Pharmaceutical Caring

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This paper explores the concept of affective caring and its relationship to education, practice, and pharmacy's professional covenant. Analysis of the nursing and medicine literature suggests that production of caring practitioners is of crucial strategic importance to modern professions, and that it may be easier to select for caring individuals than to train individuals to care. The phenomena of self-help groups is offered as evidence of the importance and scarcity of caring in modern society. Also, the nature of the changing professional relationship in the health care system is explored. Finally, it is suggested that caring practitioners can significantly contribute to the implementation of pharmaceutical care.

INTRODUCTION

As recommended by the Academic Affairs Committee of the AACP, the Commission to Implement Change in Pharmaceutical Education was formed in 1989 to address several issues, including the development of a mission statement for pharmacy practice(1). Background paper II of the Commission defined the concept of pharmaceutical care(2). In describing pharmaceutical care the Commission includes the following statement: "Finally, it espouses *caring,* an emotional commitment to the welfare of patients as individuals who require and deserve pharmacists' compassion, concern and trust."(3)

Hepler has described three periods in twentieth-century pharmacy practice (traditional, transitional and patient-care) and, with Strand, three corresponding periods in pharmaceutical education (empiricism, science, and patient care)(4,5). These periods also parallel changes in the nature of the emotional relationship between the pharmacy practitioner and the patient.

During the long traditional/empirical period of pharmacy practice, evidence exits of emotional commitment to patients. Certainly the decision by apothecaries to remain and treat plague-ravaged patients in 17th century England when the physicians and surgeons of the era had fled suggests emotional commitment(6). More recent evidence of caring (during the transitional phase of pharmacy practice) exists in the descriptions of the pharmacists in Turkel's *Working* and Koo's, *The Health of Regionville*(7, 8). Pharmacists faced with the professional impoverishment of this period offered as evidence of their professionalism the nature of their relationship with their patients(9).

At the same time, pharmaceutical education was progressing through its scientific phase in a belated response to the Flexnerian reforms that had transformed the practice (and reputation) of medicine. Emphasis on the drug product and the physical sciences left pharmaceutical services to whither on the vine(4).

Today, pharmacy as a profession may be approaching the mature expression of the patient-care era—the concept of pharmaceutical care. To some extent, it seems that pharmacy may have come full circle in its evolution as a profession, having returned to where it once stood, again emphasizing caring and concern for patients.

Still, such an emotional commitment to the patient represents a new direction for modern pharmacy, with significant implications for pharmacy education, pharmacy practice, and the relationship between society and the profession. The purpose of this paper is to provide a preliminary exploration of these implications.

PHARMACEUTICAL CARE AND PHARMACEUTICAL CARING

Earlier papers that conceptualized pharmacy practice made no reference to an emotional caring for the patient(10-12). Caring also appears to be new to the conceptualization of pharmaceutical care.

In the core papers in which the concept of pharmaceutical care originates, reference is made to a commitment to the patient's welfare, taking care of the patient, and to advocacy(4,5,13,14). With the exception of one allusion to caring for patients (in what appears to be the emotional sense) in the aggregate, the concept of caring *for* the individual patient is absent(15).

This change in the conceptualization of pharmaceutical care would appear to be part of the elaboration process several authors have called for(16,17). Strong arguments were presented for the importance of human values to pharmacy in the year prior to the release of the AACP's Special Report(18,19). Before considering the importance of caring to the profession of pharmacy, it might be profitable to examine how other professional groups have approached this issue.

NURSING

Nursing has been described as caring, and caring has been called the traditional center of nursing practice(20,21). Some have argued this constitutes revisionist history, *i.e.* that nursing's professional concern with care (in the affective sense) did not emerge until the early 1960s. In any case, caring is clearly of considerable importance today(22-24).

Why the emphasis on affective caring? From a humanitarian viewpoint, it represents a response to the widely perceived dehumanization of health care, however, it can also be seen as an attempt on the part of nursing to advance its standing as a profession(25). Affective caring contributes to the public's perception of nurses as being concerned with the patients's needs above their own—an important part of

the professional ethos that is often questioned in regard to pharmacy(26). Furthermore, nursing, like pharmacy, has long recognized the need to develop a theory of practice unique to the profession(27,28). The elaboration of the concept of caring has provided an opportunity to expand nursing's unique theoretical base(25,29).

