 and 1904 in other Provinces, resulting in the development of different standards and requirements for the training and examination of pharmacists. It should be noted that during this period (i.e. prior to 1928), various technical colleges became involved

in the education and training of pharmacists, giving rise to a range of provincial differences in pharmacy education standards.

It was only in 1928, after pharmacists had rallied to oppose the Smuts government's attempt to introduce a stamp tax on medicines, that pharmacists eventually joined together into a voluntary organization and the Associated Pharmaceutical Societies (APS) managed to exert enough pressure to have pharmacists' educational requirements addressed. At this point the Medical, Dental and Pharmacy Act of 1928 was passed and a single national Pharmacy Board was formed to, amongst other things, standardise all pharmaceutical training, qualifications and procedures within the country. The Act made provision for two pharmacists and one medical practitioner to serve as government nominees on the Board. The remaining six positions were to be elected by pharmacists themselves via the APS (*ibid*: 67). A motion was introduced at the 1927 APS Conference which called for an 'APS Ticket' of six nominations. The list of six names 'would then be circulated to every chemist in the Union by the Associated Societies, with instructions that these six only be voted for as a ticket' (*ibid*: 68).

Consequently, the establishment of the first Pharmacy Board in 1928 represented a decisive shift in the power balance between the competing interests of medical doctors and pharmacists over the content of pharmacy education. The doctors' influence over the pharmacy curriculum was now negligible. The Medical, Dental and Pharmacy Act of 1928 shifted the power to control pharmacy education and to conduct pharmacy examinations, to the Pharmacy Board. Section 27 of the Act restricted the awarding of diplomas or certificates entitling holders to register with the Board as a 'chemist and druggist', to those persons who had either passed an examination to the satisfaction of the Board or before examiners appointed by the Board.

Section 94 of the Act also provided the Board with the power to make rules on the following matters:

'The standard of general education required of candidates, the course of training and study prior to examination, the institutions at which such course may be taken and the subjects and standard of examinations which will enable a person to obtain registration as chemist and druggist on compliance with any other requirement of this Act' (South Africa, 1928).

It is worth noting that the Board changed its name to the Pharmacy Council in 1985, and has continued to perform much the same function as the original Cape Pharmacy Board did in 1892.

The brief historical investigation of the politics associated with the emergence of pharmacy education in South Africa outlined above is premised on Archer's theory of educational systems. Archer argues that a proper explanation of any educational system requires two things: (a) 'a detailed specification of the processes producing educational change and stasis', and (b) 'a theory of the conditions under which different social groups can influence the prevailing definition of instructions' (1981: 268).

After the watershed events of 1928, a pharmacy education system can be said to have emerged. It consisted of as a co-ordinated collection of schools and/or faculties of pharmacy, controlled and regulated by the Pharmacy Board/Council. It is clear from the above that the initial interest groups responsible for shaping the curriculum of pharmacy education in South Africa prior to 1928 were the medical profession and the Associated Pharmaceutical Societies¹⁹.

¹⁹ It is important to note that not all qualified pharmacists worked in the retail trade in the 19th century. There were pharmacists in hospitals, in research, in teaching and in the manufacturing and distribution side of the profession, although retail pharmacists dominated the affairs of the pharmaceutical societies by virtue of their numbers (Ryan 1986: 37).

4.1.3 Consolidation of the private sector interest group within the pharmacy profession (1928 – 1995)

Between the period 1910 and 1934, the practice of pharmacy in South Africa altered dramatically. Many of the skills pharmacists acquired during their apprenticeship were less in demand. Previously the first task of the apprentice had been 'to powder aloes in a large iron motor and make horse-balls', compound tinctures such as 'Tincture of Opium' and manufacture pills on the premises until his or her²⁰ 'hands became blistered from constant rolling with a small hand machine' (Ryan 1986: 95). These tasks soon became superfluous with the development of large wholesale houses that adopted mass-production methods to produce a wide range of pills and tablets.

This meant that pharmacists began to purchase many of the products which they had previously compounded themselves. The increased use of patent and proprietary medicines, largely as a result of expensive advertising and promotion campaigns by drug wholesalers, resulted in fewer prescriptions being dispensed and a concomitant declining demand for the pharmacists' own medicines. To make matters worse, an increasing quantity of patent medicines, medical sundries and drugs were now also being sold by merchants and storekeepers (*ibid*: 95).

It should be noted, however, that despite making progress in advancing a common set of interests for pharmacists in South Africa (particularly through the establishment of the APS in 1923), the pharmacy interest group was characterized by a number of important internal tensions and divisions. From the outset there was a tension between retail and wholesale pharmacists within this interest group. When retail pharmacists had initially proposed a separate Pharmacy Bill in the Cape Colony in 1886, which would have restricted shopkeepers from selling medicines and poisons, wholesale chemists had objected because they stood 'to lose their best customers' (*ibid*: 19).

²⁰ The first female pharmacist, Lily Cohen, graduated from the Transvaal University College in 1916 (*ibid*: 55).

Despite important differences of emphasis between retail, wholesale and manufacturing pharmacists in the APS and its successor the Pharmaceutical Society of South Africa (PSSA), they were able to successfully galvanise the separate interests of these various sectors into a single group between 1928 and 1995. There are perhaps a number of reasons for this success. Firstly, by the 1930s there was an extensive overlap in the interests of retail and manufacturing pharmacists. The considerable amount of capital required to set up a pharmacy – with its vast stock of medicines, shop fittings, pharmacy jars, carboys and implements – restricted the ownership of pharmacies to two groups: already established family businesses, and chain outlets owned by large drug manufacturing companies such as Lennon Limited and Sive Brothers and Karnovsky (*ibid*: 36).

As Ryan (1986) points out, it was in the interests of the large manufacturers to own as many distribution points for their products as possible. In many respects these manufacturers enjoyed a relationship with retail outlets similar to the relationship between a brewery and a tied public house (a pub) where only specific products could be sold (p37).

Secondly, by the 1950s there was substantial overlap between the material interests of wholesale and retail pharmacists. In the face of fierce competition from supermarkets, pharmacists began establishing large 'buying groups' which would allow participating retailers to purchase patent medicines in bulk in order to match the prices offered by shopkeepers (*ibid*: 99). This led to the establishment of a number of wholesale associations which offered merchandising and promotional business to participating retail outlets. For instance, the Plus Group established in the 1960s was estimated in 1978 to have captured 55 percent of the total pharmacy business in South Africa, with 636 retail members. Other buying groups included the Bonus Group in the Eastern Cape established in 1971, the Family Circle Group established in 1972 (which had 125 members in 1985) and the Link Group established in 1979 (*ibid*: 100).

For this reason, between 1928 and 1995 it is possible to identify the emergence of a single (although not homogenous) private sector pharmacy interest group which dominated pharmacy education and training in South Africa via its domination of the Pharmacy Board/Council.

4.1.4 The influence of the private sector interest group on the pharmacy curriculum (1928 – 1993)

Prior to 1900 there were no formal schools or colleges of pharmacy in South Africa. As noted, in the 1880s candidates seeking to become pharmacists in the Cape Colony were required to undertake a four-year apprenticeship under a chemist and druggist (as pharmacists were then called) registered with the Cape Medical Committee, and were then obliged to pass an examination set by the Committee. The syllabus of the Cape Medical Committee's Examination in Pharmacy in 1887 required students to pass five courses: Prescriptions; Pharmacy; *Materia Medica*; Botany; and, Chemistry. There was no formal academic instruction offered in these courses with lessons being offered rather through the Cape Pharmacy Society or already qualified individuals (Ryan 1986: 33 & 117).

Trainee 'chemists and druggists' had to rely heavily on the qualified pharmacist to whom they were apprenticed. As Ryan notes, 'the pharmacist agreed to teach his apprentice the chemist's trade and in some cases, supplied him with board, lodging, clothing and books necessary for his studies' (*ibid*: 35).

It should be noted that during this period all chemists and druggists compounded their own medicines. For this reason, most apprenticeship agreements specifically 'forbade apprentices from divulging the contents of their masters' mixtures' (*ibid*: 37). Clearly this limited the scope for developing generalized educational standards at the time in respect of the practical aspects of the pharmacist's work.

By the 1930s (coinciding with the increased distribution of wholesale medicines), however, the period of apprenticeship with its emphasis on the practical

compounding of drugs became shorter and more time became devoted to academic study. In 1928 the Pharmacy Board reduced the apprenticeship to three years and prescribed a course of training and study at an institution (i.e. a technical college) recognized by the Board. By 1954, the apprenticeship period was again reduced to two years, and the period of academic study increased to three years (South Africa 1954).

In 1955, the Pharmacy Board first introduced regulations relating to the 'minimum curriculum for a degree in pharmacy' (these regulations were subsequently amended in 1959). In these terms, the curriculum for the degree of pharmacy was required to include, at a minimum, the following courses:

- Botany, theory and practical
- Chemistry I, theory and practical
- Physics, theory and practical
- Zoology, theory and practical
- Chemistry II, theory and practical
- Pharmacy I
- Practical pharmacy and dispensing
- Forensic Pharmacy
- Physiology and pharmacology
- Chemistry III, theory and practical
- Pharmacognosy, theory and practice
- Pharmacy II²¹

As evidenced from the above, much of the original emphasis on prescriptions, pharmacy, *Materia Medica*, chemistry and botany by the Cape Medical Committee in 1887 had been retained. However, in an illustration of retail pharmacy interests on the curriculum, under the new Forensic Pharmacy course candidates were to be examined on their knowledge of the specific legislative provisions contained in the

²¹ Regulations and minimum curriculum for a degree in pharmacy, Government Notice No. 5433 of 18 March 1955.

Medical, Dental and Pharmacy Act of 1928, governing (among others) 'trading titles', the 'control of pharmacies', 'excessive charges'²².

As the first degrees in pharmacy were introduced in 1956²³, all pharmacists who were practising in South Africa up until the 1960s had registered to practice with the Pharmacy Board on the basis of having obtained a diploma in pharmacy. For this reason the Pharmacy Board's regulations governing the diploma in pharmacy, and in particular the syllabus for this diploma, are crucial for purposes of demonstrating the full extent of the influence of the private sector interest group over the pharmacy curriculum.

Between 1974 and 1981 a number of regulations were passed relating to the minimum requirements to be met within the curriculum of the diploma of pharmacy, in terms of the Pharmacy Act of 1974. These regulations illustrate the influence of the retail sector, particularly on the practical aspects of the pharmacy curriculum. It is worth noting that the science focus of the syllabus still remains consistent with that of the original Colonial Medical Committee (although some of the terminology and content of courses has been modernized). The 1981 regulations prescribe the following subjects for completion of the diploma:

Pharmacy I

- Botany, Chemistry I, Physics and Zoology; or
- Biology, Chemistry I, Mathematics and Physics.

Pharmacy II

Chemistry II, Pharmaceutics I, Pharmacognosy and Physiology.

²² *Ibid.* See section: Annexure.

²³ The first pharmacy degree was awarded in 1956 by the former Potchefstroom University of Christian Higher Education, with Afrikaans as the medium of instruction (Potchefstroom University of Christian Higher Education Yearbook 1956:171).

Pharmacy III

Health Education (half-course), Pharmaceutical Chemistry I, Pharmaceutics II and Pharmacology I.

Pharmacy IV

Forensic Pharmacy, Pharmaceutical Chemistry II, Pharmaceutics III, Pharmacology II, and Pharmacy Administration²⁴.

It is significant that within this 1981 prescribed syllabus the practical focus of the curriculum was heavily biased in favour of the retail pharmacy sector's interests. The Pharmacy Administration course requires a range of skills and knowledge competencies necessary for the 'running of a retail pharmacy'. These included 'a review of company law and its influence on retail pharmacy', 'running a business', 'management', 'financial administration', 'trading', 'acquiring a pharmaceutical business' and marketing and merchandising with reference to a retail pharmacy²⁵.

The abovementioned regulations governing the minimum curricular requirements for the awarding of degrees and diplomas at universities and technical colleges, respectively, remained in place until 1994, when they were superceded by a new set of regulations and educational policy initiatives (refer to section 4.2.2 for a more detailed discussed of the new regulations and educational policies).

4.1.4.1 Pharmacy education at Rhodes University

Rhodes University was the first South African university to offer pharmaceutical degrees with English as the medium of instruction in 1957. The first year of the course comprised chemistry, physics, botany and zoology and was taught to three second-year students in a borrowed Chemistry Honours Laboratory (Haigh *et al* 2005: 22).

²⁴ Regulations relating to the Diploma in Pharmacy, Government Gazette No 5897 of 3 March 1978 and amended by Government Gazette No 7566 of 1 May 1981.

²⁵ *Ibid*, section 'Schedules: Syllabuses for the Diploma in Pharmacy'.

The Bachelor of Science in Pharmacy syllabus, as set out in the Rhodes University Calendar, is almost identical to that set out in the 1959 rules and minimum curriculum for a degree in pharmacy, as prescribed by the Pharmacy Board. It required the completion of an ordinary Bachelor of Science first year course in Botany, Chemistry, Physics and Zoology, followed by two further years in which students completed the following courses: Pharmacy; Physiology and Pharmacology; Pharmacognosy; Forensic Pharmacy; and, Pharmaceutical Chemistry (Rhodes University Calendar 1959: 205 & 206).

As of 1970 the degree of Bachelor of Science in Pharmacy at Rhodes University was extended to a four-year degree. Whilst the science courses within the curriculum remained unchanged a new course on pharmacy administration was coupled to the existing forensic pharmacy course. Its content included sections on 'the organization of the pharmacy', 'records', 'business records', 'balance sheets', and 'insurance' (Rhodes University Calendar 1971: 262).

In 1972 the Department of Pharmacy changed its name to the Department of Pharmaceutical Sciences (*ibid*: 248). In 1975, representing its ongoing process of expansion, the Department became the School of Pharmaceutical Sciences - still within the Faculty of Science (Rhodes University Calendar 1975: 270). In 1976 the degree of Bachelor of Science in Pharmacy was changed to a Bachelor of Pharmacy (Rhodes University Calendar 1976: 278).

