The Need to Define “Care” in Pharmaceutical Care: An Examination Across Research, Practice and Education

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The purpose of this paper is to examine the concept of “care” and how it relates to pharmacy. A cross-discipline review of the literature is presented. Five areas are examined: the definition of care, care as behavior, the relationship of caring behaviors to health, the relationship of caring behaviors to outcomes, and the teaching of caring behaviors. How the prior work of other disciplines relates to the pharmacy profession is discussed. Case scenarios are included which are intended to illustrate the patient’s experience when caring behaviors of professionals are either absent or present. A suggested list of specific caring behaviors of pharmacists is identified which fulfill or advocate for a patient’s needs. The profession is urged to adopt specific caring behaviors within the professional standards of practice and perform these routinely in patient care. Education, practice and research agendas to further the pharmacy profession with the adoption of care values and behaviors are presented.

INTRODUCTION

Have you ever overheard a patient say, “no one seems to care”? The adoption of the concept and definition of pharmaceutical care in the last two decades reemphasized the profession’s recognition that the pharmacist’s primary responsibility is to the patient who has needs related to drug therapy. This revitalized the centrality of the relationship between the pharmacist and patient in the delivery of care. But what does this mean about what the patient should expect from the pharmacist and what the individual pharmacist should do? What behaviors are now expected from the pharmacist that may differ from traditional expectations? I believe the answers are in the further examination and development of the concept of care itself. We must identify and articulate the caring behaviors or acts which pharmacists perform in order to fulfill or advocate for fulfillment of individual patient needs. These behaviors must become expected in the professional standards of practice, resulting in routine performance in patient care. Such continued transformation, growth and maturation of the pharmacist professional is challenged by several competing pressures. The continued integration of technology and machines into daily life, the continued pursuit of efficiency in all areas of life, and the explosion of information in quantity, form and accessibility compete with our sensibilities toward the needs of others and our ability to meet their needs. The underlying belief is that the continual improvement of technological advances will greatly enhance the quality of our lives. Yet, while this almost mystical revolution progresses, “humanness” seems distant. The values, attitudes and emotions which provide context and relevance for what we do are not evident at the forefront of this change. Apathy about the “who” this perceived quality improvement applies to is the ironic result. This phenomenon permeates throughout the health care industry, including the systems of patient health care delivery. When reduced to the level of the individual, the absence of care as a value and caring behaviors is hallmark to this change. The greatest challenge posed is to infuse human context, meaning and richness to our professional choices, keeping the individual patients needs as a primary concern, and acting on their behalf.

Overt attention must be paid to the value of caring itself. An examination across research, practice and education of this area suggests substantial benefits to all. This review is intended to bring forward the highlights of prior work in other disciplines, and integrate the cumulative learning of others into the pharmacy movement. The intention is to stimulate thought and action by leaders in the profession of pharmacy to further develop and operationalize care as a value and caring behaviors into our professional culture, education and work. Scholarly work of the various health disciplines and humanities has been drawn upon and incorporated into each area of examination. The areas include:

- a cross-discipline review of the literature about the concept and definition of care;
- care - operationalized as behavior;
- the relationship of caring behaviors to health;
- the relationship of caring behaviors to outcomes; and
- teaching caring behaviors.

Education, practice and research agendas suggesting further areas of advancement and study for the profession of pharmacy are presented near the conclusion of this paper.

A CROSS DISCIPLINE REVIEW OF THE CONCEPT AND DEFINITION OF CARE

A purposeful examination of care is most evident in the literature of nursing, pharmacy and medicine over the last 20 years. The longest history and greatest prevalence of scholarship on this subject resides in the nursing profession. In a comprehen...
sive review of the health professions literature, nursing is the only discipline that recognizes care as a complete and wholly developed concept. An explicit definition of what care or caring is as it relates to the profession of nursing, is articulated within the nursing literature. This has been attempted in the pharmacy literature by offering the profession an initial reference to care when dissecting the term pharmaceutical care(3). Most professions have articulated the need for care(3-6). Our examination begins with a set of key definitions for which a common understanding is needed if we are to understand care as a concept that can be operationalized. All but the pharmaceutical care definitions are selected from the nursing literature. The nursing profession has a large momentum built on the notion that caring is the essence of nursing (see definitions for detail), and they further distinguish professional care from care as a general idea by the concept of health.

Care in the health profession context refers to those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or way of life(8).

Caring refers to the direct (or indirect) nurturant and skillful activities, processes, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathetic, supportive, compassionate, protective, succorant, educational, and others, dependent upon the needs, problems, values, and goals of the individual or group being assisted(7). Within the concept of care: we act using behavioral attributes which are dependent on the needs, problems, and goals of the individual.

Professional Care refers to those cognitive and culturally learned behaviors, techniques and processes, or patterns that enable (or help) an individual, family, or community to improve or maintain a favorable healthy condition or way of life(8).

Essence refers to a necessary constitution or an essential attribute which makes a thing or act what it is(9).

Health is defined conceptually in competing ways. In a most general definition, health refers to a state of well being that is mainly known and expressed in cultural meanings and ways. We examine the definition of health in greater detail in this paper because of its importance to our further development of the care concept.

