

The Nature of Caring in Pharmacy

Robert L. McCarthy

“While we have always cared *about* patients, now, in assuming responsibility for their drug therapy outcomes, we must care *for* them.” (11, p. 1596)

INTRODUCTION—CARING IN PHARMACY: A CHANGING PARADIGM

Throughout most of its history, pharmacy has been a profession linked to a product—drugs. Whether the pharmacist’s responsibility involved compounding the drug from raw chemicals or simply “counting, licking, sticking, and pouring,” their professional activities centered around providing medications to patients. Unlike a physician or a nurse whose primary focus was on the patient, a pharmacist’s responsibility to the patient was almost secondary. In fact, early codes of ethics for pharmacists expressly indicated that it was not within the pharmacist’s professional duty to counsel patients or answer their questions. If queried about their medications by patients, pharmacists were to refer them to the prescriber (6).

With the evolution of clinical pharmacy in the 1960s and 1970s,

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the role of pharmacists and their ethical and professional responsibilities began to change. At first in institutional settings, and later in community practice, pharmacists began to be viewed as therapeutic experts and advisors. Not only was it acceptable to counsel a patient about their medication, it began to be expected. Physicians and other prescribers started to see pharmacists as resources of drug information. The Doctor of Pharmacy degree took on new importance.

Despite the advances of the last several decades, however, it was not until the characterization of the concept of pharmaceutical care, the passage of the 1990 Omnibus Budget Reconciliation Act (OBRA '90), and the work of the AACP Commission to Implement Change in Pharmaceutical Education that the paradigm shift became codified. Although the B.S. versus Pharm.D. debate continues in some quarters, what has become virtually universally accepted is the concept of pharmaceutical care.

Competence, Trustworthiness, and Caring

For many pharmacists, the concept of "care" is somewhat foreign and unclear. Berger (3) has attempted to describe the characteristics that a pharmacist practicing pharmaceutical care should possess.

First, pharmacists must be competent. They must possess a knowledge base which at least minimally allows them to carry out their functions as reliable, therapeutic experts. However, competency is more than simply having an adequate base of knowledge. Skills which allow the pharmacist to appropriately time and organize patient counseling information, or which include the patient as a partner in their own care are of equal importance in evaluating a pharmacist's competence.

Second, pharmacists must be trustworthy. Patients must know that they can confidentially seek the advice and assistance of their pharmacist and that their wishes will be carried out. As Berger notes, "being seen as trustworthy by the patient is connected to the ethical covenant made between the pharmacist and the patient. Once the pharmacist and patient identify what each is responsible for, trust becomes a measure of the patient's perception of how well

and how consistently the pharmacist upholds his or her end of the covenant" (3, p. 2401).

Third, pharmacists must care for and about their patients. The 1994 Code of Ethics for Pharmacists directs that "a pharmacist places concern for the well-being of the patient at the center of professional practice" (1). Unfortunately, pharmacists do not always effectively communicate the fact that they do indeed care about their patients' welfare. All too often, patients perceive just the opposite. Busy practitioners who fail to spend adequate time interacting with their patients do little to alter this perception. Conversely, pharmacists who do spend time with their patients and attempt to understand their concerns are much more likely to be viewed as caring. As Berger points out, "probably nothing is more powerful in communicating caring than understanding, and thus legitimizing, the concerns of the patient" (3, p. 2401).

Pharmaceutical Care

The Commission to Implement Change in Pharmaceutical Care (CICPE) "believes that the mission of pharmacy practice is to render pharmaceutical care. Pharmaceutical care focuses pharmacists' attitudes, behaviors, commitments, concerns, ethics, functions, knowledge, responsibilities and skills on the provision of drug therapy with the goal of achieving definite outcomes toward the improvement of a patient's quality of life" (7). This characterization of pharmaceutical care by the CICPE provides a number of synonyms for caring in pharmacy: commitment, concern, and responsibility.

Pharmaceutical care forces pharmacy practitioners to change the focus of and to broaden their professional responsibility. In traditional pharmacy practice, both the legal and ethical obligations of pharmacists centered around ensuring that the proper medication as ordered by the prescriber was delivered to the patient. Physicians—not pharmacists—were the health-care professionals who held ultimate responsibility for monitoring the patient's progress and ensuring that the desired outcome was achieved. Pharmaceutical care directs that this responsibility is to be a shared obligation between the prescriber and the pharmacist.