One important result from this work is Dunlop's position that while it is possible to develop a science for caring, it is impossible to develop a science *of* caring(30). Should care be provided according to rote adherence to some diagrammatic science of caring, its recipient is no longer the subject of care but the object of care, and, as an object of care, no longer cared for as an individual. Thus, affective caring cannot be taught—only engendered, and. if it cannot be taught, it must be selected for.

Such a selection process does not appear to be a significant problem for nursing. The priority of care extends to the practice level, where individual practitioners and students consistently see themselves as caring and caring as their most important activity(31,32). Also, there is evidence that advanced technical training does not alter this caring orientation(33).

This profession-wide emphasis on caring in nursing can no doubt be in part attributed to a professionalization process that has a high degree of consensus regarding caring(34). Yet another consideration is the perception by the general public of nurses as caring individuals. People with strong predispositions toward care who are in the process of making career decisions are drawn to nursing. Thanks to nursing's multi-tiered educational system, individuals of limited means can find some way to express this in a professional identity.

To summarize, nursing has perceived caring as a societal need and is moving to meet that need. The public's perception of nursing as a caring profession and the expansion of the theoretical basis of practice have furthered nursing's quest for professional status. Also, nursing's commitment to care attracts those committed to caring.

MEDICINE

Like nursing, medicine's early interest in affective caring began with a concern over the depersonalization of health care. Efforts to humanize medical care began in earnest after the mid-1960s when medicine perceived a loss in its professional status(35,36).

Since that time, medicine has produced a considerable body of literature examining various means for producing more humanistic physicians. While it must be recognized that the humanism pursued by medicine consists of a cognitive intellectual polish as well as affective caring, it is the latter component that has been of primary strategic importance(37). The following review examines each phase of the medical education process and provides suggestions for how to produce a caring practitioner.

Pre-Professional Experience and Education

As students compete for the scarce spaces available in medical schools in a pre-medical curriculum, they emphasize science courses and easier non-science courses(38). However, there are indications that students with more courses in the humanities or social sciences become more humanistic practitioners(39). What's more, practitioners have indicated they wish they had received more education in these areas, both pre-medical and during medical school(40,41). Still, students perceive (correctly) that admissions committees stress hard-science performance and GPA, thus limiting their exposure to the humanities. This is especially unfortunate since, as we shall see in the next section, there is only a weak correlation between academic performance and clinical performance.

One other correlation between pre-medical school demographics and clinical performance is worth mentioning. Specifically, those with experience in health care before entering medical school seem to have greater patient orientation(39,42). Students with such experience may be drawn, much like the nursing students mentioned above, to medicine more for its caring aspects and less due to the attractions of economic gain or social status. This suggests that if a school of medicine (or pharmacy) wishes to attract more humanistic applicants, they should give favorable weight to courses in the humanities, social sciences and prior related experience, and to publicize this to aspiring applicants.

The Admissions Process

Much of the debate regarding the medical school admissions process and producing humanistic physicians centers on the question of whether affective caring is a quality of certain individuals or a characteristic of the majority of applicants. If it is an individual quality, then one must be selected for this. If it is a quality inherent in all applicants which is somehow extinguished by the educational process then the process must be altered. Recommendations based on both points of view need to be explored.

There is considerable evidence that a poor correlation exists between premedical GPA, MCAT scores and medical school performance, and that what correlation exists is predominately between these traditional predictors and the scientific, pre-clinical phase of medical education(39,43,44). Also, there seems to be little correlation between this preclinical phase of the educational process and students eventual clinical ability(45). With this evidence in mind, there seems to be little reason to accord GPA and MCAT scores primary importance in the selection process.

Of course, admissions committees face the possibility of litigation should they utilize more subjective measures in lieu of the normalized standards of GPA and MCAT scores. Personal traits are notoriously difficult to measure. However, certain psychological constructs associated with humanistic performance and a means to incorporate such selection criteria into the admissions process do exist(44,46-48). It has been argued that students anxious to gain admission will find some way to circumvent any attempt at systematically measuring their qualitative characteristics(49). However, the adoption of this approach should eventually result in the development of more sophisticated selection processes. In any case, there seems little to be lost and much to be gained by widening the net of the admission process. As Neame states, "to select students who are likely to be successful academically is to discriminate against those who might be the more effective practitioners"(45).