Care and caring are ultimately defined as acts or behaviors which are a response to the values and needs of the individual, with professional care specifically intended to improve or maintain a person’s health. Distinguishing between care and profession care is subtle, but important. As we further define the caring behaviors of the pharmacist, the distinction is useful in determining the difference between a professional responsibility and a desired moral choice of any individual. A professional is held accountable for fulfilling the obligation of a caring act if it is regarded as a professional act(10).

Promotion of the concept of care has occurred most recently in pharmacy with the maturation of the definition of pharmaceutical care.

Pharmaceutical Care is the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient’s quality of life(1).

Care is mentioned within the “pharmaceutical care” definition. However, the values, attitudes and behaviors which represent caring actions are assumed rather than overtly defined. A more detailed emphasis is also placed on the cognition and skills aspect of care (pharmaceutical care) when this statement is compared to the definitions of care and professional care offered by nursing.

Within the Principles of Practice for Pharmaceutical Care, published by the American Pharmaceutical Association, no specific wording is provided to assist us with an understanding of the term “care”. However, an emphasis is place on caring in the section of the document which is entitled, “A professional relationship must be established and maintained.” An excerpt of this section is as follows:

“Interaction between the pharmacist and the patient must occur to assure that a relationship based upon caring, trust, open communication, cooperation, and mutual decision making is established and maintained. In this relationship, the pharmacist holds the patient’s welfare paramount, maintains an appropriate attitude of caring for the patient’s welfare, and uses all his/her professional knowledge and skills on the patient’s behalf. In exchange, the patient agrees to supply personal information and preferences, and participate in the therapeutic plan. The pharmacist develops mechanisms to assure the patient has access to pharmaceutical care at all times.”

The relationship is central in this description, advocacy is part of this, and caring is mentioned here. What caring is - is not described here.

The ASHP Statement on Pharmaceutical Care goes into greater depth to describe what the “care” in “pharmaceutical care” means(3). Excerpts from the ASHP Statement are as follows:

“Care. Central to the concept of care is caring, a personal concern for the well being of another person. Overall patient care consists of integrated domains of care including (among others) medical care, nursing care and pharmaceutical care. Health professionals in each of these disciplines possess unique expertise and must cooperate in the patient’s overall care. At times, they share in the execution of the various types of care (including pharmaceutical care). To pharmaceutical care, however, the pharmacist contributes unique knowledge and skills to ensure optimal outcomes from the use of medications.”

The statement goes on further:

“At the heart of any type of patient care, there exists a one-to-one relationship between a caregiver and a patient. In pharmaceutical care, the irreducible ‘unit’ of care is one pharmacist in a direct professional relationship with one patient. In this relationship, the pharmacist provides care directly to the patient and for the benefit of the patient. The health and well-being of the patient are paramount. The pharmacist makes a direct, personal, caring commitment to the individual patient and acts in the patient’s best interest. The pharmacist cooperates directly with other professionals and the patient in designing, implementing, and monitoring a therapeutic plan intended to produce definite therapeutic outcomes that improve a patient’s quality of life.”

The ASHP statement has the most extensive discussion intended to more fully describe where pharmaceutical care fits into overall care, and what the care part of pharmaceutical care
is. In this explanation the pharmacist contributes knowledge and skill to ensure optimal outcomes and is committed as a patient advocate. The one-to-one relationship between pharmacist and patient is highlighted. This explanation of care describes the behavior of acting in the patient’s interest through a commitment. Although this statement helps us to better understand the depth and meaning of the term “care”, identification of specific behaviors which constitute care need yet to be identified. Authors such as Robert Buerki, Charles Hepler, Amy Haddad, Robert McCarthy and Robert Veatch, among others, have contributed substantially to the further development of our understanding of the moral and ethical aspects of care(1,2,10). This cumulative body of works provides a critical framework to build depth and bring clarity to what specific caring behaviors should be expected of a pharmacist. As pointed out by Mahowald, a care ethic emphasizes context and is case-based. In this regard, identification of specific caring behaviors becomes possible(11).

CARE AS BEHAVIOR

There has been considerable debate within the nursing scholarship about whether the value of caring can actually be expressed in specific behaviors. One view has described care as consisting of two components: psychosocial and professional-technical(12). Another view has described care as a concept constructed with a cognitive component of intellectual value and an emotional component represented by desires, behaviors or actions(13). Finally, some support only an existential view, i.e., the descriptive research tends toward a qualitative approach in which caring is viewed as “being” - and therefore, not measurable(12,14). The existential view raises the question... is caring a virtue? A virtue is described as a quality which enables something to fulfill its function well(13).

Something with the relevant virtues is a good example of it’s kind. A virtuous person is one who cares about the right things in the right way. To be good, caring must be directed at the right things. Caring is not good or bad, per se, it is just something we feel, i.e., a means to an end. Therefore, we should put aside our infatuation with the concept of care itself, concentrating instead on what we care about and the way we express care. Although the debate is meaningful, ultimately we must believe that care is expressed in behavior, i.e., that caring about someone will affect how we care for someone. This point of view is shared and eloquently argued in nursing, pharmacy and medicine. All three disciplines have argued that formulation of what are considered caring behaviors and attitudes, and educating professionals for the purpose of incorporating these behaviors, is both an essential and enormous task(2,15).

