

Governing Professionals Through Discourses of Resilience and Value: A New Legitimation for Ontario Pharmacists

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Abstract

In a neoliberal turn, the government of Ontario cut more than \$750 million in funds that were traditionally received by pharmacies through dispensing medication. These funds were replaced with a state-funded program that would reimburse pharmacists for professional services related to patient care. The problem facing professional elites from Ontario pharmacy's advocacy body was how to govern members of a self-regulating profession to switch subjectivities (identities) from the traditional dispenser of medication to providing patient care for profit. We address a gap in the literature and pose the question, how are the rank and file of allied healthcare professions governed by professional elites to become responsibilized subjects who will adopt state/profession agendas? Using a Foucauldian governmentality framework, our findings reveal that the rank and file are governed by elites through two technologies: resilience and value making possible a new "legitimate" pharmacist subjectivity related to the market and health care sustainability.

Keywords

Pharmacy, governmentality, professional identity, neoliberalism, Foucault

Introduction

Increasing healthcare expenditures have prompted many Western nations to adopt strategies from the business sector in order to curtail costs. However, initiatives such as new public management (NPM), characterized by managerial and organizational logics, are often in conflict with traditional notions of occupational professionalism such as autonomy, collegiality, and trust (Evetts, 2011; Numerato et al., 2012). Evetts (2011) describes this shift towards organizational practices as “new professionalism.” She recognizes the power of business logics to transform professional identities, structures and practices, but also argues that within these tensions of old and new professionalism there is continuity as well as change. In this paper, we argue that one element of professionalism that represents both continuity and change is how professionals legitimize themselves in the eyes of the state, professions, and their clientele (Fournier, 1999).

Johnson (1993) suggests that professionals are integral to modern state governance. Early professions such as medicine, surgery, law, and accountancy became more than occupational strategies of control—expertise became an extension of the state’s capacity to govern by constituting autonomous subjects who conducted themselves in “appropriate” ways. Rather than the state ruling from above, in what Foucault termed a “sovereign” type of power where “obedience to the law [was conceived] as the sole source of legitimate rule,” government manages its population through the citizen-subject (Johnson, 1993. p.141). Thus professions and the construction of the self-governing subject became central to micro-processes of state power as the state granted professions greater autonomy, self-regulation, and social status (Johnson, 1993). However, as Fournier (1999) agrees, professionals are not located “outside of the power/knowledge regime [they] serve to constitute and reproduce” (p. 284). Because they are “carrier[s] of the art of liberal governmentality,” they must conduct themselves “in ways that are recognized as legitimate and worthy of the professional label.” (p. 285) Thus, professionals are both the “governor and the governed,” establishing their legitimacy through criteria situated within traditional notions of liberal governmentality such as respecting “truth, public good, [and] social welfare” (p. 289). Liberalism emerges as a political philosophy characterized by the limits it places on the exercise of political power, governing the population from a distance through the reproduction of a self-regulating, autonomous subject (Johnson, 1993; Rose & Miller, 1992).

At the same time, neoliberalism, with its focus on the supremacy of the market, opens up new ways by which professionals can establish legitimacy, allowing them to re-establish themselves according to market logic. The neoliberal state reconfigures expertise under neoliberalism with its rationalities of “competition, accountability and consumer demand” (Rose, 1993, p. 284). As in the welfare state, expertise is still an essential mechanism of liberal governance, but state actors aim to control healthcare costs in various ways (Adams, 2017; Bourgeault & Merritt, 2015; Fournier, 2000; Nancarrow & Borthwick, 2005). In the middle of

competing logics of occupational and organizational professionalism, “old school professionals” are not above the marketplace and must transform into the “right” type of professional who will also be responsible for healthcare reform (Dent & Whitehead, 2002; Moffatt et al., 2014). Specifically, the “new” professional constructed through the adoption of market discourses must take on managerial and entrepreneurial subjectivities (the Foucauldian word for identity) in order to be seen as legitimate (Dent & Whitehead, 2002). But the demand for healthcare professionals to become more managerial or enterprising can be seen as threatening to traditional notions of autonomy leading to deprofessionalization and resistance to organizational change (Doolin, 2002; Forbes et al., 2004; Haug, 1972; Moffatt et al., 2014; Muzio et al., 2019). While this theory has merit on the surface, the deprofessionalization argument may be too unidirectional and deterministic and may overlook opportunities present within the confluence of organizational and occupational professionalism (Evetts, 2011; see also Fournier, 2000). Managerialism is both “multilayered and multidimensional” and some professions and practitioners may use managerial practices as ways to gain status and further careers (Moffatt et al., 2014; Nancarrow & Borthwick, 2005; Pickard, 2009). In this paper, we argue that neoliberal healthcare reform could result in the *reprofessionalization* of lower status professions pursuing re-legitimization through the market and healthcare reform.