Changes In Medical Education

It has been suggested repeatedly that the process of medical education is de-humanizing as a result of several factors: the rewarding of competence over compassion: by-making the patient the object of care rather than the subject of care; and the basic inadequacy of the medical model(50-53). To address this problem there are two options: changes in curricular content or changes in course structure.

The adoption of courses in human values and medical ethics (changes in content) has progressed to the point were it is now an accreditation requirement for medical schools(54). The majority of medical schools now require human values courses of one form or another, with medical ethics in the forefront(55-58). It is hoped that these courses will encourage students to act more humanely in their dealings with patients, and. by formalizing the art of medicine, prevent its degeneration to mere applied technology.

Suggested changes in course structure center around the need to develop an alternative to the traditional teacher-centered didactic course with its emphasis on the recall of factual information selected by the instructor(45,59). Smaller classes, in seminar or group form, with instructors acting as facilitators of learning instead of sources of information are seen as means of encouraging the student to adopt a more active role in the learning process. Some variation on this format has been suggested for humanities courses as well as more traditional medical education(54,60,61). Such a problem-based, student-centered format is expected to aid in the development of interpersonal skills and social sensitivity. It can also be suggested that such an educational environment may be more hospitable to the student with less imposing academic credentials. As discussed above, these are the students who may prove to be superior clinicians.

To summarize, the debate still continues over many of these alternatives. The research to date provides some idea of what measures an educational institution should pursue if it has made an absolute commitment to producing humanistic practitioners. Pre-professional education should require ample exposure to the humanities and social sciences. The admissions process should be restructured away from its current emphasis on MCAT/GPA performance towards some systematic evaluation of more qualitative variables, such as maturity, tolerance for ambiguity, and previous experience in the field. Once admitted, the student's course work should include humanistic material integrated throughout the professional curriculum and the courses should consist of small group interactions with an emphasis on problem-solving and fewer requirements for factual recall.

CARING AND THE PHENOMENA OF SUPPORT GROUPS

Concern with compassionate behavior on the part of practitioners is not limited to medicine, nursing or pharmacy(62,63). The larger question that arises is why so many groups have evidenced such concern. As mentioned above, nursing and medicine have pursued caring as a means to garner greater professional status or to forestall its further erosion, but why seize upon caring behavior as the agent of change? One clue lies in the use of a support-group (self-help) format to enhance the practitioners' humanistic skills(64). Since this format enhances the qualities medicine is looking for, the lay groups it is derived from may provide some insight. The phenomenal growth of lay self-help groups gives us evidence of art unmet need in society and makes it clear that caring as a part of the practitioner-patient relationship will be a welcome addition.

Self-help groups originated with Alcoholics Anonymous, founded in the late thirties. Since that time, the basic structure of this organization has been exported to a long list of behavioral and emotional problems, as well as to chronic maladies considered to be medical conditions, such as epilepsy or stroke(65,66). While such groups may exist for the purposes of support and caring for their members, they also serve in the modern search for community necessitated by our mobile society. It has also been suggested that such groups arise, in part, in response to disillusionment with existing professional services or due to a perception of elitism, ineffectiveness, and imbalance in traditional patient-professional roles(67). If the rapid growth of these groups is evidence of a growing social need, then what is the nature of that need? Three possibilities arise.

First, in today's mobile society, with its scarcity of social relationships, insufficient opportunity exists for the patient to enact the sick role. Membership in a self-help group provides an opportunity for the development of relatively stable social relationships wherein the patient can find acceptance and validation of their sick role.

Secondly, membership in a self-help group permits the patient to find assistance is dealing with the social phenomena Kleinman called the illness experience, as differentiated from the disease itself(68). Furthermore, since illness is the patient's experience of the disease, the extent to which illness is recognized and treated must influence the patient's perception of the quality of care. It is ignoring this aspect of disease that has caused medicine to be accused of "an etiological obsession" and provides one reasonable suggestion for the emerging importance of caring in health care(69).

Finally, there are the beneficial effects (in terms of health) that may accrue from membership. How illness is handled may actually have some impact on the progress of the disease and is fundamental to the process of healing(70,71). Self-help groups, by addressing the patient's need for understanding of the illness experience, may directly influence the progress of disease. This elaboration by lay people of the placebo effect echoes the therapeutic importance of caring and compassion mentioned elsewhere (18).