The dominant model today in nursing which describes caring is based on a sound research base and is known as the Carative Factors of Watson(16,17). Watson recognized that if caring behaviors are operational, then meaningful measurement of these behaviors is possible. She and her colleagues have initiated studies to help further describe these behaviors within the nursing profession. Current research is on-going in nursing which describes, quantifies and thus, operationalizes care as behaviors which are understood, recognized, and, therefore, can be modeled and taught(12,14). There are 10 Carative Factors included in Watson’s model:

- Factor 1 - The formation of a humanistic-altruistic system of values
- Factor 2 - The instillation of faith and hope
- Factor 3 - The cultivation of sensitivity to one’s self and to others
- Factor 4 - The development of a helping-trust relationship
- Factor 5 - The promotion and acceptance of the expression of positive and negative feelings
- Factor 6 - The systematic use of the scientific problem-solving method for decision making
- Factor 7 - The promotion of interpersonal teaching-learning
- Factor 8 - The provision of supportive, protective and (or) corrective mental, physical, sociocultural, and spiritual environment.
- Factor 9 - Assistance with the gratification of human needs
- Factor 10 - The allowance of existential-phenomenological forces

Of equal importance are the seven major assumptions that Watson identifies to support these factors. Fundamental to this work is the notion that caring is relationship centered. Therefore, caring can only be effectively demonstrated and practice interpersonally. Caring consists of carative factors that result in the satisfaction of certain human needs. When caring is effective, it promotes health and individual or family growth. Caring is also more “healthogenic” than curing. The practice of caring integrates biophysical knowledge with knowledge of human behavior to generate or promote health and to provide administrations to those who are ill. A science of caring is therefore complimentary to the science of curing. Caring responses accept a person not only as they are now but for what they may become. Finally, a caring environment is necessary. A caring environment offers the development of potential while allowing the person to choose the best action for themselves at a given time. Watson concludes that the practice of caring is central to nursing, i.e., the essence.

A brief digression to the concept of treatment may be useful. In many settings, the terms treatment and care are used synonymously. However, the concept of care in this examination is different than identification of the specific treatment. A specific treatment may be discontinued, however, provision of care for the patient by a health professional should continue. Optimizing a treatment is a narrower concept than optimizing care. It has further been argued that provision of care through caring acts, in and of themselves, have therapeutic value to a patient(11) From the pharmacist’s view, this means that caring acts do not necessarily have to be directly associated with a specific drug therapy.

To advance our development further, examination of cases may provide us with a more concrete illustration. Two case scenarios follow which are used to contrast the absence of caring acts against the presence of caring acts.

Case Scenario 1: The Absence of Care

This case describes the interactions and progress of a 40 year old woman, college educated health professional, who becomes a hospitalized patient for four days.

A woman was admitted to the hospital at 7 PM and delivered a baby boy at 11:42 PM on a Monday night. Exhausted, she told her husband and daughter how thrilled she was that they were there for the birth of the new family member. She slept for eight hours. Upon awakening, a series of events ensued.

8 AM: She awakens, feeling shaky. Calmly, she buzzes the nurse station and says, “I need help right away.” Looking at her
watch, it is 9:06 AM, and by 9:10 AM, no one has arrived. She buzzes again. “Please help me. I think I am going to have a seizure.”

A young nurse (in her early 20s) arrives and asks, “What’s wrong?” The patient replies, “I think I am going to seize. I don’t know what is wrong. I do not have epilepsy.”

Doctor (snaps back): I understand you are refusing ciprofloxacin. I’ve used it many times and have observed no problems in my patients. Now...I’m going to switch your antibiotic but I want you to know that I am writing a note in your chart that states that this is occurring because of your demands. I will not take responsibility alone if your treatment fails.”

The patient never knew whether the pharmacist was contacted about an appropriate alternative selection to be considered.

What actions were caring acts in this interaction, and what caring acts were missing? This requires identification of those behaviors which lead to the patient feeling cared for and acted on behalf of. An examination of the case is provided in which caring acts are identified using Watson’s carative factors as a guide.

Case Analysis. The first episode of note was the patient’s experience with a hypoglycemic episode. The nurse had an opportunity to be sensitive to the patient by responding with an empathetic approach and stating that she would act as quickly as possible to solve this patient’s problem (Factors 3 and 4). She also was placed in a professional situation where her scientific problem solving skills were challenged by the individual patient needs. She had an opportunity to solve the problem of the policy regarding blood sugar measurement by either contacting her immediate supervisor or the laboratory immediately (Factors 6 and 8). She further had an opportunity to be competent about the urgency of this situation (Factor 6). Through action she would create a helpful and trusting relationship with this patient (Factor 4). Because this nurse was not prepared to act competently in this situation, she did not provide care to the extent which would be dictated if she were acting in a caring manner toward this patients needs. It may be further understood from this case that the nurse was not patient centered, and thus, did not act as an advocate for the patient (fundamental assumption to Watson’s model and pharmaceutical care).