At the height of the School of Pharmaceutical Sciences' development and expansion, in 1980 a separate Faculty of Pharmacy was established at Rhodes University. Between 1977 and 2002 the syllabus offered within the Faculty remained remarkably consistent (with the legislative requirements at the time), save for the introduction of courses such as 'computer science' and 'statistics' in the first year (Rhodes University Calendar 2002: 96). One notable exception to this pattern was the introduction of the Community Experience Programme into the Pharmacy Administration and Practice course at fourth year level (this programme will be discussed at length at the start of the next chapter) in 1996.

As the above analysis has attempted to illustrate, after 1928 control over the pharmacy curriculum in South Africa, particularly the syllabus relating to pharmacy practice, was highly controlled and strictly regulated. The content of the curriculum is a reflection of the retail sector's domination of the Pharmacy Board, which controlled pharmacy education during this period, through a process of what Archer has defined as 'political manipulation' (refer to section 3.3.1.1 for a detailed discussion of the three forms of negotiation, including political manipulation, as advanced by Archer).

This is not the only manner in which the private sector interest group sought to secure an influence over pharmacy education during this period. Again, using Rhodes University Faculty of Pharmacy as an example, the manufacturing sector has also attempted to influence pharmacy education via a process of external transaction.

Archer describes the process of negotiation via external transaction as involving external interest groups outside educational institutions negotiating with those inside (such as academics) in order to develop educational services which meet their needs (see section 3.3.1.1 for a more detailed discussion of Archer's external transaction). External bodies who 'do not receive all of the educational services they require' will enter into negotiations with the educational profession and 'offer more resources in exchange for better services' (Archer 1979: 240).

At Rhodes University in 1987 a Biopharmaceutics Research Institute was established as a result of collaborative research between Lennon Laboratories Ltd (now Aspen-Pharmacare) and the Faculty of Pharmacy: 'The Institute provides a facility with the necessary equipment and expertise to assess new formulations of various drug products destined for both the local and overseas markets' (Haigh *et al* 2005: 23).

A recent historical account of the Faculty recounts how 'over the years strong links have been forged with the pharmaceutical industry, where contractual projects

involving bioavailability studies, analytical method development and numerous other industrial problems are undertaken. The Faculty has had tremendous support for many years from the local drug companies Glaxo and Roche who sponsor functions for our staff and students. We have also been supported by a number of other drug companies with bursaries and donations' (Haigh *et al* 2005: 24).

4.1.5 Challenges to the private sector domination of the South African Pharmacy Council

Since the South African Pharmacy Board was tasked with the control of pharmacy education in the country, following Archer, an examination of the changing goals of the Pharmacy Board (and later Pharmacy Council) is necessary to understand why pharmacy education in South Africa has the particular characteristics that it does.

The private sector domination of the pharmacy profession and the pharmacy education system in South Africa is clearly illustrated through an analysis of the composition of the various provincial and national pharmacy boards between 1928 and 1985. The composition of the national Pharmacy Board (which became the Pharmacy Council in 1985) – responsible for examining and registering pharmacists and issuing pharmacy diplomas – illustrates the relative dominance of the private sector pharmacy lobby during this period²⁶. In 1928 the Pharmacy Board consisted primarily of members elected by the APS with a ratio of three government representatives to six members elected by pharmacists (South Africa, 1928). In 1979, with the establishment of the 1974 Pharmacy Act, this ratio increased to six government representatives to eight private sector pharmacists (six elected pharmacists and two academic pharmacists) (South Africa, 1979).

²⁶ The composition of the Pharmacy Board is important given its ability to determine the pharmacy curriculum from Archer's point of view. Archer asks the question 'suppose some given group is in such a position of educational control that they can dictate the detailed contents of instruction. What will these be?' The general answer she provides is those 'contents that advance that group's material interests' (1981: 279). She suggests that there is always a relationship between interests and ideas.

In 1985, when the Pharmacy Board was transformed into the Pharmacy Council, the beginnings of a shift toward increased government representation on the Council are noticeable. With the ratio increasing to seven government representatives to six private sector pharmacists, this marked the first time that the number of government representatives outweighed the number of private sector pharmacists on the Council (South Africa, 1985).

With the transition to democracy in South Africa in 1994, the new government was quick to make its intentions known that it was no longer satisfied with its previous representation on the Council. Nor was it happy with the manner in which the highly organized private sector pharmacy lobby had dominated the pharmacy profession and the education and training of pharmacists in South Africa. This heralds the emergence of government as a powerful interest group, not only concerned with influencing the content of pharmacy education but intent on securing control of the pharmacy education system. In one of the first regulatory changes after assuming office, the government (via its domination of the Pharmacy Council) introduced an amendment to the regulations relating to the minimum requirements of the curriculum for a degree in pharmacy. This amendment required all pharmacy students to undergo 'integrated practical training at, inter alia, community health centres, hospitals and selected community pharmacies'²⁷.

In 1995 the National Department of Health amended the Pharmacy Act to provide for the establishment of an Interim Pharmacy Council, the entire membership of which was to be appointed by the Minister of Health. The amended Act made it the responsibility of the Council to advise the Minister on how to make the profession more democratic and how to reorient its norms and values toward greater 'equity, accessibility and community involvement' (South Africa 1995a).

By 1995 it is clear that the two main interest groups seeking to exert an influence over the education of pharmacists in South Africa were the private sector pharmacy

²⁷ Regulations relating to the minimum requirements of the curriculum for a degree in pharmacy, Government Gazette No.1528, September 1994. Section 2(4).

lobby (led by the PSSA, but incorporating the interests of retail, wholesale and manufacturing pharmacy) and the new government (in the form of the National Department of Health) which was beginning to challenge the dominant position of the private sector.

The government-appointed Interim Council gave way to the newly established Pharmacy Council in 1997, with a new mandate and composition. The mandate of the Council was now expanded to include the regulation of pharmaceutical services within the public health care system. Thus, in addition to its traditional role of regulating the profession (by setting minimum standards for practice of pharmacy, and education and training), the Council was also now responsible for assisting the health department 'to uphold and safeguard the rights of the general public to universally acceptable standards of pharmacy practice in both the public and the private sector' (South Africa 1997c).

The composition of the Council by 1997 represented a decisive shift in the previous balance of power between government and the private sector in government's favour. The new Council consisted of 25 members, with a ratio of 9 elected pharmacists to 16 members appointed by the Minister of Health:

- 9 elected by pharmacists
- 9 pharmacists nominated by Provincial Health MECs and appointed by Minister
- 1 officer from the National Health Department appointed by the Minister
- 2 academic pharmacists nominated by universities and appointed by the Minister
- 4 other persons (including one lawyer) appointed by the Minister (South Africa 1997c).

The government interest group was now beginning to consolidate its position of domination over the Pharmacy Council and to extend this domination over the pharmacy education system in a bid to change the content of pharmacy education

and to gain more influence over the profession. As Archer points out, educational change occurs 'because new goals are pursued by those who have the power to modify [its] previous structural form, definition of instruction and relationship to society' (1979: 2).

4.2 Negotiation within the pharmacy education system

Archer notes that prior to the establishment of state educational systems, education was a matter of private enterprise. This was clearly the case with pharmacy education in South Africa prior to 1928. During this period there was a struggle for control over pharmacy education between what Archer terms the 'dominant group' of medical doctors and an 'assertive group' of private sector pharmacists (Blackledge & Hunt 1985: 330).

According to Archer, with the establishment of a national education system, however, priority is given 'to developing those forms of instruction from which political elites would gain most' (*ibid*). Control of education passes to the politically powerful and the system becomes increasingly centralized. This, arguably, was the situation in South Africa with the emergence of a highly centralized pharmacy education system, and a tightly regulated pharmacy curriculum, between 1928 and 1994.

During the period after 1994, as I hope to illustrate in the following section, although the government managed to displace the private sector as the dominant interest group (forcing the private sector to assume the role of the assertive group) the influence of the private sector over pharmacy schools in South Africa (such as Rhodes University) remained strong. This led to a deadlock between the two interest groups and has led to a period of protracted contestation within the pharmacy education system.

As pointed out previously, following Archer's framework, with the establishment of national educational systems various forms of negotiation between competing interest groups came to replace open conflict in order to secure educational change. In the following section I provide an illustration of how the government interest group has been making increasing use of what Archer refers to as 'political manipulation' as a form of negotiation in its effort to secure educational change.

According to Archer, political manipulation is the principle resource used by political authorities and includes their ability 'to impose regulations, to withhold benefits and recognition, as well as to penalize irregular practices and offending parties' (1979: 399). It consists of those groups who dominate central decision making 'using their powers to extract the educational services desired and to preclude undesirable outputs' (*ibid*).

4.2.1 Skewed resource allocation within the South African public health care system

When it came to office in 1994, the new democratic government in South Africa (broadly representative of the interests of disadvantaged black South Africans, and organized through the 'liberation' political party, the African National Congress) was met with a deeply divided health care system. It encountered a public sector characterized by racial segregation and the skewed allocation of resources in favour of a small minority of South African citizens. Consequently, the government interest group began to grapple with the challenge of how to steer health policy in the direction of a more equitable distribution of health resources to the entire community. Of particular concern to the new Department of Health was the unequal distribution of pharmacists between the private and public sectors.

Six years after the transition to democracy in South Africa the government noted its concerns with the continued unequal distribution of pharmacists. At this time in 2001, a year before the research that formed the basis for this thesis was conducted, 36.2 million out of 43.3 million people in South Africa were dependent on public health

care facilities (HST 2001: 288 & 289). Yet, of the 10 537 registered pharmacists (SAPC 2000: 23) only 1 085 worked as hospital pharmacists in the public sector. This amounts to over 80% of the South African population relying on a public sector health care system employing only 1 085 hospital pharmacists. These figures translate to a ratio of 3.1 hospital pharmacists per 100 000 people. This distribution is particularly skewed, even when situated in the context of the health profession more generally with 120.3 professional nurses, 21.9 medical practitioners and 11.2 medical specialists per 100 000 people during the same period.

Historically, the reason for this unequal distribution of qualified pharmacists in South Africa can be traced to the fact that pharmacy graduates could register in any sector of their choice, and most pharmacists traditionally chose to practice in the privately owned retail pharmacy sector. According to Summers *et al.* (2001) over 50% of all registered pharmacists worked in the retail pharmacy sector in 1998; whereas Gilbert (1998a) has put this figure much higher, arguing that as many as 65% of all registered pharmacists are employed in this sector in South Africa.

In an effort to alleviate some of the burden on the under-resourced public health care system, the government interest group, via the Pharmacy Council, introduced a compulsory, remunerated community service year for all new pharmacy graduates at the end of 2000. This led to the introduction of 406 new pharmacists to the public sector in 2001 (HST 2001: 322).

The above serves to illustrate the devastating impact that the previous state's policy of apartheid has had on fostering inequalities in the South African health care system. It serves to show, particularly from the point of view of the government interest group, how the pharmacy profession has been affected by the political and social policies pursued by South Africa's apartheid state (Gilbert 1998a: 274).

4.2.2 Policy interventions and changes to the pharmacy curriculum by the government interest group

For this reason it was only a matter of time before the government interest group began to employ its resources and engage in a process of negotiation with other interest groups within the pharmacy education system (such as the academics and administrators) via political manipulation, in order to bring about changes to this system.

The most significant legislative interventions made by the government interest group, in its efforts to influence the distribution of pharmacists between the public and private sectors in South Africa, are set out in the human resource development aims in the National Drug Policy of 1996 and the amendments to the Pharmacy Act No. 53 of 1974..

The new government introduced a National Drug Policy in 1996 in order to transform the South African pharmaceutical sector. This policy document indicated that the entire sector needed to change in order to achieve the state's primary aim, viz. 'equity in the provision of health for all' (Department of Health, 1996:3). Part of the strategy for realizing this aim consisted of the introduction of a compulsory community service year at the end of 2000.

Specifically with regard to higher education, the National Drug Policy made the government interest group's intentions very clear by stating that it intended 'transforming training institutions so that they produce health care professionals who function effectively and efficiently in meeting the country's health care needs'. It proceeded to specify that: 'with regard to institutional training, the curricula and syllabi of the training institutions will be appropriately modified to produce suitably qualified and motivated health workers' (Department of Health, 1996:20).

Pharmacy education in South Africa (at least within universities such as Rhodes University, after 1960) had historically involved a basic science first year, followed by

three years of professional studies. At the successful completion of a university-based academic programme students were then required to undertake a one-year structured internship (formerly referred to as an apprenticeship). Those graduates who completed their internship prior to 2000 were able to register as pharmacists with the South African Pharmacy Council (SAPC) and were free to practice in any sector of pharmacy. By contrast, pharmacy students graduating after 1999 were required to complete a year of community service in the public sector after completion of their internship. Only on this basis could they register with the SAPC as qualified pharmacists (Summers, *et al.* 2001: 150).

The government interest group's interventions to address health inequalities by producing pharmacists more attuned to the needs of the South African public health system resulted in a number of amendments to the Pharmacy Act after 2000, which were designed to align pharmacy curricula with the National Drug Policy. Government shifted the responsibility for ensuring compliance with the new educational requirements set out in these amendments to the SAPC. In response to this pressure²⁸, in November 2000, the SAPC for the first time prescribed a set of outcome competencies for entry-level pharmacists, referred to as Unit Standards²⁹.

These Unit Standards, which had to be adhered to by all pharmacists, irrespective of their chosen setting, included the following:

- Organise the manufacturing, compounding and packaging of pharmaceutical products;
- Organise the procurement, storage and distribution of pharmaceutical products;
- Dispense and ensure the optimum use of medicine prescribed to the patient;

²⁸ As well as in response to its mandate as the Education, Training and Quality Assurance (ETQA) body for pharmacy education and training, recognized as such by the South African Qualifications Authority (SAQA) – a statutory body responsible for overseeing the development of the National Qualifications Framework and for formulating, publishing, and implementing educational standards in the country (South Africa 1995b).

²⁹ These were published as appendices to the Regulations relating to Pharmacy Education and Training, Government Gazette No. 1156 of 20 November 2000.