Product- or Service-Oriented Care vs. Patient-Oriented Care

When a pharmacist's sole responsibility was to ensure that the correct drug, in the correct dosage, and with the proper directions got to the patient, a focus on the product seemed logical. However, pharmaceutical care shifts the pharmacist's responsibility from a product or service focus to one which is directed toward the patient. This change makes the focus of pharmacists consistent with that of other health-care professionals, most notably physicians and nurses. This humanistic focus also seems consistent with the concept of medical caring. Medical caring should be centered on the patient, not on a product which will be used by a patient. Simply ensuring proper dispensing of a medication without concern or obligation for its result demonstrates caring *about* the quality of a *service*, not *for* the quality of life of a *patient*.

Focus on the Outcomes of Services vs. Simply Providing Services

An important component of the concept of pharmaceutical care is that which places the responsibility for the outcome of drug therapy on the pharmacist. It is not sufficient for pharmacists to claim that their obligation is fulfilled because they have accurately completed the prescription filling function. Under the concept of pharmaceutical care, a pharmacist who has correctly filled a prescription has completed a technical function which is only the first step in the pharmacist's responsibility. As Penna has noted, "practitioners of pharmaceutical care are concerned with the effect of their services on patients' quality of life and not merely with the act of providing services" (15, p. 543).

Pharmacists must monitor drug therapy for effectiveness, adverse reactions, drug interactions, and complications. They must carefully follow the progress of the patient's disease or medical condition. They must monitor the patient's compliance with their drug therapy. Most importantly, they are culpable for ensuring that the medication achieves its desired outcome and, in its absence, for recommending additional or alternative treatment.

Barriers to Pharmaceutical Care

Several significant barriers exist to pharmaceutical care becoming the standard by which all pharmacists will practice. From a

practical perspective, although many or even most within the pharmacy community have accepted the shift toward pharmaceutical care, not all have. Many older pharmacists, educated and trained in a different era, are uncomfortable with abdicating responsibility for drug dispensing. Some of these practitioners are even more uneasy about an expanded clinical role which will require them to provide services they may feel unqualified to perform. Such pharmacists believe that they have a caring attitude toward their patients which is manifested in their dispensing and, in some cases, limited patient counseling. The profession will need to assist such practitioners through the use of continuing education and mentoring to reassure them of their ability to carry out the functions and caring responsibilities expected of the "new" pharmacist.

Another significant barrier to pharmaceutical care is the many practice sites which do not lend themselves to providing expanded patient-centered services. Chain pharmacies, for example, may fill several hundred prescriptions per day with a small professional staff leaving little time for expanded caring activities. As one chain pharmacist has written, "Because of current economic conditions, more and more pharmacists are encouraged to produce higher sales and profits. The pressure for a large volume of prescription orders may inhibit the pharmacist's availability for customer service" (10). The business philosophy of such organizations, and some independent pharmacies as well, is that they will not provide pharmaceutical care services until they are reimbursed by third-party payors for such activities.

A related barrier is actually the patient themselves. Patients, like many pharmacists, view the pharmacist as a dispenser of medication. They often do not demand pharmaceutical care services because they may not know they are entitled to receive them. In a study completed by Smith and Sharpe (17), 80 per cent of patients failed to speak with their pharmacist at the time their most recent prescription was filled, and five out of six patients did not indicate the pharmacist as the individual they would ask about prescription drugs. Although this research was conducted ten years ago, patient perceptions and attitudes about the pharmacist's role have changed little. Organized pharmacy may have made a paradigm shift to pharmaceutical care, but individual pharmacists often failed to tell

patients about their new caring role. In the absence of such activities being rendered by pharmacists, patients are unlikely to demand that they be provided or that they be covered by their drug benefit plan.