THE CHANGING PROFESSIONAL COVENANT

Another possible reason for the ascendancy of caring lies in the changing nature of the patient-professional relationship. Vinten-Johansen and Riska argue that the emergence of corporate medicine severely diminishes the importance of the relationship between individual patient and physician, and with it the validity of reforms based on humanizing the physician(36). But is precisely this change in the provision of health care that, at least to the patient, increases the need for a caring health provider.

In a corporate system of health care, the provision of care is standardized(13,14). Procedures exist to ensure that care is provided appropriately. To the extent that such assurances exist, they replace certain functions of the covenant between the individual patient and the individual practitioner. The patient can not assess the value of care given (due to the complexity of care) but he or she can expect the system (which has become legally responsible in this matter) to insure that someone who *is* competent will judge the practitioner's performance. What the patient cannot expect, and in fact is likely to believe the system is actively avoiding, is full utilization of the system's resources. Practitioners will be under considerable pressure from their employers to minimize resource utilization(72).

This dilemma suggests the grounds for a new professional covenant, *i.e.*, the practitioner agrees to seek out and

actively procure the resources of the health care system sufficient to the patient's needs. Since this action introduces another level of complexity to the situation, (the patient doesn't understand their illness, nor do they understand the system) the patient is vulnerable and dependent on the professional's advocacy. In lieu of societal reification of this covenant, the patient must default to other means for evaluating the likelihood that the professional will seek out every service needed by the patient and justify it to the system's oversseers. It stands to reason, in the patient's eyes, that all other things being equal (standardization of care to some extent guarantees this) the professional who appears to genuinely care for them is more likely to serve their best interests, and affective caring is something the patient *is* competent to judge.

CARING AND PHARMACY

While the above discussion serves to establish the probable importance of caring to any professional group in health care, there are certain considerations that are especially relevant to pharmacy. The benefits of clinical pharmacy practice have been established, and to a certain degree, community pharmacists are able to perform limited clinical services, however, they rarely chose to do so(13,73-75). While the lack of fiscal reward and patient demand play an important role in determining that such services are not offered, such services must become available in the community if pharmacy's mission of pharmaceutical care is to be realized. From both a marketing and a symbolic point of view, we must first offer those services before the public can recognize and accept their value(76,77). The existence of a caring relationship between the pharmacist and the patient may be the mechanism by which the pharmacist becomes sufficiently motivated to provide these services, despite the lack of demand or reward. Furthermore, several authors have described the formidable barriers that exist to the institution of pharmaceutical care(3,79,80). While it would be naive to state that an emotional commitment to one's patient's would suffice to overcome these barriers, the existence of such a bond would certainly make it more likely that the effort will be made.

One of the specific barriers mentioned is involving current practitioners in pharmaceutical care. Hepler estimates we need at least 35,000 such practitioners to operationalize pharmaceutical care(4). Caring provides a common focus, which, unlike more esoteric clinical skills, can be found in many current practitioners in the community and may provide an avenue for their involvement in pharmaceutical care. The words of the Maryland School of Pharmacy faculty are no less relevant today than they were in 1949, ". . . the public forms its opinion of the profession from its observation of the operation of the drug store. The activities of this store, now and in the future, are therefore going to determine in a large measure the destiny of the profession"(10). Finally, Hepler has repeatedly argued that the dispensing function will eventually be automated(4,15). Mrtek and Mrtek have described the use of expert knowledge systems to educate pharmacy students about clinical pharmacy(18). With the rapid pace of improvement in computer technology, it is only a small step to imagine both dispensing and clinical consultation services being provided by such automated devices. Why should a physician seek the advice of a pharmacist about a dosing parameter when he/she can access the expertise of the very best minds in the field by punching a few keys? Caring, however, is the one thing a computer can not do. Given the rapid emergence of technology in this area, and the reduction in costs that will be realized, providing caring practitioners to society becomes an important strategic device for the profession.