The patient had not been prepared by the nurse to expect a technician to draw blood (Factor 7). The nurse had not informed the patient of the abnormally high temperature and the suspicion of an infection. Once again, no sensitivity to the patient was observable here, the opportunity to conduct a brief interpersonal teaching was not taken, and as a result, no addi-
tional progress was made on the development of a helpful trusting relationship (Factor 4).

The patient was clearly stating her needs when she indicated that ciprofloxacin was not an acceptable treatment to her. Further, the patient was offering ways to solve this problem. Several caring actions were missed surrounding this episode. The nurse did not center on the patient's needs, but rather, on the system. It may have been appropriate to contact the case manager based upon care policies of the institution. However, she transferred the responsibility to the case manager, rather than regarding the case manager as a resource to solving her problem. When the case manager did not provide an appropriate response, the nurse did not advocate for the patient until the patient's needs were met. The nurse could have taken the patient's recommended course of action, which was to consult the hospital pharmacist for an acceptable alternative within the institution! Not only did the patient not receive caring actions from the nurse, they missed out on the potential to receive caring actions from the hospital pharmacist. This second situation demonstrates the interdependency of maintaining competency with being able to act with care on behalf of the patient you are serving.

The physician in this case missed the opportunity to demonstrate sensitivity, establish a helpful and trusting relationship, use scientific problem solving to improve the care quality for this patient, and take corrective action within the care environment to meet the patient's needs (Factors 3, 4, 6, 8). The physician could have stopped in ever so briefly and acknowledge the patient's existence. The physician could have acknowledged the importance of the risks that the patient had identified about the drug therapy selected, even if in the physician's judgment, this was not an issue (Factor 5).

A working definition of care in context of the pharmacist's professional work with patients is clearly needed. This definition must express the values, attitudes, morals and ethics which pharmacists base their work on. However, as this case attempts to demonstrate, caring acts must also be described further in the form of context-specific observable behaviors which are expected from the caring pharmacist. The important work of Watson and other nursing scholars may serve as a framework for the pharmacy profession's examination and description of caring behaviors. This next scenario attempts to describe caring acts demonstrated by the pharmacist, identified through Watson's framework.

Case Scenario 2: The Caring Pharmacist

As our 40-year-old woman experiences her hospitalization, we see how the actions of a hospital pharmacist could impact her. Instead of the physician being contacted by the case manager about the patient's request for an alternative antibiotic, the pharmacist in this case acts proactively.

Not long after the patient spiked a temperature, the nurse contacted the physician by telephone and transcribed a medication order for ciprofloxacin. The pharmacist receives the order and finds it highly unusual to see ciprofloxacin ordered for use on a woman on the post-partum floor. Concerned, the pharmacist goes to the patient's chart and briefly reviews the case. He then knocks and has a brief discussion with the patient.

Pharmacist: “Hello. My name is Troy and I am a hospital pharmacist. Congratulations on your new baby!”

Patient (a bit surprised): “Why...thank you very much! Boy am I glad you are here.”

Pharmacist: “Great...what can I do for you?”

Patient: “Well, I am a pharmacist too! And I am concerned because I am breast feeding my baby. I don’t think I should take the ciprofloxacin...I understand I need treatment, but I want another choice selected.”

Pharmacist: “I understand. I reviewed your medications and saw it listed. That’s why I came up here...to find this very information. Why don’t I contact both the nurse and doctor and let them know of a few alternatives that would be good choices in this hospital.”

Patient: “I would be so grateful. That would alleviate a burden from my mind. ...And please let them know I am not trying to be difficult. I just don’t want to take any unnecessary risks.”

Pharmacist: “No problem. I will take care of that immediately. It was nice to meet you and again, congratulations.”

Case Analysis. The pharmacist acted in a proactive manner through usual medication order review in the hospital. The pharmacist was competent in his knowledge, allowing him to anticipate potential problems on behalf of this patient (Factors 6 and 8). The pharmacist was sensitive to this patient’s high degree of knowledge and concerns, listening to the patient's expressed needs (Factors 3 and 5). The pharmacist indicated that he understood he could help and would help, both developing a helping relationship with this patient and alleviating their emotional burden in the situation (Factors 4 and 9).

By acting on behalf of the patient, the pharmacist demonstrated his competency and fulfilled a responsibility to avoid potential harm for the patient and her new baby. Although the true risk to the baby is likely minimal, and certainly controversial, the pharmacist judged the situation as one in which no risk exposure was necessary. In addition, the pharmacist demonstrated he cared about the patient and cared for her through his actions.

To begin the process of describing caring behaviors, a survey was conducted on 35 pharmacists who have been practicing between three and 35 years. Each pharmacist was asked to generate a list of caring behaviors which pharmacists should be expected to provide to patients. The behaviors were analyzed by the author to eliminate duplicity and consistently express each as an action. These caring behaviors were then cross referenced to the 10 carative factors of Watson (see Table I) to illustrate the applicability of the model to these pharmacist-identified caring behaviors.