Quality Care and Cost

In our current era of health-care cost-containment, medical services are usually evaluated, in part, upon the costs associated with them. Providing pharmaceutical care services to patients is a case in point: Most practitioners would agree that pharmaceutical care is the method by which patients should be cared for by their pharmacist. However, these services may be associated with increased costs, although at least one study has indicated that the provision of pharmaceutical care both reduced medication costs and improved quality of care (12).

Nevertheless, pharmaceutical care-induced increased medication costs may still result in a number of instances. This is especially so if one carves out the costs associated with a patient's drug therapy as some have done. In order to fairly evaluate pharmaceutical care services, they must be evaluated as a component of a patient's entire health-care expenditure. If done this way, pharmaceutical care can usually be shown to not only demonstrate a true sense of patient-centered caring, but also to reduce costs associated with patient morbidity.

Consumerism and Care

It was not long ago that when patients were instructed by their physician or pharmacist to have an operation, go for a laboratory test, or take a medication, they did so without question. Today, patients have become true consumers of medical care. Patients wish to be informed and asked for their consent and they expect a certain level of service. Part of what they expect from their health-care provider is that such services will be provided with a caring attitude. As with sellers of other goods and services, pharmacists and pharmacies who fail to meet the demands of medical consumers for care will quickly find themselves without customers.

Women in Pharmacy

The last ten to fifteen years have seen a significant change in the gender composition of students at colleges and schools of pharmacy. Women represented only about one-third of their pharmacy classes during the late 1970s and early 1980s; today, they represent three-fifths of their classes. Over time, women will transform a once male-dominated profession.

What impact this change may have on the caring attitudes of pharmacists is uncertain. Some have argued that women are inherently more caring and compassionate when dealing with patients than are men, and that this gender shift will have a significant impact on the relationship between pharmacists and their patients (13). Others contend that the level of caring is a personal characteristic, possibly influenced by completing a pharmacy curriculum, but independent of gender.

American Pharmaceutical Association Code of Ethics

The Code of Ethics of the American Pharmaceutical Association is the only code of ethics that specifically guides the practice of pharmacy. A careful examination of the evolution of the Code since its inception in 1852 shows both a greater degree of responsibility to the patient expected of the pharmacist, and a greater respect for the autonomy of patients.

The 1994 Code of Ethics for Pharmacists speaks to the “covenantal relationship between the patient and the pharmacist” and the obligation of pharmacists to promote “the good of every patient in a caring . . . manner” (1). The elements of pharmaceutical care appear throughout this draft document and are consistent with the new paradigm of what is meant by caring in pharmacy.

Caring Behaviors

Providing caring through demonstrating caring behaviors has long been the professional mission of nursing. But what actually are caring behaviors and can they be transferred to pharmacy?

A recent study by Robinson-Wolf et al. (16) developed a revised

Caring Behaviors Inventory (CBI) to evaluate the dimensions of nurse caring as viewed by nurses, patients, and former patients. What they found were five dimensions of nurse caring: respectful deference to others, assurance of human presence, positive connectedness, professional knowledge and skill, and attentiveness to the other's experience.

What is interesting to note from their work is that all of these dimensions could apply equally to pharmacists practicing pharmaceutical caring. What this study also demonstrates is that medical caring is generic. Pharmacists, nurses, physicians, and other health professionals show caring toward their patients by demonstrating virtually identical behaviors.

LEGAL/REGULATORY OBLIGATIONS TO PROVIDE CARE

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90)

Most important laws and regulations are an outgrowth of the basic ethical and moral standards and behaviors established by a society. Statutes may be codifications of long-standing social practices (for example, laws which prohibit stealing or killing other people), or they may be used in an attempt to change societal behaviors (such as restrictions on firearms to reduce violent crime). In health care, including pharmacy, most laws and regulations are promulgated to protect the public (for example, to prevent abuse/misuse of prescription drugs). But as with other laws, health-care statutes can be adopted to change practice patterns and behaviors.

The provisions of OBRA '90 relating to pharmacy are an example of how Congress has attempted to legislate changes in the way pharmacy is practiced in the community. Although OBRA '90 relates only to pharmacy services for Medicaid patients, the vast majority of states in their enabling legislation have established these provisions for all patients (14).

From the standpoint of caring in pharmacy, two aspects of the legislation are especially important: mandatory patient counseling and drug utilization review.