The main question addressed in this paper is how self-governing professionals are constituted by professional leaders as responsabilized subjects who will take on healthcare reform. We draw from the Foucauldian analysis of Moffatt et al. (2014) who investigated how discourses of productivity circulate through NHS policy documents to govern healthcare professionals. But rather than investigating state policy documents for technologies of self (ways of constructing one’s professional identity), we instead examine how the rank and file are governed by professional elites using the pharmacy profession in Ontario, Canada as a case study. We first provide background on how neoliberal healthcare reform resulted in pharmacy’s reprofessionalization. We then elaborate on “governmentality” both as a theoretical framework and a method of analysis, describing how our Foucauldian archive of the writings of professional elites was constructed and analyzed. Finally, we present and discuss the research findings and offer conclusions relating to issues affecting professions in the neoliberal era.

Background

In 2002, the Commission on the Future of Health Care in Canada (the “Romanow Report”) reviewed the state of Canadian medicare and made recommendations to improve quality and efficiency. The Report problematized the increasing costs of medicare as unsustainable, suggesting that the future of Canadian healthcare depended upon decisive action based on “better management practices, more agile and collaborative institutions and a stronger focus on prevention,” all of which were predicted to generate “significant savings” (Romanow, 2002, p. xvi). In neoliberal logic, the solution to Canada’s healthcare ills devolved to individual healthcare consumers and professionals (Lalonde, 1974). Consistent with the autonomous, self-regulating citizen, Canadians were expected to govern themselves responsibly by keeping

healthy, using the system “prudently,” and supporting it through their actions and tax dollars (Romanow, 2002, p. 50). Responsibilized professionals were expected to work with governments, the public, and each other to improve the quality of services, ensure patient safety, and “exercise prudent management and careful stewardship of [finite] resources” (Romanow, 2002, p. 51).

Prescription drug costs are a significant healthcare expenditure. Approximately 60% of Canadian healthcare spending is divided among hospitals (28.3%), drugs (15.7%), and physicians (15.1%), with drug costs the second largest share of costs since 1997. Currently drug costs are predicted to have the highest growth rate of the three top expenditures (CIHI, 2018). Drugs have socio-economic benefits in treating acute and chronic illnesses, replacing intensive surgeries, and allowing recovery from illnesses at home rather than in hospitals. But to realize these benefits, prescription drugs were to be integrated into the healthcare system in a manner ensuring that they are “appropriately prescribed, utilized and that the costs can be contained” (Romanow, 2002, p. 190). The Report suggested that inappropriate drug use and errors could cost the healthcare system up to nine billion dollars a year and that managing and containing prescription drug costs would be more acceptable to Canadians than limiting drug coverage or introducing deductibles. It recommended linking medication management to primary healthcare in a “health management approach” where an individual’s health is managed by a team of experts, including a larger role for the pharmacist to ensure effective and appropriate use of prescription medication. Romanow also called for flexibility in roles and responsibilities of professionals, since rigid professional boundaries disrupt medication programs that require networks of providers to work together to address patient needs.

The pharmacy profession in Canada responded to the Report in a national publication: “Blueprint for Pharmacy: Designing the Future Together.” Pharmacists were presented as vital members of the healthcare team and medication experts, playing a key role in healthcare sustainability (CPhA, 2008). The Blueprint agreed that pharmacist interventions could improve access to primary care, the safety of the medication-use system, and rational use of medications; and to realize this vision, pharmacists must use the full range of their knowledge and skills, taking on new roles and responsibilities with appropriate financial compensation. Thus, the goal of the state to provide high quality and affordable healthcare was “translated” into the goal of the pharmacy profession to realize a reprofessionalization project within the context of healthcare sustainability. Historically, elitist medicine generated resistance to being managed by the state (Coburn et al., 1997), but pharmacy, after a half-century of being deprofessionalized as a business, finally aligned with the state. Pharmacy’s values and the state now coincided such that “a network [was] composed that enables rule at a distance” (Rose & Miller, 1992, p. 184). Responsibility for healthcare sustainability devolved to the individual pharmacist who was constructed in the Blueprint as being an “agent of change;” it was recognized that this involved a significant shift in the culture of pharmacy, focusing less

on drugs than the patient. The pharmacist would become the medication expert rather than a mere dispenser of medication.

