Interprofessional Relationships: Who Is the Boss? An Episode of Pharmacy Management Class

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PROLOGUE
Interprofessional relationships is an everlasting topic. This article demonstrates how the topic can be presented in the pharmacy management class, which has been one of the core courses in the pharmacy curriculum. Real world scenarios of professional communication/interaction are presented by the students based on their pharmacy experiences. A theoretical framework is adopted to illustrate the etiology of interprofessional relationships. Strategies are presented to help health professionals interact and communicate with their colleagues in order to serve their common “boss”—the patient—better. It has shown that a combination of student and instructor efforts can make the pharmacy management class interesting, stimulating, educational and entertaining, as well.

THE PRESENTATION
Ever since I started teaching Pharmacy Management to the professional pharmacy students, Interprofessional Relationships has always been one of my favorite topics. It is not because I am good at teaching it, but because I learn a great deal from the students through our informative, educational and entertaining teaching-learning process.

The students in this class are in their fourth year of pharmacy school. By now most of them have worked in a pharmacy and know well about the daily routine for a typical pharmacy. Unlike the old days when pharmacists’ duties included counting, pouring, typing, licking and sticking, modern pharmacists provide patient-oriented services such as medication counseling. Because patient’s welfare is the center, pharmacists interacting with other health professionals with respect to patient care has become part of their professional life. Almost

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all of my students know the importance of the relationship between pharmacists and physicians and/or nurses. Some of the students have even initiated or received phone calls from physicians and/or nurses in regard to prescriptions on the pharmacist’s behalf, and they recognize that communication among professionals is the key in the process of patient care that can have significant impact on the outcomes. Therefore, like their instructor, the students are extremely enthusiastic about this particular topic.

This spring, the students and I made a deal on this topic. Since we have a lab session for each of the topics covered in lecture, I asked the students to play roles based on their observations. This allowed them to create scenarios that included daily professional interactions among pharmacists, physicians and nurses. To correspond to their act, I taught theories on interprofessional relationships in the lecture session.

The day came. Some students wore white coats with stethoscopes. Some wore white coats without stethoscopes and some were just in their usual clothes. They also brought boxes of over-the-counter medications to decorate the classroom to make it look like a pharmacy.

Scenario #1 (performed by Group A): Mr. D comes to the pharmacy to pick up a prescription that has been called in by the nurse at his doctor’s office. The prescription is for Imdur 60mg. The patient looks at the medication and states that he is not on Imdur. The pharmacist calls back the nurse who says that the prescription she called in was Inderal 60mg. However, the hard copy of the prescription shows that the pharmacist noted that he had confirmed the prescription with the nurse as Imdur. Now the nurse insists that not only did she never confirmed the prescription, but that since the pharmacy had on a previous occasion given out the wrong medication they must be wrong again this time. The patient is uncertain whom to believe and leaves without any medication.

Scenario #2 (performed by Group B): Mr. M brings in a prescription for Cefzil 500mg. As the prescription is being processed, the pharmacist notices that the patient has an allergy to penicillin. The patient profile is checked and it is noted that there have been no prescriptions filled for cephalosporins. After speaking to the patient, it is revealed that even though he did notify the physician of his allergy to penicillin, he did not explain the severity of his reaction, which turned out to be a near fatal response when the patient was given the drug as a child. The pharmacist calls the physician’s office and explains that the patient appears to have an anaphylactic response to penicillin and has no history of ever having taken a cephalosporin. The nurse relays the information to the doctor and calls back to change the prescription to Zithromax.

Scenario #3 (performed by Group C): A pharmacist at a busy pharmacy receives a prescription for Percocet from a 25-year-old male, that has been written by a pediatrician. The patient states that he saw the doctor in the emergency room after an accident. The pharmacist decides to page the doctor, as it is unusual for a pediatrician to write prescriptions for adults. The doctor has no knowledge of the patient and asks the pharmacist to call the local sheriffs department. Further investigation reveals that a prescription pad has been stolen from the doctor’s office and several forged prescriptions have been written. The pharmacist and the doctor’s office notify area pharmacies and this leads to the arrest of the person who has written the prescriptions. The doctor thanks the pharmacist for noticing the initial discrepancy.

Scenario #4 (performed by Group D): At the local hospital anesthesiologists are given. It is unusual for a pediatrician to write prescriptions for adults. The patient profile is checked and it is noted that there have been no prescriptions filled for cephalosporins. After speaking to the patient, it is revealed that even though he did notify the physician of his allergy to penicillin, he did not explain the severity of his reaction, which turned out to be a near fatal response when the patient was given the drug as a child. The pharmacist calls the physician’s office and explains that the patient appears to have an anaphylactic response to penicillin and has no history of ever having taken a cephalosporin. The nurse relays the information to the doctor and calls back to change the prescription to Zithromax.