- Provide pharmacist initiated care to the patient and ensure the optimum use of medicine;
- Provide education and information on health care and medicine;
- Promote community health and provide related information and advice; and
- Participate in research to ensure the optimal use of medicine³⁰.

Other than the traditional roles of dispensing and ensuring optimum use of medicines prescribed by an authorized person, what is apparent in the wording of these standards is the desire to produce graduate pharmacists equipped to address primary health care needs. In particular, according to the new regulations, all pharmacists are required to be able to provide education and information to their patients on community health as well the dosage and use of medicines. This, however, requires pharmacy students to have an understanding of health needs within poor black communities and an appreciation of the specific challenges they face regarding their adherence to medicine regimens.

All of these requirements raise the question of the degree to which the pharmacy education curriculum in South African universities had been influenced by government's interventions via political manipulation, and its introduction of new policy priorities some two years after their promulgation into law. To what extent, by 2002, could evidence be found of what Archer terms the 'internal initiation' of educational change within South African pharmacy schools/faculties by academics and administrators, in line with government's new policy priorities?

In the following chapter I provide a detailed discussion of the Rhodes University Community Experience Programme as an illustration of an attempt at bringing about a change in South African pharmacy education through a process of internal initiation. I also consider the impact that this programme has had on Rhodes University pharmacy students' perceptions of the role of the pharmacist in post-apartheid South Africa.

³⁰ *Ibid*

Chapter 5

RESEARCH FINDINGS AND DISCUSSION

The previous chapter adopted Margaret Archer's theory of educational systems as the theoretical framework for analyzing pharmacy education in South Africa. It discussed the emergence of the pharmacy education system and the formation of various interest groups in the pursuit of educational control. The chapter concluded that the dominant interest groups within pharmacy education in post-apartheid South Africa were the private sector pharmacy group and the government, in the form of the National Department of Health.

Through a detailed analysis of focus group interviews with Rhodes University final year undergraduate pharmacy students, this chapter illustrates the degree to which these students' conceptions of the role of the pharmacist in post-apartheid South Africa can be said to provide a reflection of the influences of the dominant interest groups within the pharmacy education system. The first section of the chapter details how students' comments illustrate the overwhelming influence of the private sector pharmacy interest group – particularly the retail pharmacy³¹ sector – on their understanding of the role of the pharmacist in contemporary South Africa.

The chapter then goes on to discuss the government interest group's vision of the role of the pharmacist in post-apartheid South Africa. It attempts to demonstrate that the government interest group's notion of the concept of 'community' is at odds with that of retail pharmacy as articulated by the students. It argues that the government interest group's increasing frustration with the domination of the private sector interest group over the control of the pharmacy education system, may lead to increased centralized

³¹ Though the terms 'retail pharmacy' and 'community pharmacy' are used interchangeably within the pharmacy profession, I have chosen to use 'retail' to emphasize the commercial/ business aspects of this particular branch of the profession. It is also important to note that the majority of retail pharmacies in South Africa are situated in urban areas, and concentrated in the wealthier provinces within the country (Gilbert 1998a) thus restricting access to the privileged sectors of the population, which represent only a fraction of the South African population in need of pharmaceutical services.

control over the system, and the contents of the pharmacy syllabus in particular, by way of political manipulation.

In the second section of the chapter, an alternative to increasing state regulation is posed, in terms of Archer's concept of internal initiation. It is argued that individual pharmacy schools and faculties making up the pharmacy education system are in a position to take steps which would preserve their professional autonomy and preempt increased government regulation. Pharmacy academics may exercise agency and have the ability to initiate educational change which is consistent with their own professional goals, and which also addresses many of the needs of the government interest group.

The Rhodes University Community Experience Programme (CEP) is presented as a case study of such a possibility. Its development in relation to the professional goals of its initiator are explored, and the resultant influence of this course on students' notion of the concept of 'community' is investigated through a second series of focus group interviews (the first set having been conducted prior to the CEP), participant observations and documentary analysis of students' portfolios at the end of the course.

The third, and concluding section of this chapter, provides a description of the students' changed conception of the meaning of community pharmacy in post-apartheid South Africa and their enhanced understanding of primary health care. The students' new understandings are said to be largely consistent with the interests of the government interest group.

5.1 The influence of dominant interest groups on students' perceptions of the role of the pharmacist

This section provides a detailed analysis of the research findings resulting from the focus group interviews conducted with the fourth year pharmacy students at Rhodes University (prior to their participation in the Community Experience Programme)

(refer to section 2.3 for a detailed discussion of how the research data was analysed and interpreted). These interviews concerned the students' perceptions of the role of the pharmacist in South Africa. During the course of the interviews four key questions were put to the students. These were:

- How do you understand the role of the pharmacist in South Africa?
- What skills, knowledge and attitudes do you need to know to fulfill that role?
- Why do you think the study of pharmacy is often referred to as pharmaceutical science? Do you think this course will contribute to the scientific understanding of the pharmacy profession in South Africa? Why?
- Do you think that it is necessary for a pharmacist to have a broad understanding of South African society and its social problems, in order to fulfill his/her responsibilities as a pharmacist? Why?

Following Archer's conceptual framework (discussed in section 3.3.1), the students' perceptions are considered in light of the 'complex types of social and educational structures which shape the context in which interaction and change occur' (Archer 1979:4). Recognising that the initial educational structure – viz. the pharmacy education system set out in Chapter 4 – conditions (but does not determine) educational interaction, the influence of the various interest groups on such interaction is the central focus of this section. In other words, this section attempts to demonstrate how the pharmacy education system, which is shaped by the two abovementioned interest groups, has served to condition the final year pharmacy students' learning experiences and inform their perceptions of the role of the pharmacist.

5.1.1 The influence of private sector interests

The assumption that any discussion of the role of the pharmacist in South Africa implicitly involves a discussion of the role of the retail pharmacist was evident throughout the interviews with the students.

In particular, the students' comments reflect their extensive exposure to, and intellectual engagement with, the practical and ethical issues pertaining to the practice of retail pharmacy as illustrated in the previous chapter. This exposure arises largely out of their initial three years of study as well as their experiences as either temporary employees and/or consumers within this particular practice setting.

The students had all completed a two-week vacation externship programme (referred to as the Vacation Experience Programme) during the end of their second and third academic years of study. This is in keeping with the regulations to the Pharmacy Act published in 1994 which stipulates that the pharmacy curriculum has to incorporate what it terms 'integrated practical training'. Such training has to take place at, *inter alia*, community health centers, hospitals and selected community pharmacies. The Vacation Experience Programme was introduced into the Rhodes University pharmacy curriculum in 1996 with the express intention of providing undergraduate students with 'hands on experience working in [retail] pharmacies across the country during their December vacation period' (Burton 1998b: 282). It is a structured programme of work-based learning activities which provides the students with 'a more solid foundation for using [their] work experience as the basis for teaching within the classroom' (*ibid*). One student recounts her experience of working in a retail pharmacy during her end-of-year vacations:

The first time I started working in a [retail] pharmacy, I was really scared, you know, all that second year knowledge... When I went again in my third year I felt more comfortable, having some background in pharmacology, and I feel that I could communicate with the pharmacist. If a patient had a problem I

could talk to him [*sic*] about certain things and I felt very good and felt very comfortable in the pharmacy, in the dispensary [fg3 Feb02; p8]³².

Most students believed that this externship experience was very valuable and that it provided an opportunity for the practical application of the theoretical components of the academic courses. They maintained that this practical experience had helped to demonstrate the relevance of their studies to their future roles as pharmacists.

In second year, you get to a point where you try to cram so much into your head, suddenly at the exam you start asking yourself why am I doing this, and there was just no answer to that until when we started the externship programme where you meet people. These people are who I am actually studying for, it has helped me a lot. Especially, this year I have a much more positive attitude because I actually felt like I did something this vacation. Whereas in second year you're really lost, because even a [retail pharmacy] shop assistant knew more than you and they had not done a pharmacy degree and that was one very big thing, when I came into third year I felt really lost, but after this vacation I think now, I'm very positive about this year and I want to do more and I want to learn more just because I know that it's going to make a difference in the end [fg2 Feb02; p9]

The abovementioned emphasis on retail pharmacy within the curriculum appears to be justified in the minds of the students given that most seem to have entered the degree programme with the intention of becoming retail pharmacists. The majority of students interviewed only appeared to have discovered the existence of other practice settings once they had completed their first two years of the academic programme.

- S1: When I started the degree, in the second year I found out that oh you can go into industry and hospitals. Because I always thought... that pharmacy was only retail, because all my family was just in retail. So I always assumed that it was retail.
- S2: Most of the pharmacists that the public have contact with are all in retail. So you think okay that is the pharmacist.
- S3: So it's a nice surprise [to discover that there are different practice settings within the pharmacy profession] [fg01 Feb02; p10]³³.

³² The annotation [fg3 Feb02; p8] refers to the following: Interview with focus group number 3, which took place in February 2002; quotation extracted from page number 8 of interview transcript.

³³ My method of attributing quotations is as follows: Each student is assigned a number reflecting their order of contribution to the conversation in order to preserve their anonymity. They are referred to in

The full extent of the domination of the students' perceptions of the role of the pharmacist by the interests of retail pharmacy is illustrated by the students' efforts to reconcile the competing business and professional aspects of the 'role of the pharmacist' as the following focus group exchange illustrates:

S1: The way we've been educated from high school... it was always the science subjects: you do maths, physics, biology... but actually you need lots of other things. You need accounts definitely, I wish I'd done accounts. You need administrative skills so much more, so the role isn't just dispensing and most people don't realize that.

S2: I don't think the public realizes all those things...

S1: They [the public] don't realize that, because they [the pharmacists] do that after hours. At five o'clock the pharmacy shuts down and she [the pharmacist] starts calculating the money, going, telling messages, taking stuff to the bank. So much...

S3: But don't you think that's not the role of pharmacists in terms of public health? That's more like just being a businessman, and maybe that is something that should be separate from the role of pharmacists.

S4: But we mustn't take away the fact that we are pharmacists, but as well we are businesspeople. For you to be able to provide a service like healthcare for instance, you have to be able to manage the whole system... So all this business as well, of managing, accounts and all that, I think it is in a way a role that fits into the whole big picture of providing a service

S1: Definitely... [fgd 2 Feb02; p4]

The students view this conflict between the business and professional aspects of the retail pharmacy profession as a direct result of the mismatch between their perceived ideal role of the pharmacist and what Gilbert (1995) refers to as the 'occupational reality' of the retail pharmacist.

Hepler (1989) believes that the business and professional systems operating within present-day retail pharmacy are theoretically incompatible (p409). The business

the text as student number one (viz. S1), student number two (viz. S2) et cetera. Similarly, my comments, as the focus group interviewer, are cited as 'LA'.

system is geared towards maximizing profits and the professional system is concerned with ensuring optimal patient care. This incompatibility was expressed by one of the students:

[Recently] I was looking for vitamin and mineral supplement tablets but wanted the cheapest kind... so I went to the pharmacist and asked him for [some]... The first thing he did for me was he took me to the most expensive ones... that just showed me *again* that [the retail pharmacist] was trying to sell me the most expensive ones... [retail pharmacists] are not really out to perform a service they're just out for their own interest, to make money' [fg1 May02; p3, my emphasis].

These tensions were not lost on the Rhodes University students interviewed. They expressed overall dissatisfaction with the pharmacist's 'traditional' role of simply dispensing medicines according to a medical doctor's prescription. Gilbert (1998c) has made similar observations in her study of pharmacy students at the Witwatersrand University. The Rhodes University students felt that they were essentially overqualified for such a technical task, and that they would rather perform new tasks that took into account all their expertise. Instead they believed that the pharmacist should increasingly engage in what Harding *et al* (1990) refer to the 'extended role' of the pharmacist. The 'extended role' requires the pharmacist to interact directly with the public, offering a range of services including health care advice, information, recommendations, directions and instruction, in addition to ensuring that patients receive the correct medication and understand how to use their medicines correctly (Harding *et al* 1990: 1).

They blamed the general public for not recognising the pharmacist's abilities, and expressed the belief that society's perceptions of the pharmacist were the chief constraint to the realization of pharmacist's full potential.

S1: I think the role is really undermined, because... from personal experience, you go to a pharmacy and just see a guy standing behind a counter... The volume of what the pharmacist actually knows, I don't think this really appreciated...

LA: Okay... to take your point further, you started off by saying that you feel the role is undermined, undermined by whom?

- S1: The public. [They view the]... pharmacist as someone who counts tablets in that pharmacy... They don't know, [that the pharmacist has studied] four years of pharmacy, [including] pharmacology, [and that] it's intense work. They don't understand... these people [the retail pharmacists] can't just stand and count the pills, there's more to it [the role of the pharmacist] than just counting pills.
- S2: Especially when you work [in a retail pharmacy], you just sit behind the dispensary and you don't do anything except write out 'two or three times a day' and that's all we [as pharmacists] do...
- S3: So they [the public] don't realize that we have contact with the patients, they don't see it as a patient focus, they see it as a drug focus. [fg3 Feb02; p1&2]

Denzin and Mettlin (1968) argue that the consequence of viewing the drug as a product, rather than an object to direct patient-centred service towards, is that the pharmacist is forced to violate some of the basic rules of being a professional. The pharmacist becomes the agency through which the drug may be obtained rather than an individual who makes some healthcare service contribution (p377). The irony of blaming society for its lack of appreciation of the pharmacist's role, whilst simultaneously expressing little appreciation of the pharmaceutical needs of the majority of people making up South African society, was generally lost on the students.

Whilst not all students' perceived interests could be said to be aligned with those of retail pharmacists, those who expressed an interest in working in one of the other practice settings (such as hospital or academic pharmacy) were the exception. One student expressed her frustration with the public's perception of pharmacy as consisting mainly of retail outlets. As this student put it "if you see somebody [a member of the public] and he [*sic*] asks you what are you studying, and you say, well I am studying pharmacy...[he says] 'oh you are planning to open your own retail' " [fg2 Feb02; p7].