In Canada, professions are regulated provincially, and in 2009, Ontario, the most populous province, made amendments to Ontario's Regulated Health Professions Act (RHPA) expanding pharmacy's scope of practice. Concurrently, through a drug system review called the Transparent Drug System for Patients Act (Bill 102), the state also cut \$750 million in funds traditionally received by Ontario community pharmacists for dispensing medication. These interventions by state actors produced lower-cost healthcare. It was also predicted that an expanded scope of practice could potentially reduce demand on an overburdened healthcare system and allow pharmacists to perform minor medical tasks to ease wait times for patients seeking physician care. (Randall et al., 2015)

Professional advocacy groups such as the Ontario Pharmacists Association (OPA) had their objectives met with the amendments to the RHPA. They had lobbied extensively for an expanded scope of practice allowing community pharmacists to take on formerly restricted roles such as adapting, modifying and extending an existing prescription, administering drugs through injection and inhalation, and performing a procedure on tissue below the dermis. Pharmacists were granted authorization to initiate drugs for smoking cessation, and recently, Ontario community pharmacists can prescribe for minor ailments (Ferguson, 2019; HPRAC, 2009). OPA supports all Ontario pharmacists, but interventions were aimed at community rather than hospital pharmacists because public drug program spending does not include drugs dispensed in hospitals, cancer agencies, or other special programs (CIHI, 2018). OPA predicted that amendments expanding pharmacist roles could potentially save the Ontario government more than \$130 million annually (Randall et al., 2015).

OPA understood that the loss of dispensing funds would severely impact the business of pharmacy, as they are a major revenue stream. Except for the province of Quebec, pharmacists at that time were not reimbursed for professional services other than dispensing. OPA thus vigorously and successfully lobbied the government to mitigate the loss of revenue with \$100 million in funding with which pharmacists would be paid by the state to provide professional services such as medication reviews (Darby, 2012). MedsCheck, as this professional service is now known, was the first medication review service to be reimbursed by a publicly-funded drug plan in Canada (MacKeigan et al., 2017). It allows pharmacists to bill the provincial medicare drug plan, the Ontario Drug Benefit (ODB) for an annual medication review service for patients taking three or more prescription medications for chronic medical conditions.

Billing for medication counselling, as part of an expanded scope of practice, signaled a new chapter for a profession that experienced significant deprofessionalization over the decades. What was needed was the support of community pharmacists whom the cuts directly impacted. The problem for OPA was how to govern members to accept the change by adopting new roles not related to dispensing. Prior to the neoliberal turn, community pharmacists

working for corporations had little autonomy to engage in non-revenue generating activities such as patient care compared to the more profitable business of dispensing (Muzzin et al., 1998; Volume et al., 1999). OPA is Canada's largest pharmacy advocacy organization with a voluntary membership of more than 10,000 members representing approximately half of Ontario's registered pharmacy professionals (including pharmacists, pharmacy students, and pharmacy technicians) (OPA, 2023). Waring (2014) nuances Freidson's (1985) thesis about restratification of professions into hierarchies of elites and rank and file as a strategy to maintain autonomy in an increasingly bureaucratic workplace. He categorizes members of professional advocacy groups as acting as intermediaries between the state and the profession that have the task of "govern[ing] their colleagues in line with corporate [or state] interests" (p. 694). OPA does not have the same power to enforce changes as the Ontario College of Pharmacists (the regulatory body). Instead, it chose persuasion via its journal. In Foucauldian terms, despite its role, OPA elites do not wield ultimate sovereign power in a "top-down" process; instead, professional elites govern through what Foucault called "productive power" to produce the changes for which they advocate. Under new professionalism, there is a cultural shift in state/profession governance which promotes the responsabilized professional who will ensure healthcare sustainability through a professional ethic of self-governance. Our discourse analysis of the journal of the Ontario pharmacy advocacy organization promised to determine how pharmacy elites governed its members at arm's length through discourses related to the market.

Theoretical perspective and methods

Analyzing text for Foucauldian "governmentality" can make visible or problematize a phenomenon that appears "natural" through various techniques and practices based in power/knowledge relations. Foucauldian methods allow one to "[stand] against the current of received wisdom [...] [by] introducing a kind of awkwardness into the fabric of one's experience, of interrupting the fluency of the narratives that encode that experience and making them stutter" (Rose, 1999, p. 20). We chose Nikolas Rose's (1999) method of governmental inquiry to guide our research. According to Rose (1999),

to analyse political power through the analytics of governmentality is not to start from the apparently obvious historical or sociological question: what happened and why? It is to start by asking what authorities of various sorts wanted to happen, in relation to problems defined how, in pursuit of what objectives, through what strategies and techniques (p. 20).