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them with knowledge on interprofessional relationships so that they can communicate/interact effectively, an introduction of relevant conceptual framework for interprofessional relationships is necessary. It tells why pharmacists and physicians/nurses behave the way they do when they interact with each other, and strategies for tactful and professional communication/interaction.

Brown and Levinson's (7,8) analysis of face and politeness, a theoretical framework explicitly designed to explain the management of routine identity-threatening acts, fits perfectly in physician-pharmacist interactions. Lambert (9,10) appropriately adapted this framework and successfully illustrated the relationships between physicians and pharmacists. In his studies, Lambert (9,10) conceptualized threats to pharmacists' and physicians' identities in terms of the concept of face, which was originally defined by Goffman (11) as "the positive social value" a person claims for himself or herself by behaving in a particular way (11, p. 5). In a sense, face is synonymous to pride, integrity, dignity or self-esteem. According to Brown and Levinson (7), face has two aspects: positive and negative. Everyone in society has persistent positive and negative face wants (7). Positive face want is defined as "the want of every 'competent adult member' that his [or her] actions be unimpeded by others" (7, p. 62). Positive face want, on the other hand, means "the want of every member that his [or her] wants be desirable to at least some others" (7, p. 62). In other words, negative face wants involve the desire for one's own space and to be left alone. Positive face wants include the desire to be appreciated or liked. In daily life, any rational person would like to maximize the two types of face wants at different times. However, interacting with others in society inevitably threatens face wants. Therefore, understanding politeness strategies, which aim to minimize the negative outcome of face threatening actions, is important.

Brown and Levinson (7) identify four strategies for managing face threatening actions. These include, in order of increasing politeness: (i) do the act openly on the record; (ii) do the act on the record with politeness; (iii) do the act off the record; and (iv) don't the act. In context of pharmacist-physician interaction, different strategies may be appropriate in specific circumstances. Upon discovering an adverse drug reaction, how does a pharmacist convey this message to the physician? Using the first strategy, which is to do the act openly on the record, the situation will be like this. The pharmacist first documents the drug reaction, calls the physician in front of the patient, tells the physician that the drug prescribed is not appropriate for the patient, and says that drug so and so will be better. If the second strategy, which is to do the act on record with politeness is adopted, the pharmacist still documents the drug reaction, calls the physician in private, tells the physician how the patient reacted to the medication and suggests upon request or politely offer a suggestion from a different drug class. What happens if the third strategy, which is to do the act off the record, is employed by the pharmacist? The pharmacist observes the adverse drug reaction, but does not document it. The pharmacist calls the physician in private and lets the physician know what has happened. The pharmacist may or may not suggest an alternative medication. It is clear what will happen if the last strategy, which is to do nothing, is used by the pharmacist. The pharmacist observes the drug reaction and leaves it as it is. It is so apparent that the last strategy described above is a bad and wrong one. The other three strategies all seem to be right in the sense that the patient is being taken care of the adverse drug reaction. But there are differences among them that will have different impacts on pharmacist-physician relationships and different implications for patient care. In the situation where the third strategy is used, it may not create conflicts or any hard feelings between the two professionals. However, the fact that the pharmacist does not document the adverse drug reaction can put him or her in a bad situation.

With the pharmacist's role expansion, it also comes with more responsibility and liability for the pharmacists. Documenting professional services is always recommended. Therefore, in this case, it is necessary for the pharmacist to document the drug reaction, as well as the conversation with the physician. And that makes the second strategy, by which the pharmacist tactfully informs the physician and suggests an alternative, the best for this circumstance. There are no hard feelings between the two professionals and it benefits the patient in the case and future patients as well. It builds professional trust and works best for patients. In contrast, the first strategy, which the pharmacist informs the physician in front of the patient, is inappropriate. No matter what intention the pharmacist has, the physician will think that pharmacist tries to find fault with him and embarrass him and scare the patient as well. Given this occurred, it is easy to tell what will happen if there is future interaction between these two professionals. Who suffers? —Neither the pharmacist nor the physician. It is the patient.

The above example may be too simplified to illustrate more delicate situations involving health professional interactions. Nevertheless, there is no script to instruct how to act at many different circumstances. As long as the health professionals keep in mind that they have a common goal. That is to serve the patient—the boss-better. They would be willing to adopt a little strategy and treat other professionals equally and respectfully.

The patient has suffered enough from the ailment. Let’s prevent them from any man made negative outcomes generated by unhealthy interprofessional relationships!

References