Caring Behaviors and Health

In order to better describe the caring behaviors of a pharmacist, the concept of health which these behaviors are intended to support must be understood. Unfortunately, a definition(s) of health embraced by the profession of pharmacy is absent from our professional literature, and is difficult to identify in our professional culture. Health thinking across the professions has historically placed an emphasis on disease, with the roots of this concept founded in the traditional medical model. However, disagreements about the meaning of health have recently gained substantial attention because of the breadth of concepts which are potentially included. For example, one shift in recent years has included the concepts of functionality and well-being in the overall concept of health(18). Another has been on the emphasis of health promotion and disease prevention. And increasingly, we see writings in the educational area of medicine about recognition of diversity, recognition of the
Table I. A suggested list of pharmacist caring behaviors

<table>
<thead>
<tr>
<th>Specific caring behaviors of pharmacists</th>
<th>Carative factors*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act directly to fulfill any health care related needs expressed by the patient.</td>
<td>1</td>
</tr>
<tr>
<td>Visit the patient in their home environment if this is a necessary step in order to assess, or serve meeting the patient’s needs.</td>
<td>1,2,4,7</td>
</tr>
<tr>
<td>Protect the patient from harmful treatments or decisions by informing the patient of this potential, and advocating for improved alternative approaches.</td>
<td>1,4,6,8</td>
</tr>
<tr>
<td>Provide privacy to a patient during sensitive and personal communications.</td>
<td>1,3,4,5</td>
</tr>
<tr>
<td>Take the time to observe the effects of a treatment on a patient.</td>
<td>1,2,3,6</td>
</tr>
<tr>
<td>Communicate the concerns of patients to other care givers, when appropriate and necessary.</td>
<td>1,4</td>
</tr>
<tr>
<td>Consult with other health professionals on behalf of the patient.</td>
<td>1,4,6</td>
</tr>
<tr>
<td>Inform the patient that you (the pharmacist) are available now, and in the future, for any health needs he or she may have.</td>
<td>1,4,9</td>
</tr>
<tr>
<td>Act to resolve patient problems with medical care plans that are impeding access to needed treatments.</td>
<td>1,4,9</td>
</tr>
<tr>
<td>Include informing the patient that you will pray for them if this is within both of your health care concepts.</td>
<td>2,10</td>
</tr>
<tr>
<td>Employ effective listening skills with the patient and/or care providers to determine the patients needs.</td>
<td>3,4,5</td>
</tr>
<tr>
<td>Communicate in an empathic manner toward patients</td>
<td>3,4</td>
</tr>
<tr>
<td>Respond to specific patient requests in a timely manner, and within an appropriate time frame based upon the urgency.</td>
<td>3,4,6,8</td>
</tr>
<tr>
<td>Educate the patient about how to provide self-care and self-assessment of his or her response to therapy.</td>
<td>3,4,7</td>
</tr>
<tr>
<td>Some examples of this education may include teaching the patient to take and interpret a blood pressure, blood glucose, peak flow meter, or prothrombin time/international normalized ratio. Such education should also include how to respond to the findings in an appropriate way to facilitate optimal self-care.</td>
<td></td>
</tr>
<tr>
<td>Encourage the patient to become a partner in self care.</td>
<td>4</td>
</tr>
<tr>
<td>Help patients to recognize that they need to participate in their care.</td>
<td>4</td>
</tr>
<tr>
<td>Advocate for affordable medications specific to the patient’s expressed needs and resources. This may be recommending the incorporation of less expensive alternatives, enrollment of patients in an indigent care pharmaceutical program, or discontinuing ineffective medications.</td>
<td>3,4,6,8,9</td>
</tr>
<tr>
<td>Support the patient by assisting or advocating for obtaining adjunctive care services and/or resource which the patient needs to achieve health-related outcomes.</td>
<td>4</td>
</tr>
<tr>
<td>Help patients find appropriate support groups.</td>
<td>4,10</td>
</tr>
<tr>
<td>Encourage the patient to express needs directly to you in order that you may act on behalf of these interests.</td>
<td>4</td>
</tr>
<tr>
<td>Provide education that is specific to a patient’s needs.</td>
<td>4,7</td>
</tr>
<tr>
<td>Explain the proper use of a drug or device.</td>
<td>4,6,7</td>
</tr>
<tr>
<td>Provide answers which meet the needs underlying a patient’s questions.</td>
<td>4,7</td>
</tr>
<tr>
<td>Act to improve a patient’s treatment when they experience side effects.</td>
<td>4,6,8</td>
</tr>
<tr>
<td>Act to improve the patients therapeutic regime to better achieve desired outcomes.</td>
<td>6</td>
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<tr>
<td>Monitor for whether a patient’s desired outcomes are being achieved.</td>
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<tr>
<td>Maintain your professional competency through your professional life in order to fulfill caring acts on behalf of patients.</td>
<td>6</td>
</tr>
<tr>
<td>Identify, prevent and solve patient-specific medication-related problems.</td>
<td>6,7</td>
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<tr>
<td>Personalize counseling in order that it meets each patients specific needs.</td>
<td>7</td>
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<tr>
<td>Confirm a patient’s understanding of the essential information needed to fulfill their care needs.</td>
<td>7</td>
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<tr>
<td>Work with each patient to assure adherence to treatment regimen.</td>
<td>7</td>
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<tr>
<td>Follow-up with the patient through a variety of communication methods (interview, telephone, electronic communication, etc.) and based upon the patients specific problem, to determine how they are progressing toward achieving the desired outcomes.</td>
<td>7,8</td>
</tr>
<tr>
<td>Receive the prescription directly from the patient in order to encourage needed communication with the patient.</td>
<td>8</td>
</tr>
<tr>
<td>Deliver the prescription directly to the patient in order to encourage needed communication with the patient at the time of receiving treatments.</td>
<td>8</td>
</tr>
<tr>
<td>Document specific interventions in order to improve future care decision making.</td>
<td>8</td>
</tr>
<tr>
<td>Facilitate solutions to the patient’s needs to improve the patient’s well being.</td>
<td>9</td>
</tr>
<tr>
<td>Act to obtain help from others who are most qualified to help a patient meet his or her specific expressed needs. These needs may be medical, social, economic or spiritual in nature.</td>
<td>8,9,10</td>
</tr>
<tr>
<td>Pray for the patient.</td>
<td>10</td>
</tr>
<tr>
<td>Maintain an up to date listing of medications that the patient uses in order to act responsibly to meet the patients needs.</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: (Based upon a survey conducted of 20 pharmacists, mean age 44 years (28-64 years) attending a recent post-graduate continuing education seminar).