Patient Counseling and the Patient-Pharmacist Relationship

It can be argued that the provision of OBRA '90 requiring that an offer to counsel be made by the pharmacist prior to dispensing any prescription medication exists because many pharmacists were not doing so on their own volition. Whether or not this is the case, OBRA '90 should have a dramatic impact on the caring responsibility of pharmacists with respect to patient counseling. Although recent evidence (8) has shown poor compliance thus far with the provisions of OBRA '90, as enforcement increases so should compliance. No longer will pharmacists be able to say that they are too busy or pharmacies be able to discourage counseling by their pharmacists.

If mandatory counseling accomplishes nothing more, it will certainly provide the opportunity for a more meaningful, and in some cases the first, dialogue between pharmacists and their patients. This change alone will have a significant impact on the patient-pharmacist relationship. Patients will come to expect that their pharmacists will speak to them whenever they have a prescription filled. For many patients, this will provide the first opportunity to see their pharmacist as more than just a technician dispensing medications. Patients may perceive pharmacists as more like physicians and nurses—individuals who have a direct caring relationship centered upon the patient.

One factor that will have a significant impact on whether this new patient-pharmacist relationship will succeed is whether the relationship which is established can be long-term. Most patients are used to having a physician who cares for them over many years. With the vanishing of the corner drug store, such relationships between patients and pharmacists have become much less common.

A choice of pharmacy is often based upon price, convenience of location, or (with increasing frequency) whether the pharmacy is a member of a third-party provider network with which the patient is associated. The opportunity to see the pharmacist in the role of patient advocate (as opposed to drug dispenser), might lead patients to establish long-term, physician-like relationships with their pharmacist when possible.

Further, the effectiveness of pharmaceutical care requires conti-

nuity in the relationship between the patient and the pharmacist. A patient is less likely to feel comfortable engaging in a prolonged and sometimes personal medical discussion with an individual whom they do not know well. As a result, third-party drug benefit plans which change a long-established relationship between a patient and a pharmacist by requiring that the patient use a pharmacy within the network may limit a pharmacist's ability to provide pharmaceutical care. A similar problem can occur if the pharmacies within the network change frequently causing the patient to continually move from pharmacy to pharmacy.

Drug Utilization Review (DUR)

The drug utilization monitoring required of pharmacists by OBRA '90, like mandatory patient counseling, provides pharmacists with an opportunity to establish a new caring relationship with their patients. Not only will pharmacists be evaluating drug therapy prospectively by checking for drug interactions, they will be monitoring the patient *after* they leave the pharmacy to ensure that the goals of treatment are achieved.

This may provide the patient with the perspective that their pharmacist really is concerned with their well-being, and not simply with the sale of the prescription. DUR refocuses the pharmacist's attention away from the product and toward the patient.

Is Quality Being Provided? Is There the Capacity to Provide It?

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has for many years been responsible for ensuring the quality of American hospitals and, more recently, other health-care organizations, such as home infusion therapy companies. Traditionally, JCAHO standards have focused on whether an institution had the capacity to provide a given service or level of care. Recently, however, this accrediting body has made an important shift in their evaluation criteria. JCAHO is now concerned with not just whether an organization has the capacity to provide care or a service, but whether they *are* providing that service or level of care (9).

This change is consistent with the concept that the focus of health-care institutions is the patient. Many technically-oriented, sophisticated health-care organizations are capable of providing a level of caring service, but may not actually be doing so or doing so in a way which satisfies accreditation criteria, but which does not improve patient care.

A hospital pharmacy, for example, might have a procedure for reviewing and acting upon medication errors, but may not actually be learning from their mistakes and altering patient-care procedures to reduce their occurrence in the future. Similarly, an institutional pharmacy may have the clinical staff to provide patient discharge counseling, but may not be actually providing this service for patients.

ETHICAL OBLIGATIONS TO PROVIDE CARE

Ethical Principles

All medical practitioners, including pharmacists, have an ethical obligation to care for their patients. Ethical principles provide guidance for practitioners, including pharmacists, about what these patient care commitments entail.