This analytic of governmentality forms a template to address our main research question (how does the profession govern its members to become the legitimate, or "right" type of pharmacist for the neoliberal turn). It does this by answering key questions: who were the authorities? (the pharmacy profession and the state); what did they want to happen? (pharmacists to adopt and adapt to changes in the profession); how was this problem defined to

the actors in the network? (pharmacists must be responsible for healthcare reform); and what techniques were used to achieve their objective? The last question is clarified by examining the strategies and techniques that govern pharmacists to become self-governing, responsible subjects. Our discourse analysis used an archive of texts produced by professional elites. We reasoned that this approach would reveal an ensemble (or network) of technologies (or toolkit) used by OPA to govern rank and file members to achieve its objectives. This ensemble is defined as

forms of practical knowledge, with modes of perception, practices of calculation, vocabularies, types of authority, forms of judgement, architectural forms, human capacities, non-human objects and devices [...] traversed and transected by aspirations to achieve certain outcomes in terms of the conduct of the governed. (Rose, 1999, p. 52)

We began with the construction of the archive by selecting which texts would be used to start the analysis. The OPA journal, *The Ontario Pharmacist*, was a logical starting point since our research question is how the advocacy body governs its members in times of change. Their function is to advocate the interests of the profession and govern the rank and file accordingly. OPA's journal highlighted both. The first author, who has worked as an Ontario pharmacist, knew that pharmacists would turn to OPA's journal to get an authoritative view when faced with significant changes such as an expanded scope of practice and government cut-backs threatening pharmacy revenue. Our approach focused on discovering how the advocacy body governs its members (not how individual pharmacists align with governing discourses). Articles published from 2006 to 2016 were selected to capture discourses just before changes to Ontario's public drug system and the following transitional period in which pharmacists were governed to adopt proposed changes in the profession.

The first author (TM) began with a sample of texts between 2006 and 2016, identifying repeating narratives associated with change. The three authors agreed that the concept of resilience appeared with regularity and should be the entry point for identifying the ensemble of technologies presented to Ontario pharmacists. The entire archive was then coded by TM for how the pharmacy profession governed its members to become resilient subjects during this period by taking on a new/different professional subjectivity. When the resilience discourse was located in the text, the following questions were asked: how did the notion of resilience appear as a way to govern pharmacists, and how does resilience "act upon individuals' ability to steer themselves by shaping their desires and aspirations?" (Brady, 2016, p. 19). To expedite the search through a decade of pharmacy journals, the Command-S function was used to find coding search terms related to the concept of resilience in words such as: adaptability, change, challenges, embrace, evaluate, future, plan, preparedness, resilient, succeed, uptake, and uncertain. When new key words were found, all articles were re-searched to ensure that we did not miss insights. Once it was confirmed that the article referred to changes in the profession, we recorded information in the coding guide by author(s), their position in the organization, and key words and phrases in the analysis.

The next step after organizing the data was to analyse the text, identifying the governance process (Kuper et al., 2013). We followed Rose (1999), who instructs that one must look at the text not for its meaning, but how “[it] functions in connection with other things, what it makes possible, the surfaces, networks and circuits around which it flows” (p. 29). In discovering how the word “change” was operationalized to govern pharmacists to become resilient subjects, we found that constructing a resilient subject was not the only technology (or techniques) governing pharmacists in the archive. Analysis of the coding sheets revealed that another word, “value,” appeared regularly in the text. We propose that “resilience” and “value” were part of what Foucault called a discursive formation defined as a “[regularity] between a number of statements [in which] one can define an order, correlations, positions, [...] functionings [and] transformations” (Foucault, 1972, p. 38). The discursive formation, or “mantra,” related to value that appeared throughout the archive will be discussed in greater detail in the next section. Altogether, 119 articles were analyzed for concepts related to resilience and value as governing technologies. We cite representative examples of this analysis in the results section. OPA granted permission to use the journal for research purposes. The “regime of truth” or “logic” that emerged shows that OPA elites govern members through the neoliberal technologies of resilience and value. Below, we elaborate on the technology of resilience as a way to govern pharmacists to adapt to a changing professional environment, and in the section following, on value as a discourse that enables pharmacists to break free of the identity of a “pill counter” to become an expert in patient care.