The same student believed that the goals of business and the profession were incompatible, and as a result felt despondent about the reality of retail pharmacy practice:

'I don't want to be a manager in that sense, I have to think about the staff being happy and all that. My main role, to me, is to be the pharmacist. I want to be the person there with the patient coming in; I want to help them mainly. I would much prefer to work in a situation where other people are doing all that stuff that I hate, I'm not doing a managing degree, I'm doing a pharmacy degree, and that's where my passion is' [fg2 Feb02; p5]

5.1.2 Preoccupation with competition between retail pharmacists and medical doctors

Another illustration of the overwhelming influence of the private sector pharmacy interest group over students' understanding of the role of the pharmacist, is the pervasive belief expressed that the pharmacist's economic viability is threatened by the existence of the dispensing doctor. As a consequence, the students appeared to be primarily concerned with the pharmacist's professional status in relation to the medical doctor. As far as the students were concerned, the pharmacist's role (and viability) was highly dependent on the community's continued patronage as illustrated in the following exchange:

- S1: ... I have worked at two different [retail] pharmacies... through my holidays... People come to the pharmacy first and treat you [the pharmacist] like a doctor. They came with skin conditions and everything... And maybe it also depends on where you are working in fact, because the community where I was working, people really wanted to know lots about drugs and why they were taking them and side effects and wanting to know everything from the pharmacist. So it also depends where you are working, because different pharmacies do things differently.
- S2: I do agree with S1...because [of] where I was working... this last vacation. We had people coming in treating the pharmacist as a doctor asking about skin conditions and other personal problems, you'd be surprised. But people will come, and I think that was simply because with the group of pharmacies that I was working for, they actively made it known to the people what they can do and what they are about.
- S3: I think the pharmacist [is]... the first point of contact, like when people have a problem, a skin problem or eye problem. They come to the pharmacist first, because they don't have to pay for a [medical] consultation, and they can get some information...'

Later on in the discussion

S4: [The pharmacist's role depends] on which community you come from, that is what I think counts the most...[depending on the] background that you are from, the perceptions will differ ... For example in my community we have got a pharmacy, [and] people are thinking, are expecting [that] maybe they've got no medical aid, and cannot afford medicine [from the retail pharmacy]. They would rather go to a doctor who is going to dispense, then they know that for a hundred rand they are getting medicine and treatment. They are getting treatment and they don't have to think they are going to a pharmacy again and paying someone else a hundred rand for medicine, you see. So that is why I am saying, the role is different depending on where you come from [fg2 Feb02; p2].

As noted in section 4.1.1, since the mid-1880s the retail pharmacists' material interests has been threatened by dispensing doctors. According to Gilbert (1998b), there has been a significant increase, over the past 20 years, in the number of medical doctors who have been granted licenses to dispense medicines. Originally, this provision was intended to address the needs of communities where there were no pharmacies. Gilbert argues that the number of registered dispensing medical doctors has increased over the years owing to a host of primarily socio-economic factors, as well as the State's failure to provide adequate health care for all. As a result, since 1990 the numbers of dispensing doctors in South Africa has eclipsed that of retail pharmacists. By 1995, dispensing doctors outnumbered retail pharmacists by 2025 (p84).

In an open interview, The President of the Pharmaceutical Society of South Africa (PSSA) in 1994 expressed his exasperation with this state of affairs:

'we have fought tooth and nail against dispensing doctors. But because of the statuses that exist, the problem seems insoluble. The doctors say that have an inalienable right to dispense' (Simpson 1994: 691).

In line with these sentiments the students expressed frustration with the subordination of the retail pharmacist's role to that of the medical doctor, who they perceived to be 'the final decision maker' with regard to the patient:

S1: You will be so surprised, how little... the doctor actually didn't realize when they're [sic] prescribing... I was a third year pharmacy student [when I was working in a retail pharmacy]...and [I] picked up so many things that just wasn't [sic] possible. How could the doctor be giving that medication to the patient? I think we are like a back-up system, they treat us as a back-up system, they know that if they prescribe something, they don't need to check it, we will check it, it is our responsibility to call them and I mean half of the time they don't even give a second look, if this is what you [the pharmacist] say, then that is what it is.

Further on in the discussion

S2: [When I was working in] a private hospital, the doctors had been there for years, especially the more specialized [doctors] like the paediatrician. He [the paediatrician] asked for a really high dose, and the pharmacist asked 'what's this?' but he wouldn't [tell her]. The pharmacist even asked him to explain why [he had chosen the high dose] so she could look it up again...[but] he wasn't even interested in telling her why he wanted an extra high dose for this child ...sometimes they [the doctors] get a bit impossible [fg2 Feb02; p2 & 3].

These views are consistent with Gilbert (1998b) who believes that at the heart of this matter is the issue of 'professional dominance', which refers to the way in which certain professions (such as the medical profession) not only control the content of their own work but can also define the limits of the work of other occupational groups (such as the pharmacy profession).

The students also expressed the view that being able to educate members of the public with regard to the use of medicines was also of importance to the role of the pharmacist. However, they were quick to point out that, similar to the pharmacist's dispensing function, this particular component of their role was under threat from dispensing doctors.

LA: ...What would you like the public to think of pharmacists, [particularly] the role of the pharmacist?

S1: I think pharmacists should prove to patients that they know about drugs more than the doctor ...

S2: It would be nice if patients could see us as people who know more about medicines. We know about medicines, but we also know how they relate to health - not just counting them out - ...[and] being able to give the public advice on the use of these medicines [fg3 Feb02; p2].

5.1.3 Students' asocial and ahistorical view of the pharmacist's role

What is particularly striking about the students' responses to the interview questions is their asocial and largely ahistorical views on the role of the pharmacist in South Africa some six years after the country's transition to democracy. They demonstrated little concern for, or understanding of, the pressing social and policy issues affecting the pharmacy profession (as outlined in the previous chapter). Although on the whole, most students felt that it was necessary for a pharmacist to have a broad understanding of South African society and its social problems, their level of understanding appears to be once again limited to their concerns with the retail pharmacy practice setting. Furthermore, this understanding entirely ignored the health care needs of the overwhelming majority of the country's citizens who cannot afford private health care.

S1 : Ja, I think it's necessary for them [practising pharmacists to have a broad understanding of South African society and its social problems] because when we are in [a] pharmacy, especially in the retail [setting], you deal with different kinds of people and knowing their social [backgrounds]... is very important...

S2: I think the exposure would be better for... going into retail. In industry you're not really one-on-one with the South African public as it is. And the other thing I was going to say was, a lot of people ...don't actually practice in South Africa and they probably find they go abroad. So I mean to them it may be, that there's no need to know [something about] South Africa [and its social problems] ... [fg3 Feb02; p7]

It is significant to note that none of the students interviewed mentioned the momentous political changes that had occurred in South Africa since 1994 with the establishment of democracy and the ascendance to power of the African National Congress (ANC) and the associated changes in health policy. Nor was any reference

made to the public health care needs arising out of the HIV/AIDS pandemic, or health policy issues relating to the pandemic.

The students' observations seemed to be limited to the more superficial recognition of the existence of different cultural and socio-economic groups within South Africa. They felt that it was important to be aware of cultural differences because the pharmacist and the patient needed to 'understand each other', such that the pharmacist could 'build that trust' which was necessary to 'develop a relationship'. In other words, it was important purely as a functional pre-requisite for effective communication with patients from a different cultural background to that of the student, rather than for purposes of developing an understanding of the socio-economic factors affecting the patients' health care needs.

Similar findings were uncovered in a study of pharmacy students' experiences of the content of pharmacy education at the former Potchefstroom University of Christian Higher Education. The authors found that the students recognized the need for more information on the cultural aspects which affect the practice of pharmacy in South Africa (Rothmann *et al* 1998), yet its relative importance in terms of the overall course content was ranked very low.

Only one of the Rhodes University students interviewed during the focus group interviews mentioned that the role of the pharmacist was 'going to change quite rapidly' because 'when we [the four year pharmacy students] look at what we have done, last year, where we're changing...the way we think about... education, primary health care, planning, [and] counseling...' However, neither the rest of the group nor the other groups interviewed shared this sentiment.

This student's reference to primary health care is very significant. As mentioned in the previous chapter the new State, via the National Department of Health, has since 1996 set about transforming the public health care sector and shifted the emphasis of public health delivery to primary health care (Gilbert 1998a). The emphasis of the National Drug Policy (1996) on primary health care entails unprecedented changes

for the practice of pharmacy with the development of public sector treatment guidelines and essential drugs lists. This policy also requires that the education and training of pharmacists be community orientated, with specific regard to amongst other things, drug supply management, hospital pharmacy administration and primary health care (Rothmann *et al* 1998: 30)³⁴ (refer to section 5.1.4 below for a detailed discussion of the relevance of primary health care to pharmacy education in post-apartheid South Africa).

The focus group interviews, however, served to demonstrate the students' complete ignorance of these developments in health policy and their lack of exposure to the State's concerns within public sector hospital pharmacy.

LA: ...what about in the public sector? The Essential Drugs List is the list of drugs that you are allowed to use, dispense, as a pharmacist on the ward rounds. You don't decide what new drugs come onto that list, somebody else does. It is a national list for all the public hospitals in the whole country. Do you think it's still important to keep up to date [with continuing education initiatives]?

S:(Silence)

S1: What, do you mean the pharmacists are only allowed to dispense these drugs? [fg1 Feb02; p5]

Similarly, with regard to the community service year - a compulsory remunerative service year in the public sector which had been introduced two years previously - the students showed very little concern for the policy objectives that informed the introduction of this year. Instead they appeared more concerned by what they perceived to be the low rates of remuneration in the public sector. This following excerpt is drawn from a broader discussion around the practice settings within the profession.

S1: So the community service has to be in a hospital?

³⁴ Every attempt was made to obtain more up to date references in this area. However, very few studies on the perceptions of pharmacy students in South Africa have been conducted since 1998. The findings of one such study, which was undertaken in 2004, are extensively discussed at the end of this chapter.

LA: Yes, yes... legislation has been passed through the Department of Health... there is no retail government pharmacy, those are all privately owned. So government owns all the [public sector] hospital pharmacies and clinics, and that's where you will be working... (*one the students says something*) You earn what?

S2: You're earning peanuts [in the public sector].
[fg2 Feb02; p15].

What these exchanges demonstrate is a lack of in-depth understanding of the public sector, its working practices, types of patients, diseases or mechanisms for distributing medication.

5.1.4 The government interest group's vision of the role of the pharmacist

From the above it is clear that the students' perceptions of the role of the pharmacist are based on their experiences of the retail pharmacy practice setting. The students' discussions of their interactions with medical doctors and patients betray the implicit assumption that it is the pharmacist's role to provide pharmaceutical services to that sector of the South African population that can afford to pay for private health care. Consequently, students' references to 'communication' and 'patient care' and the 'general public' are all based on the assumption that 'the community' to be served by the pharmacist is in fact synonymous with the privileged minority of South African's registered with private medical aid schemes.

By contrast, the role of the pharmacist as expressed by the South African Pharmacy Council - as representative of the government interest group - involves contributing towards 'changing health care systems in South Africa' (South African Pharmacy Council 1999: 3). Similarly, the students' views are at odds with the role of the pharmacist contained in the Pharmacy Amendment Act of 2000. It makes provision for a particular category of pharmacists who will undertake a year's training in 'community service' (South Africa, 2000). The regulations governing the performance

of a compulsory pharmacy community service year define such service as ‘the provision of services...in a public health facility or a complex of health facilities’³⁵.

This broad view is consistent with the Department of Health’s National Drug Policy (1996), which maintains that pharmacists ‘have a *community* educational role in instructing patients on the correct use of drugs’. It asserts that, pharmacists ‘have a critical role to play in *primary health care* and preventative health services’ (p18, my emphasis). The term ‘community’ in its usage by the Department of Health thus refers to all citizens of South Africa, and not simply those who can afford to pay for the pharmaceutical services provided in the private sector.

Of particular interest to the government interest group is the underlying philosophy of primary health care, which informs its plans for the restructuring of the post-apartheid health system. The ramifications and implications of this emphasis on primary health care are not elaborated in any detail in the government’s National Drug Policy. To understand the full impact of this philosophy on the new government’s health policies requires an interrogation of the ruling ANC’s party political health objectives, which have heavily influenced these policies (Gray *et al* 2002).

The ANC National Health Plan, which was drawn up in 1994 (the same year that the ANC came into power) states that ‘primary health care will form an integral part, both of the country’s health system, and the overall social and economic development of the community’ (ANC 1994: 2).

The Plan goes on to explain that primary health care ‘embodies the concept of community development, and is based on full *community participation* in the planning, provision, control and monitoring of services. It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities’ (*ibid*: 8, my emphasis).

³⁵ Regulations relating to the performance of pharmaceutical community service, Government Gazette No. 1157, 20 November 2000.

The Plan acknowledges the multi-faceted nature of such an approach to health care and explains how the introduction of primary health care requires a 'thorough understanding of its various aspects' such as its 'philosophical, sociological, economic, political [and] technical' considerations (*ibid*: 10). The fundamental principle of the primary health care approach is that of 'social and economic justice' and 'this understanding is essential for health providers and the population at large' (*ibid*).

These quotations serve to provide a much clearer picture of the philosophy informing the government interest group's new health-related policies, including the National Drug Policy. They also provide a much more substantial account of the kinds of changes to the current pharmacy education system (which requires a total reorientation of its focus to disadvantaged communities and rural areas) and curriculum required to implement these policies.

The authors of the ANC National Health Plan envisage nothing less than a complete transformation of existing 'medical culture' in South Africa after the ANC's assumption of office. In the words of the ANC Health Plan, the introduction of the primary health care focus within the health system will 'inevitably bring about some *radical transformations*, not only of the health services and the training and research institutions, but also of the attitudes of both health providers and those demanding health care services' (*ibid*, my emphasis).