Fidelity

Fidelity requires that pharmacists act in such a way as to demonstrate loyalty to their patients. A type of bond or promise is established between the practitioner and the patient. This professional relationship places on the health professional the burden of acting in the patient's best interest.

Fidelity is probably the most important ethical principle with respect to the caring relationship between a pharmacist and patient. Pharmacists who fail to provide pharmaceutical care for their patients violate the essence of what a professional fidelity relationship should be.

In the past, correctly completing technical pharmacy tasks—assuring that the proper drug and strength was dispensed—was thought

sufficient for pharmacists to meet their fidelity obligations to their patients. With the advent of pharmaceutical care, however, this product-centered approach is both professionally and ethically unacceptable. Pharmacists must continue to ensure that technical functions are completed correctly, but they are also vested with an obligation to ensure that proper therapeutic outcomes are achieved with a minimum of untoward reactions.

As discussed above, long-standing patient-pharmacist relationships play a significant part in the success of pharmaceutical care. Nevertheless, caring behaviors should not be restricted to such professional relationships. Pharmacists have a fidelity obligation to *all* their patients regardless of the length of the professional relationship.

Veracity

Veracity is the ethical principle that instructs practitioners to be honest in their dealings with patients. There may be times when the violation of veracity may be ethically justifiable, such as using placebos to benefit a patient, but the violation of this principle for non-patient-centered reasons would appear to be unethical.

Veracity plays a significant role in the caring relationship between a pharmacist and patient. In a caring, professional relationship based upon professional fidelity, patients have a right to expect that their pharmacists will be forthright in their dealings with them.

Patients should expect to be counseled honestly about the likelihood of the success of medications, about the chances for adverse reaction or complications, and about the therapeutic outcome they should expect.

Beneficence/Nonmaleficence

Beneficence and nonmaleficence are complimentary ethical principles that place on pharmacists important responsibilities with regard to the care of their patients. Beneficence is an active process which requires practitioners to act in such a way as to do good for their patients. Nonmaleficence, a more passive process, instructs that pharmacists should practice in a way which will avoid harm coming to their patients, or to take due care.

Both of these ethical principles are integral to caring behaviors. Pharmacists who demonstrate pharmaceutical care act for the benefit of their patients. In many respects, pharmaceutical care reminds pharmacists of their professional obligation to their patients. Product-based care too often misfocused pharmacists' goals away from their patients. When dispensing the product is paramount, the needs of the patient become secondary. When the focus is on caring, however, the patient will receive maximum benefit.

Similarly, pharmacists once believed that accuracy in dispensing was the singular goal of nonmaleficent practice. Patient-pharmacist interaction ensuring that harm would not befall the patient, which was at least of equal importance, was often ignored. Accurate dispensing in the absence of proper patient counseling does not mean that the pharmacist is taking due care.

Justice

Justice has a long history as an ethical principle. Aristotle defined justice as "treating equals equally and unequals unequally." Today, when we think of justice, words like fairness and equality come to mind.

Distributive justice refers to the equal distribution of the benefits and burdens of society among all of society's members. We often think of distributive justice in terms of our health-care delivery system. This principle is frequently used as a justification for providing health care as a right to all Americans.

Caring by health professionals is not always provided with equal fervor to all patients. Justice instructs health-care providers, including pharmacists, to demonstrate an equivalent amount of care towards all their patients. However, issues such as the patient's socioeconomic status, sadly, often impact the level and intensity of care provided by the pharmacist. Medicaid patients are many times provided a much lower quality of care than say a patient who is a cash-paying customer or who has a generous drug-benefit plan.

All too often, the care provided by the pharmacist is viewed in terms of the personal reward for the pharmacist—the level of reimbursement the care is likely to reap. Justice and pharmaceutical care demand that the focus be on the patient and their medical needs, not on the financial impact on the pharmacist.

As the United States embarks on the possibility of significantly reforming its health-care system, equal access to quality care must be the cornerstone of any reform effort.

THE PATIENT-PHARMACIST RELATIONSHIP

A One-to-One Relationship

Developing caring behaviors in pharmacists will not be a simple task given the history of product-based practice. To achieving success in this area, pharmacists will need to model their practice after physicians and nurses. In patient-nurse and patient-physician interactions, a one-to-one relationship is emphasized.