Governing through the technology of resilience and openness to change

As noted, drug system reform (Bill 102) resulted in major revenue loss for pharmacies. As one commentator pointed out,

[t]he decision to reduce generic drug pricing and eliminate professional allowances [...] will significantly outweigh the increase in dispensing fees or future professional services, making the provision of health care services [...] difficult and will have long-term negative implications for the profession and the businesses that support it (Miller, 2010, p.30).

However, as pharmacy elites went on to say, the provision of \$100 million in funding for professional services and increased scope of practice changes provided pharmacists with at least some additional revenue for clinical services not related to dispensing. Here pharmacy elites were encouraging pharmacists to transition from being medication dispensers to providing clinical services as a legitimate source of revenue. Another commentator insisted that resistance was not helpful: “In the early years, much of the discussion [...] revolved around limited uptake by pharmacists. Questions were posed about the willingness of pharmacists to transition from dispensing towards the provision of clinical services” (Pojskic, 2013, p. 10).

Statements in the archive reveal how this professional governmentality operates in lockstep with the state through encouraging the production of active and responsible subjects, with resilience as one specific form of neoliberal self-governance. Our archival analysis reveals that OPA elites entice the individual pharmacist to become a resilient subject through various technologies such as the discourse of change, which appears repeatedly, functioning in multiple ways to produce a resilient subject. For example, change constructs the world as beyond our control, as if the only way to survive is knowing how to adapt. In the discursive formation that circulates throughout the archive, authorities construct the profession as adapting to change to escape a dystopia of strained relations between the state and the profession. In the OPA journal specifically, change is constructed as a constant ongoing process out of the profession's control, but one which heralds a visible utopic future *if* pharmacists adapt. The phrase "we live in interesting times" is mentioned more than once, reflecting this dystopic/utopic duality where change is constructed as a "blessing/curse." On the one hand, the government takes away professional allowances, but on the other, it allows pharmacists for the first time to bill for professional services other than dispensing (Burns, 2007a, p. 34). The implementation of Bill 102 was clearly recognized as negatively affecting the profession: "Pharmacies have been losing money as fast as they fill prescriptions. [...] The result is a crisis in the making. [...] Some say they cannot stay in business much longer" (Edwards, 2006, p. 34). However, within this dystopic construction, professional elites emphasized a "silver lining." One dangled a "bright future" for those wanting to realize professional fulfillment in a tumultuous environment:

It's difficult for anyone to know what's coming next [...] [and] these changes affect, in one way or another, how pharmacists practice and how they are compensated. It is truly an age of uncertainty. [...] [However], amidst this cacophony of issues and problems [...] [there are] opportunities for an expanded scope of practice for pharmacists. (Darby, 2008, p. 5)

The resilience discourse operates in tandem with change discourses about adapting during times of change. Together they attempt to govern the actions of pharmacists by limiting their options through a technology. Authors such as Joseph (2013, p. 43) label this formation with a political acronym, TINA (There Is No Alternative). As the discourse goes, changes to legislation occur quickly, arguably leaving pharmacists in a position where they have no choice but to adapt their business model from dispensing to one focused on providing clinical skills for profit. One writer in the pharmacy advocacy journal gives pharmacists only one option—to accept these changes: "Ontario's drug system reform regulations [...] have created an imperative for pharmacies to consider strategies to shift their workflow to one that is more patient-focused. The business model is evolving quickly and pharmacists have no choice but to keep up" (Malek, 2010a, p. 12). The "patient-centred" model is familiar in pharmacy publications and education over the past few decades, but here it becomes an imperative tied to state funding.

In the OPA archive, neoliberal technologies such as responsibility and reflexivity are woven together to support the construction of resilient pharmacists who govern themselves. In a neoliberal world, “resiliency and adaptability have become central techniques of the self” which require flexibility in managing “one’s own risks” and being “innovative, adaptive and responsible” (O’Malley, 2010, p. 505). In a statement from the archive, pharmacists are exhorted to change through technologies of individualism, responsabilization, reflexivity and an appeal to the pharmacist’s ethical self who will bring about the “greater good”:

In order for this change to happen, we must first reflect on how we, as pharmacists, are prepared to change. Are we willing to change how we practice, how we [...] take on new, more complex responsibilities? [...] This change is not just good for pharmacy. It is good for our patients. It is good for the viability of the health care system. It is also our responsibility as health professionals. (Burns, 2007b, p. 42)