*Key to Carative factors:
1. The formation of a humanistic-altruistic system of values
2. Instilling of faith-hope
3. Cultivate sensitivity to one’s self and others
4. Develop a helping-trust relationship
5. Promote and accept expression of positive and negative feelings
6. Systematically use scientific problem-solving for decision-making
7. Promote interpersonal teaching-learning
8. Provide a supportive, protective, and (or) corrective mental, physical, sociocultural and spiritual environment
9. Assist with gratifying human needs
10. Allow for existential-phenomenological forces
value of the whole person — the richness of their life, and of caring and spirituality as legitimate aspects of medical practice as they relate to the physician-patient relationship (19-22). The implications of divergent concepts of health have far reaching consequences, as “measures of health outcomes” are changing to reflect this shift. Further, there is a clear mismatch observed between organizational level implementation of medical practice which continues to be based upon the traditional medical model, and the concepts of health of the patients, public, and organizations served.

Although no uniform model of health has been universally accepted by the various factions of peoples and interests in our society, there are four prominent models drawn from the medical and public health literature which conceptually define health (Table II)(18). Health care research has continued to broaden rather than narrow it’s scope to include examination of the impact of health delivery and care as defined in the three alternative models to the medical model as shown in the table. Models of health have also been suggested by specific professions. Allen’s Model of Health is emphasized in the nursing literature and has been most closely matched with the caring concept. In this model, the individual concept of health is only partially related to the presence or absence of illness(23). Figure 1 displays how these two concepts, health and illness, are interrelated in this model.

What is the pharmacy profession’s position on health? What patients believe “health” is, is as important to our practice context as our own professional beliefs. If we are to choose to act on behalf of a patient, in the patient’s best interest, and in response to the patients needs, we must know what their beliefs about health are. It is only then that we can begin to have the required knowledge of the patients needs which will allow us to choose actions which are most consistent with meeting these needs. This knowledge is also important to our ability to choose those areas of communication necessary to educating the patient about how their needs may be met. There are often several care options available to an individual, and knowing which approaches are within the patients frame of reference allows for the individualized communication and optimal care decisions.

Models of health are important to understanding the extent to which caring behaviors should be incorporated into the training of pharmacists in the conduct of their professional work. Caring behaviors in the context of health must be operationalized in order to be incorporated, a difficult task at best. Pharmacy needs to express its work in the context of those health models. It is natural to then also discuss the need for pharmacists through out their careers to reflect on personal views of what health is. And further, pharmacists in training, our students, must similarly examine their own personal beliefs and understanding of health. A survey (nonrandom) was recently conducted of 103 first year doctor of pharmacy students. This survey demonstrated that only seven percent personally identified most closely with the biomedical model,
while 37 percent with the World Health Organization Model, 48 percent with the wellness model, and eight percent with the Environmental Model (the survey did not include the Allen model from nursing). Similarly, a survey was conducted on 35 postgraduate pharmacists in attendance at a continuing education seminar (average age 43 years; range of 28-64). These pharmacists indicated that none identified most closely with the medical model, 28 percent with the World Health Organization Model, 67 percent with the Wellness model and none with the Environmental Model. With this range of beliefs existing in our own profession, we should expect to observe such diversity in responses from the patients that we serve.

CARING BEHAVIORS AND OUTCOMES

A commonly accepted definition of a health outcome is “the end result of treatment or care delivery”(24). However, more recent numerous writings have emphasized the need to understand outcomes from the patient’s perspective, something experienced, and often without interpretation by others for the patient. Outcomes are either general or condition specific, and may be categorized usually to three conceptual domains: clinical, economic, or humanistic (see Figure 2)(25).