In its statement on pharmaceutical care, the American Society of Hospital Pharmacists has noted that "at the heart of any type of patient care there exists a one-to-one relationship between the caregiver and the patient. In pharmaceutical care, the irreducible 'unit' of care is one pharmacist in a direct professional relationship with one patient" (2, p. 1721).

Patients frequently refer to "my physician" or "my nurse" who cared for them when they were sick. Seldom do we hear a patient refer to "my pharmacist." The lack of identification with a "personal" pharmacist is not, however, a long-standing perspective. During the times in which most community-based practice was the local corner drug store, patients did feel a sense of personal identification with a pharmacist. Drug chains, price shopping, and the use of exclusive provider networks have brought us to where we are in pharmacy practice today—the era of the faceless, nameless practitioner.

Pharmaceutical care might provide the profession with the opportunity to reclaim its one-to-one relationship with patients. By refocusing on the patient, by speaking with the patient, by monitoring the patient, and, most importantly, by showing concern for the patient, pharmacists may again assume the role of "neighborhood pharmacist."

The Importance of Empathy

One of the most significant challenges to changing the caring behaviors of pharmacists is the need to develop empathetic practi-

tioners. Berger has argued that students who are recruited for and attend pharmacy school are students who possess a strong scientific and analytical base. He contends that the poor communication skills of many pharmacists are directly attributable not to what they are taught, but the type of personalities they possess before they ever begin their pharmacy education (4).

A similar argument can be made for the lack of empathy demonstrated by pharmacists. Schools and colleges of pharmacy that select students based on standardized test scores and grade-point averages fail to evaluate the caring traits these individuals may or not possess. Empathy is not a learned trait in its most basic form. Compassion cannot be taught; rather, it is an inherent characteristic. Pharmacy education can provide the professionalization of what it means to be a pharmacist, but it cannot instill warmth, caring, and the desire to help others in an individual who is not already prone to do so.

As a result, some have argued that we must reassess the methods by which we evaluate students for admission to our schools and colleges of pharmacy. Applicants with a strong basis in the humanities, ethics, and communications are as important as those who excel in chemistry and the biological sciences. The personal interview, the use of role-playing scenarios, and sample problem-solving cases might provide as important, if not more important, insight into an applicant's suitability for a pharmacy career as their grades in organic chemistry and physiology.

Understanding the Individual Needs of Patients

Tangential with the importance of pharmacists developing one-to-one relationships and showing empathy towards their patients is the need to understand their patients as individuals. In a truly caring, professional, one-to-one relationship, pharmacists should not expect that what is an effective way of dealing with one patient will also work with another. We are all individuals with individual needs, concerns, and expectations. Pharmacists who appreciate these variations will be able to "tailor-make" their caring behaviors to each individual patient.

Creating an Environment for Communication

In a science-heavy curriculum like pharmacy, courses which fall into non-scientific areas are often given a lower priority by both faculty and students. As discussed above, Berger (4) has observed that students who enter pharmacy school not only have poor communications skills, but frequently experience communication apprehension. Taken together, therefore, it is not surprising that many pharmacists graduating from schools and colleges of pharmacy have a strong data base, but are often unable to effectively communicate this data base to others.

Pharmacists who are unable to effectively communicate with their patients and other health-care professionals are at a significant disadvantage in a number of respects. From the perspective of the patient, the pharmacist's ability to transmit their concern and understanding will be significantly hampered.

Pharmacists must be able to communicate, both verbally and sometimes in writing, in order to demonstrate a sense of empathy. It is these skills which enable them to establish a caring environment in which the patient feels comfortable in asking questions and responding to the pharmacist's queries.

This caring environment is also impacted to a great degree by the physical surroundings in which the patient-pharmacist interaction occurs. A busy pharmacy counter is not a setting conducive to establishing a caring environment centered on the patient. Pharmacists must endeavor to utilize private counseling areas and other out-of-the-way settings within the pharmacy in which a confidential exchange of information can occur without patient anxiety. In addition to the simple fact of ensuring a confidential area for the exchange, pharmacists also demonstrate their sense of caring for the patient by stopping what they are doing and making the patient the focus of their activity for at least a few minutes.