The archive assumes that not all pharmacists are enthusiastic about the elite agenda and several archived articles emphasize that pharmacists who resist change must be convinced to be responsible members of a legitimate profession. One statement supports monetary encouragement over coercion in disciplining pharmacists who act “irresponsibly”:

Not all pharmacists, for a variety of reasons, will want to expand their activities, responsibly and accountably [...] The proposed legislation and regulations should enable, rather than oblige, pharmacists to participate in enhanced activities. In spite of this, OPA asserts that professional activities are valuable services and need to be recognized as such with appropriate reimbursement. (Janecka, 2008, p. 7)

To summarize, professional elites reinforced the need for change through moral arguments that linked proposed practice shifts to responsiveness, social responsibility, and professional legitimacy (further elaborated below). Those who resist the uptake of new proposed practices are put in the untenable position of discursively couching their resistance in a plausible alternative for good patient care and responsible use of healthcare resources.

Governing through the technology of value in neoliberalism

Interlocking with “resilience” in our archive, “value” forms part of a discursive formation that guides pharmacists to take on the state’s agenda of professional sustainability. A mantra or discursive formation emerges from the archive: resilient pharmacists who go beyond the traditional dispensing role and provide professional services for profit can optimize patient outcomes, reduce healthcare costs, and maintain the viability of the business of pharmacy. This set of discourses of “value” (added) circulates throughout the archive and makes possible the subject position (position in the division of labour) of the “patient care” pharmacist who is valued by the profession, patients, other healthcare professionals and government.

Arguably, “patient care” pharmacist discourse has been taken up since the emergence of pharmaceutical care in the 1990s. It stresses “the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient’s quality of life” paralleling medical care and nursing care (Hepler & Strand, 1990). Judging by the archive (and sociological writing), before Covid-19, pharmacists’ traditional relationship with patients has been somewhat invisible (e.g. McCormack, 1956). Only their business subjectivity was noted (and devalued) by sociologists in previous decades. Under neoliberalism, the new pharmacy subject position is recognized as of value under the logic of the market. As Davies and Bansel (2010) put it, “the market becomes the singular discourse through which individual and institutional acceptability will be recognized” (p. 5). Value operates throughout the archive to construct a “truth” about the new “patient care” pharmacist: he or she has value as an expert when performing a professional function that sustains pharmacy at the same time as it lowers healthcare costs under medicare. In the following archival statement, pharmacy leaders recognize that clinical skills are not a new professional jurisdiction, and celebrate how a state with a neoliberal agenda now recognizes the pharmacist’s value as a professional (conflated with healthcare sustainability):

While neither pharmaceutical opinions nor follow-up consultations are new services offered at the pharmacy level, the recognition of the value of these services by the Ontario government, and their willingness to remunerate for them are. Pharmacists can now do more to affect patient outcomes, improve and optimize patient care, and deliver cost savings to the health system, while being recognized for their evolving roles and the enormous impact they have on their patients. (Li & Malek, 2011, p. 7)

Historically, Ontario pharmacists have always offered their patients access to services and information over and above those related to dispensing, with these services being part and parcel of the pharmacy experience, done at little or no charge to the patient in the best interest of community healthcare (Muzzin & Hornosty, 1994). But in response to drug system reform, the elimination of professional allowances, and new opportunities presented by Bill 179, practitioners are urged to expand services as a way to prioritize valued patient care and demonstrate the skills and value of pharmacists which will also help offset the changes brought about by government.

In the OPA archive, professional services are touted as providing game-changing evidence of the pharmacists’ value above and beyond dispensing. A certain “truth” emerges that centres *what* pharmaceutical knowledge counts. Pharmacists are now legitimated as neoliberal subjects who will lower healthcare costs by providing professional services for profit. In Foucauldian terms, a subject position is made possible by uptake of new discourses. The bottom line now is that pharmacists must govern themselves to reject the subject position of a dispenser and occupy the subject position of the patient care pharmacist who provides clinical skills for a fee. The “truth” for the pharmacist that emerges from the archive emphasizes the “value”

of clinical skills and patient care communication over traditional dispensing. As one professional elite anticipated:

Pharmacists' training can take them well beyond the established professional boundaries. Pharmacists are equipped with the knowledge and expertise to do so much more than fill a prescription. Our real value comes from our ability to treat the whole patient. (Malek, 2010b, p.11)