Clinical outcomes usually include traditional measures such as mortality rates. Condition specific might include hemoglobin A1c in diabetes, or forced expiratory volume in one second (FEV1) in chronic obstructive pulmonary disease. Traditional measures of economic outcomes include cost/hospitalization or reduction in length of stay. Condition specific outcomes might include estimating a cost/course of therapy. Humanistic outcomes have traditionally included measures of satisfaction, health status, and quality of life. Generic instruments may be used or condition specific measurement may occur, depending on the purpose for such data.

If caring behaviors were incorporated into practice—would outcomes improve? If care skills were identified and applied would patient outcomes improve? It would seem that if applying caring skills results in a patient perceiving improved health, then applying caring skills will improve health outcomes. It is critical that this measurement occur at the patient level, the patient level being the “unit of analysis”. There are obvious challenges to such research, however, the addition of quasi-experimental, naturalistic, qualitative and mixed methods to our research armamentarium will provide us with a broader array of approaches to this work.

Continuous quality improvement depends on outcomes measurement for making decisions. The quality movement in health care has progressed from a systems level view through the 1970s and 1980s to a more comprehensive approach which is specific to the patient practitioner level. We now conduct continuous practice improvement programs which provide regular, ongoing feedback about the quality outcomes of our work. Donabedian’s structure - process - outcomes model is appropriate for this framework and provides us with an understanding that caring behaviors could be considered processes which affect outcomes associated with particular practice models or approaches(27).

Practice improvement links outcomes measurement data to the continual improvement of professional practice by identifying system errors and identifying processes that interfere with achieving best practices. (This same approach may be applied to our teaching.) To successfully link these two concepts, we must: (i) desire to measure quality and reduce “bad variation,” while keeping the “good;” (ii) believe in an integral relationship of structure to process to outcome, and (iii) believe that reliable, valid measurement, and thus results can be obtained from research which incorporates continuous improvement theory and methods. Our future research must identify and incorporate care behaviors as part of the process of delivering care, and subsequently attempt to measure the impact.

TEACHING CARING BEHAVIORS

Patients need pharmacists to use caring behaviors in the delivery of services. Once we have applied a systematic process to identify and determine context specific professional caring behaviors, the comprehensive design of instruction becomes possible, both as concept and performance-based. Using the carative factors of Watson, we can see that many behaviors of pharmacists that are well-established and performed routinely on behalf of patients would be considered caring. However, in contrast to the profession of nursing, unless the behavior is directly linked to a specific drug treatment, many of these professional behaviors are not considered the central professional activities of a pharmacist, are not expected from the pharmacist, and are therefore, not routinely performed (Table I). By no means are the behaviors that are listed in this work either final or exhaustive, however, they are a reasonable starting point. Substantial descriptive, qualitative and quantitative research opportunities abound in this area.

The affective domain using Krathwohl’s taxonomy is an important tool to the development of operationally based behaviors in the area of attitudes, values and beliefs(28). The
teaching of the caring behaviors will rely heavily on the affective domain. However, it is important that as educators, the incorporation of the relevant information from all three learning domains: affective, cognitive and psychomotor (Table III) be integrated to fully incorporate caring values and actions into the performance skills of pharmacy students and pharmacists(28-30). Use of the affective domain becomes primary when describing learning objectives related to values, beliefs, emotions and feelings. However, we must also provide the reasoning, knowledge and understanding of what caring is, and how to perform such acts in order to expect caring behaviors to occur. Educational objectives must be written to reflect the relevant learning domains and performance behaviors which match the learning objectives must be identified and described in a measurable way(31).

This is a substantial undertaking, as we must teach our students that the culture of the profession of pharmacy “values this value.” This, in short, means creating a learning environment which “values this value.” It is essential that the schools incorporate purposeful educational efforts in this area to the same degree that schools have invested in other practice competencies.

Another challenge to the profession is in the selection and inclusion of individuals who are more likely to have the underlying “emotional intelligence” to prefer to be a caring professional who acts on this value(32). Teaching the desired behaviors and having someone demonstrate them back is possible with all of our students. However, increasing the likelihood that these individuals will conduct themselves as life-long participants in the profession who prefer to incorporate these behaviors into their daily work depends upon whether they possess essential human competencies such as self-awareness, self-control, sensitivity, compassion, empathy, confidence and already value trust and mutual respect(32,33) We are beginning to place a great deal of emphasis on the ability of an individual to experience empathy. It is essential that our pharmacist professionals are capable of experiencing empathy. However, it is just as important that we realize that individuals who are capable of experiencing empathy are not necessarily going to take action of a caring nature toward another(34). If listening in an empathic manner is the most appropriate action that a pharmacist can take, i.e., this fulfills the patients expressed needs (I just need someone to listen), it would fit the description of a carative factor. In this sense, empathic listening becomes a caring behavior. It in effect, may be therapeutic in itself. However, an empathetic response is not necessarily a caring behavior which fulfills the patients needs. Once again, context is important(35).