The Economic Impact on the Patient-Pharmacist Relationship

As discussed above, the paradigm shift to pharmaceutical care is not without its financial implications. Community pharmacies which are filling several hundred prescriptions a day would argue that they cannot afford to spare a pharmacist to counsel patients—an

activity for which they will not be compensated. Unlike physicians and nurses, pharmacists, for the most part, are not paid for patient-care activities. Rather, they are reimbursed for their professional services through their dispensing activities.

The current method of remunerating pharmacists can become a barrier to pharmacists demonstrating caring behaviors toward their patients. Payors will need to adopt a new approach to the way in which pharmacists are compensated for professional services which is based on the concept of pharmaceutical care. The problem with achieving this change, as has been noted, is whether payors should begin paying for patient-centered services so that pharmacists will perform them, or whether pharmacists should show the cost-effectiveness of cognitive services to prove why payors should compensate them for providing such services.

The Patient-Physician-Pharmacist Triad

Ideally, pharmaceutical care should provide pharmacists and physicians with an opportunity to work collaboratively for the benefit of patients. However, as pharmacists shift their role from a product-centered one to one which focuses on the patient, the likelihood of conflict with the physician increases. In their historical role as compounders and dispensers, pharmacists infrequently were faced with conflicts with physicians. As pharmacists embrace the new, emerging practice roles associated with pharmaceutical care, such conflicts will increase and have already appeared in many settings.

The patient-physician-pharmacist triad has always existed, but a new form of this triad is developing: In the past, the patient sought the counsel and diagnosis of the physician. If a prescription was necessary, it would be written by the physician and the patient would take it to the pharmacist for filling. Until recent decades, minimal interaction between the pharmacist and patient would occur; patients with questions would be referred back to their physician for the answers.

With the advent of clinical pharmacy and changes in the code of ethics, interaction between patient and pharmacist increased dramatically: Sometimes this would lead pharmacists to question physicians about their prescribing habits. Occasionally, this questioning

might even lead to a conflict in which the physician insisted on prescribing a medication and/or dosage that the pharmacist considered not in the best interest of the patient.

These occasional pharmacist-physician conflicts continue today. With the growing acceptance of the concept of pharmaceutical care, however, such conflicts are likely to be more frequent and intense. The triad then becomes more pronounced with the physician advocating one course of action to the patient and the pharmacist sometimes urging another.

The result of this increased tension may produce better care for the patient in the long run, but at the cost of increased friction between the physician and pharmacist. As pharmaceutical care evolves, pharmacists must recognize that their first priority is to provide optimal care for their patients. As caring professionals, pharmacists and physicians must reach an accommodation which will achieve this goal.

THE ROLE OF PHARMACISTS IN CARING FOR SPECIAL POPULATIONS

Showing caring toward all patients is an important component of the pharmacist-patient interaction. However, certain groups of patients require additional compassion, concern, and understanding on the part of pharmacy professionals.

Terminally Ill Patients

One of the many things for which pharmacy can be proud of is its early involvement in hospice care for the terminally ill. Many physicians, as an outgrowth of their professional training, have had great difficulty accepting the hospice concept as being a compassionate way of dealing with patients at the end of life. Medical education stresses the role of the physician as an individual who cures. Terminal illness is regarded by some physicians as a failure to achieve their responsibility to their patients.

The same cannot be said for pharmacists and nurses: Nurses and pharmacists in large numbers have filled the void which existed in

the care of patients with terminal illnesses. Pharmacists and nurses have been able to work together to ensure that patients receive adequate medication and nursing care to make them as comfortable as possible during the final stages of their life.

Hospice work can certainly have its low and depressing moments, but at the same time it can provide pharmacists with a unique opportunity to be a health professional who does more than dispense drugs. A pharmacist who is versed in the treatment of pain and attendant medication side effects can work with the patient and the patient's family and friends to choose a therapeutic regimen that best meets the patient's physical and psychological needs.

The Elderly

The largest users of medication are the elderly. It only stands to reason, therefore, that this group of patients requires and deserves special care by the pharmacist. The elderly not only use the most medication, but they use chronic medication most frequently. It is these chronic medications which require careful and diligent management and monitoring by the pharmacist. Patients who use medications for months to years are more likely to require dosage adjustments or therapeutic regimen additions and deletions or experience adverse reactions.