Although pharmacy has been practiced in Ontario for over 150 years, these archival statements suggest pharmacists' role in healthcare is only now visible in the neoliberal agenda of lowering healthcare costs. OPA elites predict a professional utopia in which government goals of increased access and cost savings promise to increasingly recognize pharmacists' value and require that pharmacists do even more to reduce healthcare costs. According to one leader, "there is a growing awareness [...] that greater utilization of pharmacists is part of the solution for addressing the challenges that are facing health care" (Pojskic, 2012, p. 10). Notably, this is a never-ending process: the profession (consistent with this discursive formation) has come a long way in terms of expanding the role of the pharmacist beyond traditional dispensing, but even relatively recent regulatory changes may not realize the pharmacist's full potential. According to another archived article: "the authority to provide injection services [...] is a big win for pharmacy [...] but even with this change, pharmacists are not being utilized to their fullest capacity" (George, 2012, p. 17). This article also comments on how pharmacists' scope of practice continues to evolve within the government's agenda for driving down healthcare costs with reference to "public service" discourse, tying them together:

Pharmacists can contribute significantly to better health outcomes, drive system and cost efficiencies through decreased wait times and fewer emergency department visits, and provide more timely access to the care that Ontarians want, need and deserve. Injection services, flu shots, the pharmaceutical opinion program, smoking cessation, and moving forward the authority to prescribe for minor common ailments such as uncomplicated ear infections and bladder or urinary tract infections—these will all improve community health and patient access while reducing system costs in a significant, tangible way. (George, 2012, p. 17)

This response to the new legislation has thus set the stage for increasing pharmacists' scope of practice, and within these changes establishing a more fully legitimized, valued pharmacist professional identity. An insider celebrates that after "Bill 179 was passed [...] it set in motion a process that would enable pharmacists to better realize their true potential through an increased scope of practice" (Malek, 2010a, p. 12), and pharmacists must be ready and willing to take up this discourse. In the recent global pandemic, pharmacy elites were well-positioned to reinforce the push for pharmacists to take on their role as "valued" healthcare profession-

als by enlisting ubiquitous pharmacies in vaccine roll-out programs, demonstrating the capacity to quickly pivot pharmacy operations to integrate long lines of patients requiring vaccinations (NPAC, 2021).

Discussion and concluding thoughts

The dominance of organizational logics that underscore state programs such as NPM challenge traditional ideals regarding professional conduct, which were historically based on notions of occupational autonomy and collegiality, but have now expanded to include logics of the organization and the market (Evetts, 2011; Fournier, 1999; Pickard, 2009). New professionalism signals a shift in how professionals legitimize themselves within a network of liberal government discourses in which they are accountable to themselves and other constituents in the network including clients, the state and the market. Such accountability requires that professionals conduct themselves in ways that are currently considered legitimate. Sociological studies that investigate the impact of managerial practices on healthcare professions focus on outcomes such as deprofessionalization or proletarianization (Forbes et al., 2004; Numerato et al., 2012); however, these have been criticized for ignoring the ever-shifting historical or cultural contexts in which many entrepreneurial professionals practice (Numerato et al., 2012). Foucauldian governmentality approaches allow for a more nuanced investigation into state/professional relationships, offering ways to explore “the contours of power within [healthcare] reforms” (Moffatt et al., 2014). They provide a theoretical framework that assumes the fluid nature of power/knowledge relations within the network of discourses of liberal government. In this discursive formation, commodification of expertise under NPM does not necessarily signal “deregulation nor increasing intervention” by the state but a “rearticulation of the state-profession relationship; a shift in the focus of government concerns regarding expertise” (Johnson, 1993, p. 145). Rose (1993) concurs that expertise is reconfigured differently within neoliberalism because it “relocates expertise within a market governed by the rationalities of competition, accountability and consumer demand” (p. 285). In other words, although expertise has been commodified under market logics, it still remains an integral technology of governance (Johnson, 1993).

The Foucauldian concept of governmentality focuses not on institutions but on the *practices* of government (Joyce, 2001) or those specific mechanisms or technologies that allow for the operationalization of state initiatives and governing from a distance (Moffatt et al., 2014). Under neoliberalism, healthcare sustainability is operationalized not by top-down or direct control, but through the construction of the responsabilized, self-governing professional whose desires must be aligned with those of government programs and professional ambitions. This requires that professionals re-legitimize themselves and make themselves accountable through the rationalities of new professionalism. The problem for professions established in the welfare state that historically resisted change when initiated from above, is for elites to convince the rank and file to adopt new roles and subjectivities related to healthcare reform.