It stands to reason then that after 1994, as a result of the new health care policy objectives of the government interest group (overwhelmingly dominated by the ANC)³⁶, the Pharmacy Council became increasingly concerned with changing the 'traditional undergraduate curriculum based on product knowledge with the pharmacist's primary role being that of a dispenser'. As of 1999, the Council began advocating for a 'practice-orientated curriculum in which patient-centred therapeutic and clinical knowledge [and] social responsibilities' (amongst others) were seen as

³⁶ The ANC, since 1994, when it came to office, has occupied around two-thirds of the seats of the South African National Parliament.

key features of the education of pharmacists (South African Pharmacy Council 1999: 3). As already noted, this culminated in the formation of unit standards contained in the regulations relating to the pharmacy education and training published in November 2000 (refer to section 4.2.2 for a detailed discussion of these unit standards).

Of particular relevance to this thesis is Unit Standard 6 (of the seven outcome-competencies for entry-level pharmacists) in which the entry-level pharmacist will be expected to 'promote *community health* and provide related information and advice' (my emphasis, Annexure A of the Regulations relating to Pharmacy Education and Training, Government Gazette No. 1156 of 20 November 2000).

Whilst the dominant usage of the terms 'community health' and 'community pharmacy' within the pharmacy profession pertains (to this day) to the health needs of private sector retail patients' it is clear that the meaning of the term 'community health' as contained in recent policy documents (such as the National Drug Policy and the above Regulations relating to Pharmacy Education and Training) is consistent with that contained within the ANC National Health Plan outlined above. That is, community health should be viewed as a component of primary health care, with the aim of (amongst other things) reducing inequalities in access to health services, especially in the rural areas and deprived communities.

From the point of view of the government interest group then, this raises the unsatisfactory nature of the students' comments cited above. These comments reflect their superficial understanding of the socio-economic factors affecting disadvantaged patients' health care needs. It also raises the important question of the options open to the government interest group to bring about its goal of ensuring the transformation of 'medical culture' in South Africa and the steps at government's disposal to do so. Following Archer's framework, the primary recourse of the government interest group consists in its use of direct political manipulation in the form of policy formulation. Consistent with previous applications of this strategy government could, with relative ease, pass regulations to transform the current

pharmacy curriculum and syllabus into a set of centrally regulated programmes reflective of its primary health care focus.

In the absence of any form of internal change initiated by academia and the pharmacy profession, it is conceivable that a more heavy-handed regulation of the pharmacy curriculum could result from government's continued frustration with the pace of implementation of its primary health care philosophy. However, as I aim to show in the following section, increasing regulation of the pharmacy curriculum is not inevitable, and the relative autonomy of this curriculum can be defended from direct government intervention (and undue private sector influence). This outcome could be preempted, and ultimately avoided, through internally initiated change within pharmacy schools and faculties. This coincides with Archer's third form of negotiated change within the pharmacy education system, internal initiation.

5.2 Changes to pharmacy education through internal initiation

As noted, according to Archer, educational change through internal initiation can come about as a result of small-scale independent initiatives taken by particular establishments (schools, colleges or universities) or on a larger scale due to 'collective professional action'. She asserts that 'the relations [between interest groups] which are significant here are those taking place between professional educators on the one hand and the suppliers of resources on the other'. She goes on to point out that 'obviously since the majority of resources are public ones supplied by the State, interaction between the profession and the governing elite will be most important' (1979: 240).

In terms of the overview of recent pharmacy policies sketched above, I believe that there is considerable scope for internally initiated change to pharmacy curriculum in South Africa, as the governing elite are still sufficiently open to what Archer refers to as 'collective professional action'.

Unlike the prescriptive syllabus contained in the apartheid era 1981 Pharmacy Act regulations (discussed in the section 4.1.4), the Unit Standards contained in the 2000 regulations are sufficiently broad to allow pharmacy schools and faculties to amend their curricula in order to suit their local community needs. For example, the Faculty of Pharmacy at Rhodes University in Grahamstown has taken the initiative to develop a course which exposes students to the primary health care needs of poor township communities, as result of its close proximity to informal settlements (see section 5.2.1 below for a detailed description of the Rhodes University course).

The ability to design and present such courses, speaks to the increasing autonomy experienced by professional educators (that is, university lecturers) to engage in teaching activities that meet the community's needs. Such instances of 'internal initiation' demonstrate the agency on the part of the actors (professional educators) within the educational system to create change. In Archer's terms:

Those best placed to instigate educational change by this method are those who propose modifying educational services in such a way as to enrich the profession or enhance its status in the community (Archer 1979: 250).

Enriching the teaching profession involves meeting its own professional goals as opposed to simply setting out to meet the needs of other interest groups. Such professional goals, within the context of this thesis, are linked the professional activities of university teaching and research.

It should be noted that the professional goals set by the Rhodes University Faculty of Pharmacy must be situated within the broader context of the goals identified by professional pharmacy educators (including pharmacy academics and administrators) internationally, which in recent years have emphasized the central concepts of pharmaceutical care³⁷ and lifelong learning or continuing professional development (CPD)³⁸.

³⁷ The South African Pharmacy Council, in line with these international trends, has acknowledged the pivotal role of pharmaceutical care in the undergraduate curriculum. According to the Education

Hepler (1989), one of the architects of the concept of pharmaceutical care, defines this as a 'relationship between the patient and a pharmacist in which the pharmacist accepts responsibility for drug use control functions and provides those services governed by awareness of, and commitment to, the patient's interests' (p412).

In 2000 the International Pharmaceutical Federation (FIP) - an international body set up 'to represent and serve pharmacy and pharmaceutical sciences world-wide' (International Pharmaceutical Federation 2005) - released a policy statement on 'Good Practice in Pharmacy Education' in which it recommends that 'educational programmes should ensure that patient-focused pharmaceutical care...is a mandatory part of the curriculum (International Pharmaceutical Federation 2000: 3).

Similarly, with respect to lifelong learning, in 2002 the FIP released a policy statement recommending the principle of CPD as a 'fundamental ethical requirement of all health professionals' (International Pharmaceutical Federation 2002:1). The degree of commitment to this international principle is evidenced in the fact that the Faculty of Pharmacy at Rhodes University hosted the Fifth International Conference on Lifelong Learning in Pharmacy in Grahamstown in June 2002.

The Rhodes Faculty of Pharmacy has effectively incorporated both of the above principles into its own mission statement: 'The mission of the faculty is to promote pharmaceutical care through education, research, scholarship, creative endeavor and service' (Rhodes University Calendar 2002: 94).

In Archer's view, 'the independence of the profession enables it to make substantial internal innovations on the basis of its own experience, the teaching situation it faces and the collective goals formulated by its associations' (1979: 250). I believe that the CEP constitutes an example of such an innovation, initiated in pursuance of the

Committee of the Council, the Unit Standards incorporated the principles of pharmaceutical care (SAPC 2001: 4).

³⁸ According to Knox and Daya (2002) lifelong learning and Continuing Professional Development (CDP) are terms that can be used interchangeably. They define CPD as 'postgraduate professional education involving a cycle by which individual practitioners assess their learning needs, create a personal learning plan, implement the plan and evaluate the effectiveness of the educational intervention as it applies to their pharmacy practice' (p 26).

pharmacy profession's own interests. Yet, as I hope to demonstrate in the following sections, it is compatible with the interests of the governing elite (in particular the ANC's definition of 'community health').

5.2.1 The Rhodes University Community Experience Programme

The Community Experience Programme³⁹ (CEP) is a semester-long primary health care experiential learning⁴⁰ course that is presented to fourth (final) year undergraduate pharmacy students. Together with a medical interpreter, the students visit several public sector outpatients once a fortnight, with the intention of discussing any health problems that the patients may wish to disclose. These patients suffer from chronic diseases such as hypertension, diabetes, asthma and epilepsy. The students conduct semi-structured interviews to determine how well controlled the patients are on their drug treatment and to elicit their perceptions regarding their health. These discussions take place within the patients' homes in Joza, a township outside Grahamstown

The CEP attempts to provide the students with the kind of real-life experiences that they can expect to encounter in community pharmacy practice. In addition, it assists them in developing the ability to see health and illness from the perspective of the patient.

The majority of the patient volunteers live in Joza, a poor semi-urban township on the outskirts of Grahamstown, and commute at least once a month to a community health center close to Grahamstown's central business district. The volunteers are approached by the programme co-ordinator at the health centre, where they are invited to participate in the programme. If the patients consent to participate, a

³⁹ I would like to acknowledge that a programme is commonly known as 'a purposeful and structured set of learning experiences that leads to one or more qualifications' (Higher Education Quality Committee 2003: 16). In this portfolio, however, I have chosen to use the term to signify a single course.

⁴⁰ Experiential learning can be defined as 'a process in which an experience is reflected upon and then translated into concepts which in turn become guidelines for new experiences' (Kolb *et al* 1971 *in* Criticos: 1989: 66).

suitable date and time is negotiated on behalf of the students. With the exception of the epileptic patients, most volunteers are pensioners and disability grant holders.

Joza township is situated on a hill overlooking Grahamstown's business district, middle-class suburbs and Rhodes University. Its tarred roads, post office, community hall, primary health care clinics and low-income housing have resulted in its status as a semi-urban township. However, the outlying areas of the township tell a different story as they are characterized by dirt roads, mud-huts and sparse vegetation. There is a 70% unemployment rate in Joza, and a burgeoning HIV/AIDS epidemic that threatens to overshadow all the other health care needs of the community.

In the four years that the pharmacy students spend doing their undergraduate degree in Grahamstown, only a handful of them will ever have visited Joza prior to starting the CEP. In fact, the vast majority of the students have never been into a South African township before and are very apprehensive at the start of the programme.

It was assumed that two, of the four, specific learning outcomes for the CEP could only be acquired, by the students, in a community pharmacy setting (i.e. workplace). These were:

1. Describe and explain orally and/or in writing the moral and ethical considerations faced by the pharmacist in community practice
2. Explain the need for respect for patients without judgement or prejudice with regard to race, gender, culture or life-style choices

I would argue that these two learning outcomes are prerequisites for meeting the changing role of the pharmacist as required in terms of the National Drug Policy, in post-apartheid South Africa. They reflect the aims of this Policy, in that they form the basis for producing 'suitably qualified and motivated' pharmacists that are able to contribute to the transformation of the South African public health care system.

Moreover, it is unlikely that, without the learning experiences acquired during courses such as the CEP, students would consider a career within the public health care system in the first place.

5.2.2 The autonomy of academic interests and the CEP

The CEP was first introduced into the Rhodes pharmacy curriculum in 1996. According to its initiator, Pharmacy Administration and Practice lecturer Mrs S Burton, the rationale for introducing this course was to:

‘provide an educational environment which allows for the development of pharmacy students...it seeks not only to develop within the students a “professional mentality” but also to provide students with opportunities to develop their social and intellectual skills, as well as prepare them to become lifelong learners through the development of their learning styles’ (Burton 1998a: 4).

According to Burton, the value of providing students with the necessary skills and knowledge to become lifelong learners was to equip them to ‘respond effectively in an ever-changing environment’ and be empowered to ‘adapt to... changing professional roles’, ‘work collaboratively on complex social issues’ and ‘to identify and be capable of responding to the changing nature and needs of individuals and society’ (*ibid*: 2). The focus of the course on lifelong learning is consistent with the Faculty’s own professional objectives. The stated mission of the Rhodes University Faculty of Pharmacy includes the following priority: ‘to prepare its students for entry into the practice of pharmacy as informed, caring, ethical and enlightened citizens and professionals’ (Rhodes University Calendar 2002: 94).

As opposed to being a response to the new government interest group’s concerns with primary health care, Burton’s approach to the development of the CEP was motivated by the educational theorist Kolb’s definition of learning, that is: ‘Learning is the process whereby knowledge is created through the transformation of experience’

(Kolb 1984: 38). In these terms, she set about designing a course which exposed pharmacy students to all of the four stages of Kolb's experiential learning cycle (concrete experience, reflective observation, abstract conceptualisation and active experimentation).

Through what Burton refers to as 'a relocation of the learning environment' from the traditional lecture room to the community, the CEP aimed to shift the role of the student from that of a 'passive observer' to 'an active contributor, participant and problem solver' (Burton 1998a: 4).

Ultimately Burton aimed to demonstrate to the students the power of the 'community as a classroom' thus equipping them with a vision of the possibilities that exist for lifelong learning within the workplace (*ibid*: 8).

In the following section I attempt to explore whether, despite being primarily directed by academic interests, the CEP (as a form of internally initiated change) can be said to be consistent with the government interest group's concern for 'community health' and primary health care. This will involve a detailed analysis of a set of focus group interviews with fourth year Rhodes University pharmacy undergraduate students (after they had completed the CEP), participant observation field notes and the students' CEP portfolios (refer to section 2.3 for a detailed discussion of how the research data was analysed and interpreted). The same questions were put to these students (see section 5.1 above for a list of the interview questions) during the focus group interviews that were put to them during their pre-CEP interviews. In this section I consider the degree to which the students who had participated in the CEP can be said to have changed their fundamental perceptions of the role of the pharmacist, and in particular the degree to which they had acquired concepts consistent with the government interest group's definition of 'community health'.

5.3 Students' perceptions of community pharmacy in post-apartheid South Africa

Though students' comments with regard to the role of the pharmacist, after having participated in the CEP, were to a large extent consistent with their original views (viz. they were still preoccupied with the needs and concerns of the retail pharmacist), their conception of what constituted 'the community' - in need of pharmaceutical services - had changed.

In the first set of focus group interviews the students had equated 'the community' with the affluent suburban retail pharmacy patrons (on medical aid) that they had encountered during their Vacation Experience Programme placements (refer to section 5.1.1 for more information on these placements). After having participated in the CEP, however, the students' had a more inclusive understanding of the term. The community now included disadvantaged persons from deprived communities (such as Joza) and rural areas.

Furthermore, the new concepts that the students took on board as a result of the CEP incorporated the understanding that community health needs are not solely dictated by biomedical factors, but are to a large extent a direct function of external societal factors (mainly socio-economic factors such as poverty, unemployment and illiteracy). There was a discernable shift from focusing on the individual patient's medical characteristics to recognising the existence of these external societal factors and the role they play in the individual's health status.