Monitoring side effects is especially important in elderly patients. Like pediatric patients, the elderly are more susceptible to adverse reactions and are more sensitive to the therapeutic actions of drugs. Careful monitoring by the pharmacist can avert serious consequences.

As a group, the elderly also respond more positively to caring behaviors than perhaps any other group besides children. Pharmacists who are able to establish a relationship with their elderly patients based on compassion and trust are more likely to be able to effectively care for them. Setting the tone of an interaction with the elderly that involves seemingly nonpertinent subjects, such as their cooking or their grandchildren, can often lead to a more forthcoming interaction about their medical condition. Elderly who do not feel a level of comfort with their pharmacist are less likely to engage in a meaningful dialogue about their medications. A caring

pharmacist can mean the difference between an effective and a failed therapeutic intervention.

The Mentally and/or Physically Disabled

Like the elderly and children, the mentally and/or physically handicapped patient is in need of a special level of caring on the part of pharmacists. As with the elderly, these patients are unlikely to respond to a pharmacist's efforts to assist them if they have not been able to establish a level of comfort with the practitioner.

Physically and especially mentally handicapped patients often elicit a sense of fear and rejection from the public. Bryant (5) and his colleagues found that hospital pharmacists, unlike many members of the public, do not view mentally ill patients with fear or prejudice.

There are several quite simple things that pharmacists can do that can have important impact on how they are viewed by the physically handicapped. Installing access ramps into their pharmacies, setting up private patient counseling areas that are wheelchair accessible, assisting patients in OTC product selection (which both gets the pharmacist involved therapeutically and allows them to reach products inaccessible to wheelchair or visually impaired patients), and providing written counseling information in Braille are just a few of the things that pharmacists can do which says that they care about their patients. When physically handicapped patients see these types of facilities and actions by the pharmacist, they realize they are dealing with a health-care professional genuinely interested in their welfare.

Mentally handicapped patients provide a greater challenge for pharmacists. Depending on their degree of mental illness, the pharmacist may be unable to demonstrate to the patient a caring attitude. In fact, in cases of severe mental illness, the caring relationship may be established with the caregiver. Regardless of the level of impairment, however, pharmacists must make a special effort to show compassion and concern. Even actions as simple as the willingness to spend extra time explaining a drug regimen to the patient or contacting multiple caregivers to ensure that all have the same information about the patient's drug therapy can be enough to establish that a real concern exists for the patient's well-being.

Children

The old saying that everyone loves children and animals is especially applicable to medical care. Children, like the elderly and mentally handicapped, often require the pharmacist to spend additional time with them to ensure that effective two-way communication has been established. Like the mentally handicapped, the caring relationship may be established with a caregiver or parent rather than directly with the patient. Also, similar to the elderly, children are more susceptible to untoward drug reactions than the population at large. Therefore, pharmacists must be especially prudent in their monitoring functions and in ensuring that important information is both transmitted to and received from the patient or caregiver.

CONCLUSION

Pharmaceutical caring is really a new idea with old roots. When the corner drug store was the sole means for having prescriptions filled, patients usually found a compassionate and caring pharmacist more than willing to spend time with them, listen to their problems, and offer advice. Over the years, pharmacy practice, like many other facets of medicine, has become much more complicated. The advent of chain pharmacies, competition, and the escalating cost of medical care have led pharmacy away from its original practice philosophy, one which was centered on caring.

It seems pharmacy is now poised to reclaim its former role of a caring, health-care professional. However, at the same time that the profession is going back to its roots, it does so with a different focus. Even during the bygone era of caring, neighborhood pharmacies, the primary focus of the pharmacist was the drug itself. In the era of pharmaceutical care, the caring is back, but the focus is on the patient, not the drug.

Pharmaceutical care is not only the morally correct mission for pharmacy, it is also in pharmacy's best interest. In an age of computerization and robotics, pharmacy will cease to exist as a profession if it insists upon holding on to the product as the focus of its professional activities. Automation can do many things, but it cannot care.

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