Our findings contribute to the sociological study of the professions in addressing gaps in our knowledge of how allied healthcare professionals are governed within their own professions by their own members. Unlike other governmentality studies that focus on how the state fashions medical professionals into managerial or enterprising subjects (Doolin, 2002; MacKinnon, 2000; Moffatt et al., 2014; Sheaff et al., 2004), we examined how pharmacists, as members of a historically self-regulating profession are governed by elites to adopt neoliberal state reform. Archives constructed from professional advocacy journals can provide rich data to track these power/knowledge relations. In our case study, we discovered how elites attempted to construct “legitimate” professional identities from narrowly-defined neoliberal “truths.” Our findings reveal, in true governmentality fashion, that elites need not suppress professional freedom when they can provide incentives to embrace neoliberal policies. The rank and file are “free” to adopt subjectivities responsible for healthcare reform and discard traditional roles not valued under market logics.

In 2008, Canadian pharmacy translated federal programs of healthcare sustainability into its own professional space that aligned state objectives and their reprofessionalization project of pharmaceutical care. This positioned pharmacists as visible, resilient, and valued members within the healthcare team. But as noted, the role of “medication expert” or “patient care” pharmacist was not new for pharmacy. Neoliberal healthcare reform, 20 years after pharmaceutical care discourse was introduced, enabled Ontario pharmacists to finally shed their traditional identity as dispensers and compounders of medication and reprofessionalize as experts in pharmaceutical care. Our case study reveals the irony for pharmacy to reprofessionalize through neoliberal state policies. The (re)construction of clinical services as a commodity within market discourses was once a reason for its devaluation (in liberal professional discourses). Now new professionalism, as defined by the state, promises to *legitimize* pharmacists’ professional subjectivities in terms of their value within neoliberalism. Under this enabling technology, pharmacists’ scope of practice is expanded by the state away from merely dispensing towards non-traditional (and subjectivity-constructing) practices such as immunization and prescribing. The extension of billable services to include medication reviews makes visible the value of the pharmacist to the state beyond a traditional role of dispensing. Thus, the formerly “devalued” pharmacist, as urged by pharmacy elites, can gain status by buying into a discursive formation legitimizing the role of the pharmacist as a full-fledged healthcare expert. This discursive formation taps into a historically devalued construction of pharmacists as mere businesspeople in earlier eras. Prior to 2008, implementing pharmaceutical or patient care in the community has been challenging, as studies have shown that pharmacists have little control over their work. Pharmacy’s loss of professional autonomy was labelled proletarianization, defined in neo-Marxist sociology as the loss of control “over the context and content of [work] because of the bureaucratization and corporatization of healthcare” (Coburn et al., 1997, p. 2). Community (or retail) pharmacy has long been associated with corporate pharmacy, and the majority of pharmacists working in Canada are employed as staff pharmacists (CIHI, 2020). Because their work is determined by head office

quotas, staff pharmacists have had little input into hiring support staff to whom they might delegate technical work (Rosenthal et al., 2016).

Neoliberal drug system reform has arguably “forced” pharmacists, who struggled to label themselves a “profession” and not a “trade” historically, to identify with new business models which recognize their important responsibility for healthcare and business sustainability through professional intervention. Our archival discourse promises a utopic future *if* pharmacists take on the subject position of the active and responsible pharmacist performing the state agenda. In our archival texts, elites governed pharmacists by appealing to their individual responsibility to “save” the profession because switching subjectivities was not only good for the profession, but also for patients and the healthcare system. Those who resist risk a dystopic future for the profession.

Using a Foucauldian theoretical perspective opens up new areas of research highlighting state/elite professional relations in (re)establishing professional legitimacy in an era of neoliberalism. In the case of pharmacy, future studies could investigate how “resilient” pharmacists have realized the profession’s construction of a “utopic” future. For professions across the board, we might ask, where does the push for resiliency as a technology of self-governance lead? Arguably, health professions in Canada are facing professional burnout by which resilient subjects in an ever-demanding marketplace require lifelong adoption and adaptation of new discourses and practices (Walkerdine, 2006).

Our research addresses an under-researched aspect of professional governmentality since little is known about how professions other than medicine are governed by their advocacy groups to become responsabilized subjects who will take on a state/professional agenda (Annandale, 1989; Coburn et al., 1997, Sheaff et al., 2004). Our findings are thus relevant to a range of professions which are yet to be explored using a Foucauldian lens.

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