PHARMACY EDUCATION

There may be a serendipitous congruence between factors that would facilitate the development of caring practitioners and other trends in pharmacy education. As mentioned earlier, the medical literature suggests that small class size, less structured courses and student-centered, problem-based learning result in more humanistic practitioners. At the same time, many authors have called for or instituted problem-based, student-centered learning as especially suitable to the challenges of pharmaceutical care(80-82). Adoption of this method of instruction will likely result in more caring practitioners. The heightened interest in such methods is itself an argument for the importance of caring to pharmaceutical care. Furthermore, there has been an increased interest in humanities and ethics courses in the pharmacy curriculum(83,84). This echoes changes in medical education that are felt to contribute to student's humanistic behavior. Also, the psychological construct of femininity is thought to embody many of the characteristics desirable in a caring practitioner(47). While the characteristics of this construct are found in men, they are thought to be more common in women. With the majority of new pharmacy graduates now being women, the potential for having more caring practitioners has increased(85). These trends do not eliminate the need for action in pharmaceutical education. Three areas in particular require further action: individual faculty attitude; faculty consensus: and the admissions process.

In the problem-based, student-centered curriculum, opportunities for one on one interaction with faculty members will be far more common than it is today. It is this kind of interaction that is especially important in the transmission of values that occurs during the professionalization process. If individual faculty members are not committed to caring as a part of the clinical therapeutic interaction and the student interaction, this attitude will be conveyed to their students.

Similarly, the degree to which faculty values are in congruence has a profound impact on the extent to which students internalize these values(34). Those values which enjoy consensus among faculty tend to be adopted wholeheartedly by students while in those areas where there is dissent, the student's values are mixed. These two factors suggest the need for administrators to build consensus and awareness of the importance of caring if it is to be adopted as an important value in student's conceptualization of their professional role.

Finally, changes are necessary in the admissions process. The arguments made for problem-based, student-centered learning include the belief that rote memorization will not serve the educational needs of future pharmacists. Criteria like the PCAT and GPA seem to serve mainly as predictors of performance in didactic, teacher-centered learning(39,43-45). Admissions committees could give greater weight to other, less traditional means of evaluation that consider candidates' humanistic qualities. This would sig-

nificantly increase the likelihood that the practitioners of tomorrow would be more caring in their approach to practice.

As apart of the admissions process, consideration should be given to pre-professional course requirements. In the absence of confirmatory research in pharmacy, further proposals regarding pre-pharmacy school requirements is necessarily speculative. The findings in medicine that prior experience in health care or greater exposure to the humanities or social sciences prior to medical school are associated with more caring practitioners does suggest alternatives to the current emphasis on science in the admissions process.

CONCLUSION

In 1983 the American Board of Internal Medicine required demonstration of humanistic skills for Board certification(87). This development underscores the perceived importance of caring in primary care. Several authors have called for more of a humanistic orientation in pharmacy(18,19). To borrow Hill's 1989 statement, "What we as pharmacists believe our profession to be determines what it is"(88). The above arguments are intended to demonstrate that by focusing on caring as an important part of pharmacy practice, the profession will not only follow the lead of other professional groups, but may also realize benefits of specific importance to pharmacy.

The question that remains is how to go about producing caring pharmacy practitioners. As discussed earlier in this paper, research in medical education has delineated two basic approaches. Either pharmacy education can be altered by introducing more humanities courses and using problem-based learning, or the selection process can be designed in such a manner as to admit students with a predisposition for caring.

While this paper is intended to serve as a stimulus for further research in pharmacy education in both of these directions, we would like to suggest that as an initial direction of research the admissions process may prove more fruitful. Given the current political insolvency of the profession of pharmacy, whatever changes in pharmacy education that are proposed should desirably show an effect quickly. Selecting more caring students at the beginning of the process appears to be an intervention that would produce the desired changes sooner than would attempts to change the entire educational process. Secondly, a practical point is that it is far easier to select a different first year pharmacy student than it is to replace or change the behavior of a professor of pharmaceutics with thirty years of teaching experience.

Pharmacy faculty have a demonstrated ability to teach scientific principles and their application. Strategically, it is preferable to go with one's strengths; teaching science is one of pharmacy education's greatest. In fact, since students entering pharmacy are so scientifically adept, the science teaching skills of pharmacy faculty may be a form of overkill. For faculty to become as accomplished in inoculating scientifically superb students with a caring approach would require substantial, even fundamental changes. To educate scientifically competent students should be well within the capacities of the current system. The focus of the admissions process should be changed from selecting students for their scientific excellence to selecting those with scientific competency *and* concern and care for the patient.

For a profession which has decided that its mission is the brave new world of pharmaceutical care, it is important to consider the words of Dr. Menninger: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient"(89).

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