5.3.1 The pharmacist's community health role

As stated above, the National Drug Policy of 1996 envisioned the role of the pharmacist to include, amongst other things, 'a community educational role in instructing patients on the correct use of drugs' (Department of Health 1996: 18).

Similarly, Unit Standard 6 (of the seven outcome-competencies for entry-level pharmacists) stipulates that the entry-level pharmacist will be expected to 'promote community health and provide related information and advice'⁴¹.

The process of instructing patients within the community on the correct use of drugs and providing information and advice on 'community health' is commonly referred to as patient counselling.

A fundamental prerequisite for effective patient counselling is of course the ability to effectively communicate with patients in the community. This presupposes a clear understanding of patients' health care needs in disadvantaged community settings.

Some of the students interviewed during the course of the research study, only seemed to truly understand the extent of patients' health needs after having participated in the CEP, and after having obtained first hand experience of the living conditions of patients in their township homes. Exposure to this context also provided students with an understanding of some of the constraints that pharmacists working in the public sector experience. Consider the following exchange:

- S1: Before the [CEP] course I thought we would go and look at the patients and say 'well, this is what the patient is given now. Ok do these drugs interact? Yes or no? And that's where it ended. Now you find that it doesn't end there, you've got to get a [medical] history of the patient... It [the interview with the patient] just gives you a whole lot of information that you didn't think you're going to find...
- S2: But I'm a bit worried about the programme, we went to the patients and we saw them at [their] homes and there was time to talk to them. But as a [practising] pharmacist, I don't think [in a public sector hospital] there is time to actually get into that much detail with the patient. The pharmacist will get the prescription, there's a long queue, they just dispense and the next patient comes up. So, the role is there, but I don't know if there's time to actually impact it onto the society... The patients are on all these drugs dispensed by a pharmacist, but then

⁴¹ Annexure A of the Regulations relating to Pharmacy Education and Training, Government Gazette No. 1156 of 20 November 2000).

maybe there isn't time for that particular pharmacist, especially within the public sector, to go and speak to the doctor...

S3: I think what allowed us to see so much more was to go into the person's home...Just from being in their home you had some sense of where they were coming from. You could see: Did they have electricity? Did they have a TV? Did they sleep in a bed? You could see more or less how many people were there... I think you pick up a lot almost subconsciously [about] where they're coming from. I think that helped us a great deal, but you're not going to have that [opportunity] when you're interviewing at a hospital or some kind of clinic. It's a disadvantage.

Later in the discussion

S4: I think maybe we should have pharmacists working in the community, [called] community pharmacists like the hospital pharmacists... Because as it is right now it's difficult for pharmacists to really sit down and do what he is doing, monitoring and following up and all like, it's ideal but not attainable [fg2 May02; p2& 3].

The central role that patients' socio-economic conditions and health needs play in affecting their drug regimens and their potential compliance with these regimens only became evident to the students after the CEP. This led to a greater understanding of the constraints placed on public health care facilities in South Africa, and on the ability of pharmacists in this sector to adequately address patients' needs and educate them on their medical conditions. In the words of one student: 'in the public sector there is just not much time because of the numbers that rely on that sector'. His solution to the problem was the development of another branch of pharmacy similar to public sector nurses.

We have nurses that are in community context that go into the community and talk to the people and do all that, we could have pharmacists doing that. You know, like a special bunch of pharmacists going to the community. [They could] talk to the people [and] try and cover as much ground as they can. Maybe they might have a workshop or actually do house visits. Maybe in certain communities there are people suffering from hypertension, they should go all and meet at such and such a person's house. Then they try and make it more one to one, because of the whole thing that the doctor's have a talk, and the whole hierarchy, the patients are at the bottom. So there is not that much of a personal [interaction]... [fg2 May02; p3].

During a tutorial (forming part of the CEP) with a medical doctor working at Day Hospital (a community health care centre frequented by public sector patients in Joza living with chronic diseases), the students appeared shocked at the lack of patient knowledge about their medical conditions. On a number of occasions they asked the doctor whether the pharmacists counselled the patients, as ‘the patients were very ignorant of their diseases and drug treatment’, which the students found utterly unacceptable.

After the CEP the students started to develop a deeper understanding of the role of cultural and ethnic beliefs on the practice of pharmacy. The following excerpt from the focus group interviews concerns the important relationship between language and culture, and how understanding a patient’s first language is an important element to the effective counselling of patients:

- S1: I think the main difference for me anyway, is that I only really speak English, and in the public sector most of the people don’t speak English, so for me that is the main difference between public and private sector, because even if I’m working in pharmacy and an Afrikaans person comes into me, there is usually at least one person that can speak Afrikaans. Whereas, ok you often have to use interpreters in the private sector but I think it is to the greater extent in the public sector, and that is quite worrying to me.
- LA: Do you feel that that is a barrier for you?
- S1: Yes, I think it is a barrier in some ways. I don’t have, I’ll never have as much understanding of their culture as a person who comes from the same culture, and I mean, a bit of Afrikaans in my entire school career and I couldn’t pick that up so I’m not one of these people who is really good at learning languages. So for me communication is a problem, and it’s one of the concerns in an area that I would have to work very, very hard at, to achieve the same kind of relationship with a patient.
- LA: So if I understand you right, you’re saying that learning the language is very, very important part of understanding the culture.
- S1: I think culture and language is so closely related, I think it’s very difficult to learn a language without understanding certain concepts of the culture because even the way people speak, is, it’s just the way things are phrased or the descriptions of words, or the use of words is imbedded within a culture, and ja, I just think language, language is

important in developing a relationship with a person. I think there are ways around it, that you can still have a successful relationship with a person and you cannot speak their language and you are from a different culture, I think it just takes a little bit more time and I found in the pharmacy...you get used to it and to adapt [fg2 May02; p4].

5.3.2 The primary health care role of the pharmacist

As noted earlier, the National Drug Policy requires that pharmacists 'have a critical role to play in primary health care and preventative health' (Department of Health 1996: 18). I have already argued that it is necessary to interpret this policy in terms of the ANC's 1994 National Health Plan. In this plan the primary health care approach to the restructuring of the national health system can be seen to encompass three related elements (for more information see section 5.1.4 above):

- It embodies a participatory concept of 'community' – which requires participation in the planning, provision, control and monitoring of health care services (see section 5.1.4 above)
- It aims to reduce inequalities in access to health services, especially in rural areas and among deprived urban communities.
- It is informed by the fundamental principle of 'social and economic justice'.

In these terms, primary health care can be understood to mean a participatory approach to the provision of community health care to rural and deprived communities in order to overcome the social and economic inequalities which impede access to health services.

Amongst the Rhodes University fourth year pharmacy students interviewed after the CEP, there appeared to be a growing understanding of the social inequalities within the South African society. The notion that patients in need of pharmaceutical services no longer constituted a homogenous group of people who could afford private health care, and therefore visit their local retail pharmacy for information and medication, can be illustrated by the following excerpt:

- S1: Because you can't treat all people the same...I mean surely people in a city are different from people in the community and you can't say oh you know what, take this medication three times a day with this, this. Because we have to have an idea of what's available in the community and how do they eat, how they think basically, it's really different.
- S2: We can relate that to our practical experiences in Joza, some of the people don't have food to eat so they can't take their medication.
- S3: Because the more you know about things like that the more unpleasant experiences you can diminish.
- LA: What do you mean by unpleasant experiences?
- S3: Like, say you have no idea that they don't have a fridge or they're illiterate and you treat them as you would treat somebody else who is literate and has a fridge, and then it will be an unpleasant experienceyour counselling won't go well, so you can make that better by knowing more.
- S4: I think there is also a different focus on different kinds of health problems. There are people who are more wealthy or do not have certain health problems that people who are poverty stricken have. I saw a lot of patients with eczema and things like that, just general public health, that they would need help with. And we need to know that they would probably have more things like that than people who make money, a sort of different focus [fg1 May02; p16 & 17].

Another student picked up on the vital importance of understanding the patient's socio-economic issues with regard to counselling.

You have to know ... dispensing a drug to a person you're counselling him but, you need to know what's happening at his home to counsel them exactly., It's no use counselling them about the disease or this or how you take [medicines], when you know when he goes home because of his condition, there's poverty or violence or whatever, he's not going to be able to take that drug. He's going to have some problems. So I suppose it is important to know in what situations your patients are in. So you just adjust your counselling for them [fg3 May02; p10].

The students' enhanced understanding of social inequalities especially with regard to the pervasiveness of gender inequalities and domestic violence is illustrated by the following participant observation field notes:

'The second practical was quite disturbing. The patient was suffering from depression as well as the epilepsy. It eventually turned out that her epilepsy had developed as a result of domestic violence, and she was still quite visibly distressed by the experience. So I decided to end the interview as I felt that it would have been inappropriate to carry on while she was crying and describing these traumatic experiences.

It was a real wake up call for us all and I'm sure it was an experience that the students will never forget. We went in there with a whole set of assumptions about what caused the epilepsy and what concerns the patient would have (for example, accessing a disability grant)' [fieldnotes, 8 April 2002]

In light of the findings detailed above, it is my view that, despite being primarily directed by academic interests, the CEP can justifiably be interpreted as a successful instance of internally initiated change within the Rhodes University pharmacy curriculum. It is also apparent from the above discussion that new concepts taken on board by the students – including their expanded concept of 'community health' and their exposure to the concept of 'primary health care' – represents a form of internal initiation that is consistent with the policy intentions of the government interest group⁴².

On the whole, it could be concluded that the CEP constituted an exemplary mechanism, from the point of view of the government interest group, for introducing students to its re-defined pharmaceutical and health care priorities, were it not for one notable exception. After completing the CEP the Rhodes University students' views remained inconsistent with the government interest group's notion of community health in one very important respect. At no point did the students

⁴² It could be argued that insufficient note has been taken within this thesis of international trends relating to the introduction of community-based or primary health care courses into the pharmacy curriculum. I would argue, however, that cognisance of international trends in this regard is unconstructive in the South African context given its unique historical legacy of apartheid. The South African health care sector's first world/third world dichotomy (represented in the form of the private sector/public sector divide) makes comparisons with first world countries difficult to sustain. These studies are largely limited to pharmacy students within developed countries, perceptions of cultural or ethnic issues relating to the practice of pharmacy and tend to focus on minority groups. As a consequence the content of such research is primarily about the communication barriers between minority and majority groups in the form of language (for example, Sause & Galizia 1996). The socio-economic problems raised in such studies bear little relevance to those in South Africa (resulting in very little, if no, focus on poverty, lack of education, unemployment, etc). Whilst comparisons with other developing countries are likely to be more relevant, the inability to access such studies written in English effectively excluded their use.

acknowledge the need for a participatory approach to health care. None of the students appeared to realize that their patients had a right to participate in identifying and planning their health care needs⁴³.

This significant oversight may have resulted in the students exiting the course with an impression of the role of the pharmacist quite antithetical to that envisaged by the authors of government health policy. That is that community pharmacy is centred around health professionals, where ‘the community – the “patients” – [remain] the passive recipients of health services and the doctors and health professionals alone [are] the dispensers of health’ (ANC 1994: 10).

The continuing influence of the private sector interest group on pharmacy students’ perceptions of the role of the pharmacist is not unique to Rhodes University. A study conducted in 2004 by Lutchman *et al* (some two years after the research for this dissertation was conducted) on final year pharmacy students’ attitudes towards pharmacy as a career in South Africa - at four of the eight pharmacy schools in South Africa - found that ‘the majority of respondents indicated that they would like to pursue a career in [retail] pharmacy’. Alarming, it also found that only 12 per cent of the pharmacy students showed a positive attitude towards the public hospital environment (2004: 36).

The positive sentiments towards retail pharmacy were attributed to there being ‘more opportunity for the pharmacist and the patient to interact’, ‘it being a financially rewarding sector’ and ‘it offered greater job satisfaction’. By contrast, the negative sentiments towards public sector pharmacy were attributed to excessive ‘workload’, ‘poor facilities’, ‘budgetary constraints’ and ‘lack of staff’ (*ibid*: 36 & 37).

⁴³ This may, to a large extent, have been due to the way in what the course was structured. During their visits to patients’ homes, students were required to prepare a practical report (or ‘write-up’), which consisted of, amongst other things, the interview transcript as well as an identification of actual and/or potential drug-related problems. These reports also included an explanation of how the student would hypothetically go about resolving these actual/potential problems presented by the patient. It is perhaps one of the shortcomings of the CEP, from the point of view of the government interest group, that at no point were the students encouraged to ask the patients to participate in the identification of their actual/potential drug-related problems. Nor were the students encouraged to ask the patients to participate in a process of planning the resolution of these problems.

Lutchman *et al* concluded that since most students were likely to pursue a career in retail pharmacy 'if this trend continues, it is very likely that there will be a shortage of pharmacists in certain fields of pharmacy especially...the public health sector'. The authors believe that 'the onus is on the collaborative efforts of government, pharmaceutical bodies and academic institutions in addressing the concerns of future pharmacists and avoiding potential problems' (*ibid*).

What this study by Lutchman *et al* in 2004 serves to demonstrate is how the pharmacy students' affinity for retail pharmacy extends beyond the reported case study of Rhodes University CEP, and is in fact systemic in nature. It is further indicative of the fact that the private sector interest group (the retail pharmacy sector in particular) has successfully maintained its influence over numerous pharmacy curricula across the pharmacy system some 10 years after democracy, amidst numerous policy changes and uncertainty within the profession (see next chapter). This is in stark contrast to the government interest group's failure, also highlighted in the Lutchman *et al* 2004 study, to effectively change the pharmacy curriculum to meet its objectives as set out in the National Drug Policy of 1996.

Chapter 6

CONCLUSION

In this thesis I have traced the manner in which competing interest groups have sought to exert an influence over the training and education of pharmacists in South Africa between 1880 to date. I have asserted that the key competing interest groups attempting to control the pharmacy profession and influence the pharmacy curriculum since 1994 have been the private sector interest group and the government interest group.