The American Council on Pharmaceutical Education (ACPE) is expecting the professional schools to implement systematic outcomes assessment of our training programs and graduates. Clear, behaviorally oriented statements are included in the American Association of Colleges of Pharmacy Center for Advancement of Pharmaceutical Education (CAPE) Educational Outcomes to assist academicians in this process. Elements of the caring concept are expressed in both the professional practice based and general ability based outcomes portion of the document(36). However, at a more basic level, CAPE outcomes have been expressed, sometimes at the organizational level and other times at the student or professional - patient relationship level. These elements are not always consistently expressed at the patient level “unit of analysis,” or the individual student level of performance. As we forward our professional efforts in the area of caring behaviors, a revisit to and refinement of the CAPE outcomes will be a necessary part of the educational reform process.

*See ref.# 28-31.

### Table III. Taxonomies of learning domains

<table>
<thead>
<tr>
<th>Hierarchical Relationship</th>
<th>Affective Domain</th>
<th>Cognitive Domain</th>
<th>Psychomotor Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characterization:</td>
<td>Evaluation:</td>
<td>Origination:</td>
<td></td>
</tr>
<tr>
<td>values have formed a characteristic behavior within learner</td>
<td>Ability to judge the value of information</td>
<td>Creative development of new movement patterns - well developed skills</td>
<td></td>
</tr>
<tr>
<td>Organization:</td>
<td>Synthesis:</td>
<td>Adaption:</td>
<td></td>
</tr>
<tr>
<td>development of an internally consistent value system</td>
<td>Form new patterns or structure to information</td>
<td>Skill is natural - individual adapts without overt thinking</td>
<td></td>
</tr>
<tr>
<td>Valuing:</td>
<td>Analysis:</td>
<td>Complex Overt Response:</td>
<td></td>
</tr>
<tr>
<td>worth attached by the learner demonstrated through behavior</td>
<td>Understand information by both content and structural form</td>
<td>Movement with eventual proficiency</td>
<td></td>
</tr>
<tr>
<td>Responding:</td>
<td>Application:</td>
<td>Mechanism:</td>
<td></td>
</tr>
<tr>
<td>Interest exists and more is desired through seeking participation</td>
<td>Ability to use knowledge in new and concrete ways</td>
<td>Movement of lower complexity are habitual</td>
<td></td>
</tr>
<tr>
<td>Receiving:</td>
<td>Comprehension:</td>
<td>Guided Response:</td>
<td></td>
</tr>
<tr>
<td>simple awareness</td>
<td>Grasps the meaning, understands</td>
<td>Achieving adequate movement through trial and error</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Knowledge:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remembering previously learned information</td>
<td>Set:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ready and willing to act</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perception:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Responding to appropriate sensory cues</td>
<td></td>
</tr>
</tbody>
</table>

▲ See ref.# 28-31.
There are many areas of important work for our profession to further develop in order to advance our progress in caring. A large investment of time and resources will be necessary. Such an investment always poses risks. However, the benefits of such an investment will be to take us closer to the realization of our professional maturation to a being a more fully developed care provider and advocate for our patients. Surely, we must acknowledge failure to fulfill our potential to advance the health of our patients to the extent and degree intended by the pharmaceutical care movement. Possibly, the recognition and incorporation of care by our profession as a larger, but consistent concept with our mission of pharmaceutical care, will provide the impetus and way to accomplishing these goals for our patients. We must strive on the notion of a patient-centered profession, rather than marginally survive on a product-centered view. In no way should one suggest that we abandon the product. It is central to why patients seek us in the first place. Rather, it is suggested that the larger concept of care should surround the smaller concept of pharmaceutical care as we envision fulfillment of our responsibilities to our patients. Our practice, research and education agenda for future work should include:

- purposeful examination of health models which the profession of pharmacy will support;
- defining caring behaviors as viewed by the pharmacist advocacy role for the patient;
- defining caring behaviors through the eyes of the patient;
- incorporating these behaviors as standards of practice within the profession;
- determining specific measurements which reflect patient outcomes related to the incorporating of caring acts;
- evaluate the ACPE ability-based outcome statements to assure that caring behaviors are stated as an explicit expectation for pharmacy student outcome assessment;
- incorporating caring behavior expectations into the professional pharmacy curriculum; and
- assessing student performance of these behaviors as an integral part of the professional training program.

There are other concerns not listed on the agenda, which deserve mentioning. For example, the risk of abusing such approaches leading to quackery in practice is a concern. It is possible that the use of caring behaviors resulting in a trusting relationship being developed could increase the opportunity for harm to patients who are in need. An enterprising, dishonest practitioner, could certainly take such techniques and employ them in self-centered, serving ways. However, my sense is that our profession has erred on the other side of this extreme, which is to not have incorporated enough of these caring behaviors in a meaningful way. We are likely to have caused more harm through omission, rather than inappropriate application of such behaviors. Additionally, the use of outcomes measurement concurrently should reveal negative consequences from care applied inappropriately.

Another area of concern is overcoming the barriers which may exist that block our ability to incorporate caring behaviors into practice and education. This also will need serious investigation. However, until we have adopted such behaviors as a professional responsibility and standard, it will be difficult to know what the actual barriers are. Eventually this agenda will unfold.

Explicit definition of caring behaviors is the essential next step in pharmacy. Our profession is already well recognized for developing experts in drug therapy knowledge. The next step is to expand our responsibility to having expertise in the delivery of care.

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References


