VIEWPOINTS

Patient-Centered Care: It's About Time

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I have spent over 30 years in pharmacy education. I am excited and frustrated about the future of pharmacy education and the profession. So, for what it's worth I thought I would share some of that excitement and frustration.

In the month of July this year I was asked to serve on 2 national adherence panels over a period of 2 weeks. . . 1 in Washington, DC, and 1 in Boston. There were many important constituents there. . . the American Academy of Family Practice Physicians, National Association of Chain Drug Stores, Pharmaceutical Research and Manufacturers of America, American Association of Retired Persons, the National Consumers League, CVS Caremark, Centers for Medicare & Medicaid Services, National Council on Patient Information and Education, etc. What struck me was how little some people knew about what pharmacists could do or how little they really saw pharmacists as part of the solution to the adherence problem (crisis). What also struck me was how many of the solutions discussed had nothing to do with *how* we (any health care provider) talk to patients....instead we heard about e-prescribing, dosage simplification, more information and education for patients, electronic pill bottles, assessments of patients (electronic or written), identifying potential adherence problems, etc. There is no doubt that all of these "tools" or methods are useful and may be very helpful. However, they are all somewhat limited. And if we do identify an adherence problem with a patient or discover a potential problem, do we know how to talk to a patient in a way that does not create defensiveness and more resistance? What seemed equally important to some attendees was how can we do all of this in 2 to 5 minutes?

Both conferences focused on adherence to medication regimens. If we do assist the patient in being more adherent to his/her diabetes drug regimen, do we need to talk to the patient about lifestyle changes? It is unlikely that the medication alone is sufficient to manage the illness.

Here is something that has become very apparent to me. . . there are several fundamental inadequacies in most health care (pharmacy) practitioners' training in school:

Still taught a paternalistic model of care. Students are taught that they are the expert and this leads to a very

paternalistic model of care in which patients are told what to do and failure is attributed to the patient's actions, not their own. A more effective model is a patient-centered model in which patients are also experts. . . experts on how they make sense of what is happening to them, whether they want to engage, what the illness means to them, how they will fit managing the illness into their lives, etc. This must be assessed and care must be negotiated. Adherence is done at the individual level. It is not a statistic. A few examples will clarify this point. Two patients forget to take their medication on a regular basis and as a result, they are not controlling their illness. One patient has a difficult time remembering because it is hard to work taking his medication into his daily routine. He wants to take it but forgets. The other patient does not think the medicine is necessary or all that important and therefore forgets to take it. Two very different solutions and approaches are needed to improve adherence with these patient. Example 2: A patient has osteoporosis and the physician is about to prescribe a once-a-month dosage regimen because the pharmaceutical company representative told the physician that adherence improves as you simplify the dosage regimen. Unfortunately, this patient would prefer to take the medication daily because that would help her establish a routine and once a month would not. But, she is not asked and consequently has difficulty with the once a month dosage regimen, eventually stopping it. At the pharmacy, the medication is dispensed without question or consultation. The patient is asked to "sign here" when she picks up the medication, after a box is checked that says, "I do not want to talk to the pharmacist." We talk about *patient-centered care*, but we often do not understand what it means.

Not taught how to address adherence problems. Health care providers are taught about diseases/illnesses and medications, but not about the most prevalent adherence problems for each disease and medication or how to address the problem with the patient. In schools of medicine, nursing, and pharmacy, the extent of the adherence problem is often discussed, but not on a disease/drug basis or in terms that explore the patient's nonadherence and what can be done about it collaboratively with the patient. Why are we so surprised that this problem is so serious

and prevalent when we do not even train health care providers to deal with it in a meaningful and appropriate manner? For example, the following is a typical interaction:

Patient: *I just don't see the point in taking this medication when I feel fine and I am not overweight.*

Provider: *You need to take the medicine so you don't have a stroke or heart attack. You don't want to have a stroke or heart attack do you?*

Patient: *No*

And the conversation is over. The health care provider believes the problem is solved and the patient will take the medicine. Unfortunately, the patient's primary concern was never addressed because the conversation was essentially cut off by the health care provider. It never surfaces that the patient is very apprehensive about the drug's potential side effects. Consequently, the patient still does not take the medicine.

While technology is certainly a vital tool and can provide better information to identify adherence problems (along with brief questionnaires), ultimately a practitioner has to know how to talk to the patient when resistance or ambivalence about behavior change occurs or when problems are identified. This requires training that is substantially different than the training most health care providers receive.

Not taught to be agents of change. Students, particularly in pharmacy school, are not taught how to be change agents. How do you facilitate change in pharmacy practice when you start your career (and unfortunately too many of our students "take jobs" rather than "start practices")? How do you begin to change the practices and environments in which we work so that we actually interact with patients on a consistent and meaningful basis? How can students in a community pharmacy setting interact more often with patients when the focus is on filling the next prescription? This is especially difficult when patients use a touch screen to accept picking up their prescription at the pharmacy and the default screen says, "I don't want to talk to the pharmacist" or "I don't want counseling." Is this acceptable to us in pharmacy education? Is this acceptable to our students? If not, what are we doing about it? Worse yet, why is it acceptable to anyone?

Moral and ethical obligations not emphasized enough. We do not have a serious and continuous dialog with our students and faculty members about moral and ethical obligations in providing care and what it means to have moral courage as a practitioner. This is where I am most concerned about our training in pharmacy education. I will borrow from Bill Campbell's 2008 Rho Chi Lecture at the University of North Carolina at Chapel Hill

to make my points. Bill challenges all of us in pharmacy education to uphold our social contract. Bill states, "What is required is that students must also accept responsibility for the outcome of care. If technical tasks are performed accurately but an avoidable adverse drug event occurs, we would grade the student to be deficient. If the student performed all necessary tasks but there was a failure in therapy because the patient was confused about regimen, we would grade the student's performance to be unacceptable. In other words, the social contract we impose on students is *to accept responsibility for the outcomes of their actions.*"¹ He then challenges us as faculty members, "Can we perform our technical tasks as educators 'correctly,' but see medication errors, failed therapy, and adverse drug events escalate, and still claim we are successful educators? No, and to do so is hypocrisy. If we are honest, we must admit that we as educators are failing to meet our social contract."¹ The social contract must be to advance the practice of pharmacy *to help patients*, not just deliver curricular content.

As stated previously, do we consider it ethical when patients are offered counseling through a discouraging touch screen message or a clerk or technician who says, "You don't need to talk to the pharmacist, do you?" Even if the clerk said, "Do you have any questions you would like to ask the pharmacist?" how would the patient know what to ask? How would a patient prescribed an ace inhibitor necessarily know to ask about a cough as a possible side effect? How would the patient know what caused it if it occurs and has not been told?

Pharmacists say they do not have time to counsel patients. We are told that the current business/insurance model does not adequately compensate pharmacists for counseling. There is some truth to this. However, here are some equally challenging questions. What *are* pharmacists getting \$100,000 plus per year to do? And if all they do is dispense drugs, can we expect these salaries to remain this high? If a patient brought a new prescription to the pharmacy that could kill her if taken, given her medical conditions and other medications, would the pharmacist take the time to intervene despite how busy he was or whether he was paid? How about if the medication only blinded the patient? Caused explosive diarrhea that hospitalized the patient in 3 days? The point is, why do we think we have the right to decide the amount of harm a patient might be exposed to because of time or money? Ethics and morality depend on caring about the welfare of our patients. It is part of our social contract. Ethical decision-making involves identifying which moral issues (of many) are the most salient or important for my attention and concern? What merits my moral caring or concern?

What merits our moral caring or concern in schools of pharmacy? I have heard numerous experts estimate that the problem of nonadherence to medication regimens ranges from \$100 billion annually to \$290 billion. I do not think we have to argue about which figure is correct. It *is* a serious problem. Will we continue to literally ignore it in colleges and schools of pharmacy?

The Opportunity Before Us

I know what you are probably wondering at this point: so where is the part you are excited about? Here it is: we have an opportunity in our colleges and schools of pharmacy and in our profession to have a substantial impact on the quality of life of our patients and on reducing health care costs. However, if I have one more person asks me what we can do in a 2-minute encounter with the patient with no follow-up or continuity of care, I am going to

scream. The answer is simply this: not much that is useful! Are we going to keep focusing on the 2-minute solution or are we going to seriously identify what it will take to have an impact on the patient in a substantive way and then figure out how to do it? We must change the way we train our students. Paternalistic models of care do not work. Training someone who is an expert in pharmacotherapy, but cannot communicate with the patient or address adherence problems does not seem to be working. We cannot simply deliver curricular elements. We must develop a patient-centered model that actually has an impact on outcomes or we are failing in our social contract. Developing that model is my challenge to all of us.

REFERENCES

1. Campbell W. 2008 Rho Chi Address: One easy piece. *Am J Pharm Educ.* 2008;72;118.