In the thesis I have maintained that there is a strong likelihood that political manipulation, in the form of a more heavy-handed regulation of the pharmacy curriculum, could result from government's continued frustration with the pace of implementation of its goals set out in the National Drug Policy (1996) as informed by the ANC's 1994 National Health Plan.

The ANC Plan expresses the view that all health care professionals should be treated as 'agents for transforming health and its socio-political environment', and maintains that the education of such health care professionals is the 'shared responsibility of community, service, and training institutions' (p52). It calls for the refocusing of 'educational institutions in terms of community-based orientation and accessibility' (*ibid*: 62). It is my assertion that these stated intentions should not be taken lightly.

A number of recent policy changes initiated by the government interest group, which have directly challenged the private sector interest group's domination of the pharmacy profession since 1994, serve to indicate the seriousness of government's intention to transform the profession:

- In 1997, in an effort to improve the accessibility and affordability of medicines, legislation was passed in the form of a Pharmacy Amendment Act to open up ownership of pharmacies to lay persons (South Africa 1997c). This enabled the purchasing of retail pharmacies by business people and retail chains (such as Clicks) with the necessary capital (Stoltz 1998). Until this point only registered pharmacist could legally own pharmacies.⁴⁴
- In 2000, a compulsory community service year for all pharmacy graduates was introduced via a Pharmacy Amendment Act creating a new category of pharmacy personnel, that of the 'community service pharmacist' (South Africa 2000). This move served to increase the number of pharmacists working in the public sector and to force pharmacy graduates to gain exposure to public sector pharmacy facilities (such as public hospitals and primary health care clinics) in addition to undertaking internships in other sectors such as the private retail sector.
- In 2004, a set of pricing regulations was passed in an effort to introduce a transparent pricing system for all medicines and to limit the dispensing fee to be charged by retail pharmacists, in line with provisions set out in the Medicines and Related Substances Control Amendment Act of 1997 (South Africa 1997b). Although these regulations were successfully challenged in the Constitutional Court by representatives of the private sector interest group, the Constitutional Court upheld government's right to control the price of medicines in line with the provisions of the Medicines Act (South African Pharmacy Council 2005: 8)⁴⁵.

⁴⁴ Government's motivation for opening up of the ownership of pharmacies to laypersons was articulated by the 1997 Deputy President of South Africa, Jacob Zuma, in a speech to the National Assembly: 'There are very few pharmacies serving traditionally black townships and rural areas. The majority of the population of our country do not have access to comprehensive and dedicated pharmaceutical services' (Stoltz 1998: 70).

⁴⁵ Though the ANC Health Plan did not explicitly call for the opening up of ownership of retail pharmacies, mechanisms to ensure the improved accessibility of medicines to deprived communities and rural areas were encouraged. By contrast, the need for the introduction of a compulsory community service year and the development of regulations for the control of pricing of medicines by retail outlets were clearly spelt out in the plan (ANC 1994: 3).

What these policy interventions demonstrate is the strength of the commitment on the part of the government to transforming the pharmacy profession to meet the pharmaceutical needs of the majority of South Africans, particularly those in under serviced and rural areas. For this reason I would argue that it is highly unlikely that the pharmacy education system will be left unscathed, and that the government interest group will fail to follow up on the objectives relating to the transformation of educational institutions contained in the ANC Health Plan. Given the government interest group's domination over the South African Pharmacy Council (as discussed in section 4.1.5) and the Council's powers 'to establish, develop, maintain and control universally acceptable standards in pharmaceutical education and training' (South Africa 1997c), the government could with relative ease introduce regulatory provisions to bring about the changes it deems necessary to meet its goals.

In addition, it is important to note that the accreditation criteria of the Higher Education Quality Committee (HEQC) - a permanent committee of the Council for Higher Education (CHE)⁴⁶ that was established to perform the quality assurance functions of the CHE - take account of the extent to which a programme is aligned with national goals (Council for Higher Education 2004). Thus, if pharmacy schools are ever subject to a national re-accreditation process, they will have to demonstrate the alignment of their curricula with national goals.

By way of conclusion, however, as discussed in the previous chapter, an alternative solution to the likely political manipulation of the pharmacy curriculum by the government interest group via increased regulation, can be found in the form of internally initiated change within pharmacy schools and faculties. I have argued in this thesis that pharmacy academics and administrators may exercise agency and have the ability to change the educational system in line with their own professional goals. Furthermore, internal initiation is capable of producing the kind of educational change reflective of the goals of both the government interest group and the professional interests of pharmacy academics and administrators.

⁴⁶ The CHE is a juristic body established by the Higher Education Act of 1997 to, *inter alia*, advise the National Minister of Education on any aspect of higher education (South Africa 1997a).

However, as the case study on the Community Experience Programme (CEP) at Rhodes University has shown, a single semester-long course in the final year of the four-year pharmacy curriculum is unlikely to create the kinds of changes envisaged by the government interest group in the National Drug Policy in the short term – such as the creation of ‘suitably qualified and motivated’ pharmacy graduates who are committed to working in the public sector (Department of Health, 1996:20). The development of small-scale independent initiatives, such as the Rhodes University CEP, may eventually result in structural elaboration within the pharmacy education system, but such change will necessarily be incremental and be realized over the long term. Although Archer (1979) maintains that small, local changes within the education system eventually accumulate to produce a significant scale of change, the government interest group is unlikely to patiently wait for such a change to occur. The government interest group is more interested in developing a rapid pattern of change, or what Archer terms a ‘stop-go’ change, within the pharmacy education system (Blackledge & Hunt 1985: 335).

Consequently, I would argue that only large-scale ‘collective professional action’ (Archer 1979: 240) is likely to provide the kind of rapid change within the pharmacy education system that will prove consistent with the government interest group’s needs. In the interests of maintaining the (at least relative) autonomy of pharmacy schools and faculties, pharmacy academics and administrators might consider negotiating directly with the polity on an organized basis and, in so doing, meet the needs of the government interest group and affect policy formation that is consistent their own professional goals.

Arguably, such an outcome will only be possible if pharmacy academics and administrators are prepared to alter the focus of the entire pharmacy curriculum, as offered across the various pharmacy schools and faculties making up the pharmacy educational system, to explicitly address the profession’s role in addressing current health inequalities in South Africa. In particular all pharmacy students’ learning experiences will have to take into account the government interest group’s conception of the role of the pharmacist in contributing to ‘community’ health care in

post-apartheid South Africa. That is, these learning experiences will need to address the view that pharmacists 'have a community educational role in instructing patients on the correct use of drugs' and 'a critical role to play in primary health care' (Department of Health 1996: 18). The form of structural elaboration required in these terms is one which, following Archer, would serve to condition, without determining, the students' perceptions of the role of the pharmacist. It would therefore retain the current pharmacy teaching profession's emphasis on academic standards and professional values.

Whether these proposed interventions will necessarily result in a change to students' subjective perceptions of their potential levels of job satisfaction working in the public sector is beyond the scope of this thesis. However, what can be said is that in order for the government interest group to attract more pharmacy graduates into the public sector, it will of necessity require a change in the students' current (retail pharmacy dominated) understanding of the role of the pharmacist in post-apartheid South Africa. It remains to be seen whether such change will be achieved via a process of externally imposed political manipulation or through internal initiation.

LIST OF REFERENCES

- Abercrombie, N., Hill, S. & Turner, B.S.** (1984). *The Penguin Dictionary of Sociology* (2nd ed.). London: Penguin Books.
- Angrosino, M.V. & Mays de Pérez, K.A.** (2000). Rethinking observation: from method to context. In N.K. Denzin and Y.S. Lincoln (Eds.). *Handbook of Qualitative Research* (2nd ed.) (pp. 673-702). Thousand Oaks: Sage Publications.
- African National Congress.** (24 January 2006). *A National Health Plan for South Africa of 1994*. <http://www.anc.org.za/ancdocs/policy/health.htm>
- Agrawal, M. & Sause, R.** (1998). Serving multi-ethnic populations: measuring the cultural sensitivity of pharmacy interns in New York City. *The International Journal of Pharmacy Practice*, 6, 83-90.
- Archer, M.S.** (1979). *Social origins of educational systems*. London: Sage Publications.
- Archer, M.S.** (1980). Macro-sociology and comparative education: two points of view. *Comparative Education*, 16(2), 179-195.
- Archer, M.S.** (1981). Educational systems. *International Social Science Journal*, 33(2), 261-284.
- Archer, M.S.** (1996). *Culture and agency: The place of culture in social theory* (revised ed.). Cambridge: Cambridge University Press.
- Atkinson, P.** (1997). *The Clinical Experience: The construction and reconstruction of medical reality* (2nd ed.). Aldershot: Ashgate.

- Babbie, E., Mouton, J., Vorster, P., and Prozesky, B.** (2001). *The practice of social research: South African Edition*. Cape Town: Oxford University Press Southern Africa.
- Bassey, M.** (1995). *Creating Education through Research*. Newark: Kirklington Moor Press.
- Benton, T.** (1977). *Philosophical foundations of the three sociologies*. London: Routledge & Kegan Paul.
- Blackledge, D. & Hunt, B.** (1985). *Sociological interpretations of education*. London: Croom Helm.
- Buckland, R. & Neville, T.** (2004). *A story of Rhodes: Rhodes University 1904 to 2004*. Braamfontein: Macmillan.
- Bulmer, M.** (1987). Ethics in Social Research. In J. Kuper, (Ed.). *Methods, Ethics and Models*. London: Routledge & Kegan Paul.
- Burton, S.** (1998a). *Preparing pharmacy students for lifelong learning*. Paper presented at 3rd International Conference on Lifelong Learning in Pharmacy, Hillerod, Denmark.
- Burton, S.** (1998b). The Vacation Experience Programme. *South African Pharmaceutical Journal*, 65(9), 282.
- Chambers, A.F.** (1982). *What is this thing called Science?* (2nd ed.). Milton Keynes: Open University Press.
- Chalmers, R. K., Adler, D. S., Haddad, A. M., Hoffman, S., Johnson, K. A. & Woodward, L.M.B.** (1995). The Essential Linkage of Professional Socialization and

Pharmaceutical Care. *American Journal of Pharmaceutical Education*, 59 (Spring): 85-90.

Cohen, L., Manion, L. & Morrison, K. (Eds.). (2000). *Research Methods in Education* (5th ed.). London: Routledge Falmer.

Council for Higher Education (2004). *Higher Education Quality Committee: Criteria for programme accreditation*. Pretoria: CHE.

Craib, I. (1984). *Modern Social Theory: From Parsons to Habermas*. London: Harvester Wheatsheaf.

Criticos, C. (1989). (Ed). *Experiential Learning in formal and non-formal education*. Durban: Media Resource Centre.

Cuff, E.C. & Payne, G.C.F. (Eds.). (1984). *Perspectives in Sociology* (2nd ed.). London: George Allan & Unwin.

Cunningham-Burley, S., Kerr, S., and Pavis, S. (1999). Theorizing subjects and subject matter in focus group research. In R.S. Barbour & J. Kitzinger. (Eds.). *Developing focus group research* (pp. 186-199). London: Sage Publications.

Denzin, N.K. & Mettlin, C.J. (1968). Incomplete professionalization: the case of pharmacy. *Social Forces*, 46(3), 375-381.

Department of Health (1996). *National Drug Policy for South Africa*. Pretoria: Government Printer.

Descartes, R. (1637). A Discourse on Method. In V.G. Potter (1993), *Readings in Epistemology* (pp. 21-33). New York: Fordham University Press.

De Vaus, D.A. (1986). *Surveys in Social Research*. London: George Allen & Unwin.

Durkheim, E. (1938). *The Rules of Sociological Method*. New York: The Free Press.

Durrheim, K. & Wassenaar, D. (1999). Putting design into practice: writing and evaluating research proposals. In M. Terre Blance & K. Durrheim (Eds.), *Research in Practice* (pp. 54-71). Cape Town: UCT Press.

Flew, A. (Ed.) (1984). *A Dictionary of Philosophy*. London: Ran Reference.

Friedson, E. (1981). The future of occupational monopoly. In A.I. Wertheimer & M.C. Smith, *Pharmacy Practice: Social and Behavioural Aspects* (2nd ed.) (pp. 17-25). Baltimore: University Park Press.

Garfinkel, H. (1964). Studies in the routine rounds of everyday activities. *Social Problems*, 11(3), 225-250.

Garfinkel, H. (1967). Reflexive properties of practical sociology. In C. Lemert (Ed.). (1993). *Social Theory: The Multicultural and Classic Readings* (pp. 474-478). Boulder: Westview Press.

Giddens, A. (1977). *Studies in social and political theory*. London: Hutchinson & Co.

Gilbert, L. (1995). The Pharmacist's Traditional and New Roles – A study of Community Pharmacists in Johannesburg, South Africa. *Journal of Social and Administrative Pharmacy*, 12(3), 125-131.

Gilbert, L. (1998a). Community pharmacy in South Africa: A changing profession in a society in transition. *Health and Place*, 4(3), 273-285.

Gilbert, L. (1998b). Dispensing doctors and prescribing pharmacists: a South African perspective. *Social Science & Medicine*, 46(1), 83-95.

Gilbert, L. (1998c). The Role of Training in Transforming Community Pharmacy – A Case Study of Pharmacists and Students in Johannesburg, South Africa. *Journal of Social and Administrative Pharmacy*, 15(1), 23-32.

Glickman, M. (1987). Case Studies. In J. Kuper (Ed.). *Methods, Ethics and Models*. London: Routledge & Kegan Paul.

Gouldner, A.W. (1970). *The coming crisis of western sociology*. London: Heinemann.

Gray, A., Matsebula, T., Blaauw, D., Schneider, H., Gilson, L. (2002). *Policy change in a context of transition: Drug Policy in South Africa 1989-1999*. Johannesburg: Centre for Health Policy, Witwatersrand University.

Green, J. & Hart, L. (1999). The impact of context on data. In R.S. Barbour & J. Kitzinger. (Eds.). *Developing focus group research* (pp. 21-35). London: Sage Publications.

Gubrium, J.F. & Holstein, J.A. (2000). Analyzing interpretive practice. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 487-508). Thousand Oaks: Sage Publications.

Haigh, J., Kanfer, I. & Purdon, L. (2005). *A brief history of the Faculty of Pharmacy at Rhodes University*. South African Pharmaceutical Journal, May, 22-24.

Hamilton, P. (1974). *Knowledge and social structure: An introduction to the classical argument in the sociology of knowledge*. London: Routledge & Kegan Paul.

Hammer, D.P., Berger, B.A., Beardsley, R.S. & Easton, M.R. (2003). Student Professionalism. *American Journal of Pharmaceutical Education*, 67(3), Article 96, 1 - 29.

Harding, G., Gantley, M. & Taylor, K. (2001). Analysing qualitative data. In K. Taylor & G. Harding (Eds.). *Pharmacy Practice* (pp. 486-492). London: Taylor & Francis.

Harding, G., Nettleton, S. & Taylor, K. (1990). *Sociology for pharmacists: an introduction*. London: Macmillan.

Hassell, K. & Hibbert, D. (1996). The use of focus groups in pharmacy research: processes and practicalities. *Journal of Social and Administrative Pharmacy*, 13 (4), 169-177.

Health Systems Trust (2001). *South African Health Review 2001*. Durban: The Press Gang.

Hepler, C.D. (1989). Unresolved issues. In A.I. Wertheimer & M.C. Smith (Eds.), *Pharmacy Practice: Social and Behavioural Aspects* (3rd ed.) (pp. 401-416). Baltimore: Williams and Wilkins.

Higher Education Quality Committee (2003). *Improving Teaching and Learning Resources*. Unpublished draft resources. Council on Higher Education.

Huberman, A.M. & Miles, M.B. (1994). Data management and analysis methods. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 428-442). Thousand Oaks: Sage Publications.

Hume, D. (1748). An Enquiry Concerning Human Understanding. In V.G. Potter (1993), *Readings in Epistemology* (pp. 131-152). New York: Fordham University Press.

International Pharmaceutical Federation (2000). *Statement of policy on Good Pharmacy Education Practice*. The Hague: FIP.

International Pharmaceutical Federation (2002). *Statement of professional standards – Continuing Professional Development*. The Hague: FIP.

International Pharmaceutical Federation (2005). Mission. *International Pharmacy Journal*, 19(1), 1.

Janse van Rensburg, E. (1995). Trends in educational research. *Discourse*, 6(1), 30 –33.

Janse Van Rensburg, E. (2001a). (Research Methods Short Course) An Orientation to Research, Environmental Education Unit, Rhodes University, Grahamstown.

Janse Van Rensburg, E. (2001b). (Research Methods Short Course) Criteria for Judging Research Validity, Environmental Education Unit, Rhodes University, Grahamstown.

Jones, P. (1992). *Theory and Method in Sociology: A guide for the beginner*. London: CollinsEducational.

Kant, I. (1781). Critique of Pure Reason. In V.G. Potter (1993), *Readings in Epistemology* (pp. 188-208). New York: Fordham University Press.

Keat, R. & Urry, J. (1981). *Social Theory as Science* (2nd ed.). London: Routledge & Kegan Paul.

Kelly, K. (1999a). From encounter to text: collecting qualitative data in interpretive research. In M. Terre Blance & K. Durrheim (Eds.), *Research in Practice* (pp. 379-397). Cape Town: UCT Press.

Kelly, K. (1999b). Hermeneutics in action: empathy and interpretation in qualitative research. In M. Terre Blance & K. Durrheim (Eds.), *Research in Practice* (pp. 398-420). Cape Town: UCT Press.

Kelly, K. (1999c). Calling it a day: reaching conclusions in qualitative research. In M. Terre Blance & K. Durrheim (Eds.), *Research in Practice* (pp. 421-437). Cape Town: UCT Press.

King, R. (1980). Weberian perspectives and the study of education. *British Journal of Sociology of Education*, 1(1), 7-23.

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health & Illness*, 16(1), 103 – 121.

Kitzinger, J. & Barbour, R.S. (1999). Introduction: the challenge and promise of focus groups. In R.S. Barbour & J. Kitzinger. (Eds.). *Developing focus group research* (pp. 1-20). London: Sage Publications.

Knox, C. & Daya, S. (2002). Fifth international conference on lifelong learning in pharmacy. *South African Pharmacy Journal*, 69 (7), 26 & 27.

Kolb, D. A. (1984). *Experiential learning: experience as the source of learning and development*. New Jersey: Prentice-Hall.

Kritikos, V., Watt, H.M.G., Krass, I., Sainsburg, E.J & Bosnic-Anticevich, S.Z. (2003). Pharmacy students' perceptions of their profession relative to other health care professions. *International Journal of Pharmacy Practice*, 11, 121-139.

Locke, J. (1690). An Essay Concerning Human Understanding. In V.G. Potter (1993), *Readings in Epistemology* (pp. 57-104). New York: Fordham University Press.

Lutchman, D., Maharaj, A., Mkhize, N.H., Mkhumane, N.N. & Ramkisson, A. (2004). A measure of the attitudes of final year students towards pharmacy as a career in South Africa. *South African Pharmacy Journal*, 71(4), 36 & 37.

Madriz, E. (2000). Focus groups in Feminist Research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 835-850). Thousand Oaks: Sage Publications.

Manasse, H.R., Stewart, J.E. and Hall, R.H (1981). Inconsistent socialization in pharmacy – a pattern in need of change. In A.I. Wertheimer & M.C. Smith, *Pharmacy Practice: Social and Behavioural Aspects* (2nd ed.) (pp. 37-54). Baltimore: University Park Press.

May, T. (1993). *Social research: issues, methods and process*. Buckingham: Open University Press.

Mehan, H. & Wood, H. (1975). The Ethnomethodology of the Human Reality Constructor. In R. Collins (Ed.). (1994). *Four sociological traditions: selected readings* (pp. 322-340). New York: Oxford University Press.

Merton, R.K. (1976). *Social Ambivalence and other essays*. New York: The Free Press.

Morgan, D.L. (1988). *Focus groups as qualitative research*. Newbury Park: Sage Publications.

Neuman, L. W. (2000). *Social research methods: qualitative and quantitative approaches*. Boston: Allyn and Bacon.

Parsons, T. (1961). The School Class as a Social System: Some of Its Functions in American Society. In A.H. Halsey, J. Floud & C.A. Anderson (Eds.), *Education, Economy and Society: A reader in the Sociology of Education* (pp.434-455). New York: The Free Press.

Parsons, T. (1972). Definitions of Health and Illness in the Light of American Values and Social Structure. In E. G. Jaco (Ed.), *Patients, physicians and illness: A*

sourcebook in behavioural science and health (2nd ed.) (pp.97-117). New York: The Free Press.

Platt, J. (1981a). Evidence and proof in documentary research: some specific problems of documentary research. *Sociological Review*, 29(1), 31 – 52.

Platt, J. (1981b). Evidence and proof in documentary research: some shared problems of documentary research. *Sociological Review*, 29(1), 53 – 66.

Popkewitz, T.S. (1984). *Paradigm and ideology in educational research*. London: Falmer Press.

Potchefstroom University of Christian Higher Education Yearbook (1956). Potchefstroom.

Rhodes University (28 September 2005). Ethical guidelines.
http://www.ru.ac.za/research/policies/ethical_standards/ethical_standards.htm

Rhodes University Calendar. (1959). Grahamstown: Rhodes University.

Rhodes University Calendar. (1971). Grahamstown: Rhodes University.

Rhodes University Calendar. (1975). Grahamstown: Rhodes University.

Rhodes University Calendar. (1976). Grahamstown: Rhodes University.

Rhodes University Calendar. (2002). Grahamstown: Rhodes University.

Romm, N. & Sarakinsky, M. (1994). *Social Theory*. Johannesburg: Lexicon Publishers.

Rothmann, J.C., Gerber, J.J., Lubbe, M.S., V. der M. Sieberhagen, G.V. & Rothmann, S. (1998). Pharmacy students' experiences of the content of pharmacy education: a phenomenological study. *The International Journal of Pharmacy Practice*, 6, 30-37.

Ryan, M. (1986). *A history of organised pharmacy in South Africa: 1885 – 1950*. Cape Town: The Society for the History of Pharmacy in South Africa.

Schutz, A. (1962). (First published in 1954). Concept and Theory Formation in the Social Sciences. In K. Thompson & J. Tunstall (1971), *Sociological Perspectives* (pp. 488-500). Harmondsworth: Penguin Books.

Schwandt, T.A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, Hermeneutics, and Social Constructionism. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed.) (pp. 189-213). Thousand Oaks: Sage.

Silverman, D. (1993). *Interpreting qualitative data: methods for analysing talk, text and interaction*. London: Sage Publications.

Simpson, D. (1994). Pharmacy in South Africa. *The Pharmaceutical Journal*, 253, 685-692.

Smith, F. (1999). Analysis of data from focus groups: Group interaction – the added dimension. *The International Journal of Pharmacy Practice*, 7, 192 – 196.

Smith, F. (2001). Focus Groups. In K. Taylor & G. Harding (Eds.), *Pharmacy Practice*. London: Taylor and Francis.

South Africa (Republic). (1974). *Pharmacy Act No. 53*. Pretoria: Government Printer.

South Africa (Republic). (1979). *Pharmacy Amendment Act No. 20*. Pretoria: Government Printer.

South Africa (Republic). (1985). *Pharmacy Amendment Act No. 69*. Pretoria: Government Printer.

South Africa (Republic). (1995a). *Pharmacy Amendment Act No. 6*. Pretoria: Government Printer.

South Africa (Republic). (1995b). *South African Qualifications Authority Act No. 58*. Pretoria: Government Printer.

South Africa (Republic) (1997a). *Higher Education Act No. 101*. Pretoria: Government Printer.

South Africa (Republic). (1997b). *Medicines and Related Substances Amendment Act No. 90*. Pretoria: Government Printer.

South Africa (Republic). (1997c). *Pharmacy Amendment Act No. 88*. Pretoria: Government Printer.

South Africa (Republic). (2000). *Pharmacy Amendment Act No. 1*. Pretoria: Government Printer.

South Africa (Union). (1928). *Medical, Dental, and Pharmacy Act No. 13*. Pretoria: Government Printer.

South Africa (Union). (1954). *Medical, Dental and Pharmacy Amendment Act No. 29*. Pretoria: Government Printer.

South African Pharmacy Council (1995). Vision. *Pharmacaie*, 13(3), 3.

South African Pharmacy Council (1999). Development of a new undergraduate curriculum, *Pharmaciae*, 3(2), 3.

South African Pharmacy Council (2000). Annual Report.

South African Pharmacy Council (2001). Pharmaceutical Care – the way forward., *Pharmaciae*, 9(5), 4.

South African Pharmacy Council (2005). Constitutional Court Ruling. *Pharmaciae*, 13(4), 7 & 8.

Stake, R.E. (2000). Case Studies. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed.) (pp. 435-454). Thousand Oaks: Sage.

Stoltz, E. (1998). Ownership of pharmacies. *South African Pharmacy Journal*, 65(3), 70.

Summers, R., Haavik, C., Summers, B., Moola, F., Lowes, M. & Enslin, G. (2001). Pharmaceutical Education in the South African Multicultural Society. *American Journal of Pharmaceutical Education*, 65(Summer), 150-154.

Taylor, S.J. & Bogdan, R. (1998). *Introduction to qualitative research methods: a guidebook and resource* (3rd ed.). New York: John Wiley and Sons.

Terre Blanche, M. & Durrheim, K. (Eds.). (1999). *Research in Practice*. Cape Town: UCT Press.

Terre Blanche, M. & Kelly, K. (1999). Interpretive methods. In M. Terre Blanche & K. Durrheim (Eds.), *Research in Practice* (pp. 123-146). Cape Town: UCT Press.

Vaughn, S., Schumm, J.S. & Sinagub, J. (1996). *Focus Group Interviews in Education and Psychology*. Thousand Oaks: Sage Publications.

Weber, M. (1949). (First published in 1904). The Ideal Type. In K. Thomson & J. Tunstall. (1971), *Sociological Perspectives* (pp. 63-79). Harmondsworth: Penguin Books.

Weber, M. (1964). (First published in 1922). The Definitions of Sociology, Social Action and Social Relationship. In K. Thomson & J. Tunstall. (1971), *Sociological Perspectives* (pp. 128-143). Harmondsworth: Penguin Books.

Yin, R.K. (1984). *Case study Research: Design and Methods*. Beverly Hills: Sage Publications.

FOCUS GROUP INTERVIEWS

SEMI-STRUCTURED INTERVIEW

QUESTION SCHEDULE

Question 1:

How do you understand the role of the pharmacist in South Africa?

Question 2:

What skills, knowledge and attitudes do you need to know to fulfill that role?

Question 3:

Why do you think the study of pharmacy is often referred to as pharmaceutical science? Do you think this course will contribute to the scientific understanding of the pharmacy profession in South Africa? Why?

Question 4:

Do you think that it is necessary for a pharmacist to have a broad understanding of South African society and its social problems, in order to fulfill his/her responsibilities as a pharmacist? Why?

<p style="text-align: center;">Consent to participate in research study and to publication of results</p>
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1. I understand that Lucie Allan, of the Faculty of Pharmacy at Rhodes University, will be conducting a research study on how the Community Experience Programme influences student perceptions of the pharmacist's role in South Africa.
2. I have been asked to participate in this research study. I understand that my participation will consist of the following:
 - Allowing Lucie access to my Community Experience Programme practical write-ups and portfolio.
 - Being interviewed twice by Lucie.
 - Providing Lucie with background information about my educational experiences relating to the pharmacy profession.
3. I accept that the results of this research study will be used towards the completion of Lucie's master's degree. In addition, the results may (at a later stage) be used for writing papers for presentation at conferences or publication in academic journals.
4. I understand that before any results from the research are published, I will be given an opportunity to see them and discuss any changes that I feel are necessary.
5. I understand that my real name will not be used in any report describing the research study.

6. I agree to participate in the research study but I understand that if at any point I change my mind, I am entitled to withdraw my agreement to participate.

Signature:

Name:

Date signed: