"Patient contact . . . reveals an added dimension to our previously established services."

Sister M. Gonzales

(1971)

At the time she received this award, Sister M. Gonzales, R.S.M., was the Director of Pharmacy and Central Service at Mercy Hospital, Pittsburgh, Pennsylvania.

An Added Dimension

It is the best of times, it is the worst of times, it is the age of wisdom, it is the age of foolishness, it is the epoch of belief, it is the epoch of incredibility, it is the season of Light, it is the season of Darkness, it is the spring of hope, it is the winter of despair, we have everything before us, we have nothing before us.

So wrote Charles Dickens in 1859 in the opening paragraph of his immortal classic *A Tale of Two Cities.* These words can appropriately be applied to the present state of pharmacy and, particularly, pharmacy as it is practiced in hospitals today. Only we, the practitioners, can assure by our personal contributions that positive statements from the above quotation become reality. We have within our reach . . . the best of times . . . the age of wisdom . . . the spring of hope.

Today, one major concern is the patient–pharmacist relationship. We are moving from a service of things to a service of people, service to and with others—the patient, nurse, physician, as well as specialized services to our fellow pharmacists. Sufficient studies have now demonstrated what should long have been an obvious fact—many

pharmacists have been overeducated to do "count and pour" jobs. Admittedly, "count and pour" is an oversimplification of the traditional pharmacy service, but we have been educated to do more. And that "more" is a service that is needed! Our experiences with drug information services demonstrated also that it was not enough for us to sit and wait for the physician to ask us questions. Somehow, we had to find a way to be on hand to assist and offer information before we were asked to do so. Incorporating the pharmacist into the team in a more realistic way seemed to be the answer.

The evolution from the "pharmacist-in-the-pharmacy" to the "pharmacist-in-the-patient-care areas" has been a torturous one. Full potential is far from being achieved, but we are working on it; and almost each day, new doors are opened as this concept grows and the needs we fulfill are recognized. Another example of this challenging aspect of pharmacy is seen when a pharmacist interviews the patient.

Let me briefly describe what I envision comprises a patient interview, because it is this type of patient contact that reveals an *added dimension* to our previously established services. We have what is called the initial interview, at which time the pharmacist chats with the patient in an effort to learn as much as he can about the patient's medication regimen and habits.

This first contact with the patient is used to obtain as much detailed information as possible concerning the patient's use of prescription and nonprescription medications. The interview often uncovers situations which are clinically important to the patient and to his physician such as the patient who is not taking his medication as prescribed, or the patient who has simply stopped taking prescribed medications, or the patient who has experienced allergic or adverse effects. Occasionally, we find that the reason the patient is in the hospital is drug related.

The information obtained in the interview must be communicated to the patient's physician. This is done in a variety of ways, perhaps the most effective being the documentation of the medication history in the patient's chart as a permanent part of his record.

Interim visits with the patient throughout his hospital stay offer us the opportunity to participate in the assessment of the patient's response to therapy. It also provides the patient with one more indication that "this hospital is concerned about me!"

Discharge interviews are of considerable value to many patients. The likelihood that a patient will follow his prescribed regimen is directly proportional to his understanding of the purpose of the therapy. For many patients, this is a paramount consideration. It presents a challenge to the pharmacist to discuss and explain the therapy in terms the patient can understand and to give a reasonable and balanced discussion of potential side effects to which the patient should be alerted.

Frightening things emerge when a patient "tells all" to a pharmacist. And how can we expect our patients to know that some of the nonprescription medications they have been taking could alter their well-being? The lay person today learns his pharmacology from the television commercials and his physiology in the pages of *Readers' Digest.* And these popular founts of wisdom seldom relate the side effects of the miracles they promote. Further, the often harried physician is not geared to in-depth exploring of his patient's medication sprees. Yet, somehow, the patient willingly re-

lates to a pharmacist a detailed history of all of the medicine he has been taking. And haven't we all had nurses present us with brown paper bags of drugs that patients have brought with them to the hospital?

So it is a new era, and understandably so. Medication regimens resulting from potent, often specific, drugs are complex. And the patient-oriented pharmacist cooperating with a pharmacist-conscious physician or nurse can together achieve a high level of service. As we study this type of service, it seems we have been a missing factor for too long—or may I use an already overused phrase and say: the hospital pharmacist was needed to "put it all together."

To prepare our pharmacist to serve in this new role, all manner of changes have been made. Universities have established new departments; schedules have been rearranged to permit students to work in clinics, to make patient medication rounds, and to attend grand medical conferences. The recent literature is replete with examples of what I am saying. However, there would seem to be one area about all of this that is slighted and about which much more needs to be said—the importance of the *manner* in which pharmacists approach the ill patient. Do we detect a dangerous gap here? Not all of us are equally equipped to daily confront the ill, any more than all physicians are so blessed. It takes a certain type of individual to effectively work with sick people. Some are gifted with personalities that lend well to daily contact with the sick, others we must train. And we would be unrealistic if we said all pharmacists can, or even desire to, serve in this capacity.

We are in a period of great medical achievement—a time in which much medical gadgetry is used. Many practice in the impressive, stainless steel and glass glare of the modern hospital. But, unfortunately, on close inspection it would seem that in these monoliths of modern medical madness, everything and everybody come before the patient. In following my trend of thought here this evening, I would not have you think I am in any way degrading these spectacular, computerized, scientific advances that we now have for our use. I am not!

What I am saying is let us take all that is good today and yet not dehumanize the patient. The emotional side of the sick must never be overlooked. I personally wanted to use this forum this evening to focus on this aspect of hospital pharmacy service. We hospital pharmacists have within our grasp a powerful means of helping to mend this gap in today's hospitals and health programs. It could be our timely contributions to add to—not subtract from—the care of the sick patient just by our manner of approach and our personal philosophy of the uniqueness of each patient. Would that we will grow daily in this specialty of helping the sick, but remember—we must always help them one by one!

Health maintenance organization programs dominate the political scene today. Such political crusading can only result in a greater number of health programs and increased numbers of people applying for health care. Our national leaders are well advised to give to these health plans their most careful attention. In our own situation, three primary care stations and a Care-mobile that operates from Mercy Hospital in Pittsburgh have revealed alarming statistics of a large population of chronically

and acutely ill people who have never had any medical treatment or ever been seen by a physician—this in a midtown ghetto that is surrounded by six large hospitals. Our health care systems are demanding to be revised. But, here again, the patient can easily be only one more statistic in such systems and personal, individual care can be overlooked.

President Nixon recently made a revealing remark that was reported in the *U.S. News & World Report* of January 11, 1971. He had just been given a clean bill of health after his annual physical checkup. Mr. Nixon said, "I've seldom been sick in my life. But I know the main thing that patients need is not for someone to talk about their illness but to have someone smile at them." With a President that thinks like this, perhaps there is hope that in the legislating of new health programs, there will be heart as well as help.

Physician-teachers from Hippocrates to Osler have lengthy writings on the importance of good physician–patient contacts. Osler has said somewhere, and I will paraphrase him to make it apply to pharmacists, that "no matter how vast is your knowledge of pharmacology or how experienced you may be in recognizing the drug–laboratory test interferences or the drug–drug interactions, it is of little value if you do not approach the patient with real concern and interest. If a patient senses your haste or your impatience with his rambling accounts, you will leave him depressed, rejected, and you will have done nothing to his mental attitude which is so important to the healing process." I hope Osler forgives the liberties I have taken with his words, but all of his writings, as well as those of many of his present-day counterparts, stress the invaluable contributions that can be made by a warmhearted attitude towards patients.

So it is just because of our increased contact with patients, physicians, and nurses—but mostly patients—that we need to rethink the importance of our personal contributions. We are no longer handling bottles and things but people. And people, not things, engender problems; people need help, appreciate care, and recognize love. Yes, love at its purest and most unselfish, most precious best. And love is something more than a word surrounded by flowers painted on the side of a Volkswagen bus. The opposite of love, you know, is not hate but indifference. And no one can inflict a greater hurt than an indifferent, thoughtless person. The ill patient, alone for many hours, uncertain of the outcome of his illness, is a prey to indifference the likes of which a busy, healthy individual would not notice.

Not only does the individual sick person view his world differently from the healthy, but there are numerous factors that influence him other than his illness. The young and not-so-young can profit by an occasional meditation on the trauma produced by illness. Illness causes fears, frustrations, and impatience in most. Pain elicits a variety of reactions often determined by the patient's cultural or ethnic background. The transition from health to a recognized, accepted illness is bound to be a period of anxiety and apprehension. An educated, successful businessman's reaction is often similar to that of a newly caged lion, while the grandmotherly little lady may use her illness to attract all the attention and pity she can capture. Her moanings and groanings are often (not always) a means of milking every drop of sympathy she can get from relatives and strangers alike.

It is too complex, emotionally distraught individuals such as these that we are sending our pharmacists. Have we honestly prepared them adequately for this pivotal role?

It would seem that hospital pharmacy and hospital pharmacists experience a recurring cycle of metamorphosis. At our first seminars and early conventions, the live topic was bulk compounding and we went home feeling richer if we had gathered some new formulas. Later we were euphoric with success when we had compiled our first hospital formulary. Then came the hassle of generic dispensing and proper labeling with the proven necessity of having good controls and control numbers. And remember when having a walk-in refrigerator was a mark of prestige? Honestly, I may not have fallen into this temptation to reminisce if the familiar faces of long-time friends were not in front of me. But I think we do admit that although the pharmacy and therapeutics committee brought us closer to physicians, and inservice nursing programs as well as teaching pharmacology in schools of nursing opened doors in the nursing field, we still had, for the most part, only over-the-counter contact with our patients, usually on an outpatient basis.

To function as an integral part of the health team, to daily meet and talk with the ill, is a new challenge for us in these years of the shaking seventies! A challenge we need to acknowledge, define, meet, and accept.

There are some in our modern society who claim we live in an age of insensitivity. Perhaps we do, but I hope not. There should be no taboo on tenderness. It was Hippocrates who cautioned that our first rule should be "do no harm"; Dr. Francis Peabody simply says, "The secret of patient care is caring for the patient." Bishop Fulton J. Sheen amusingly reminds us that the best medical men should be equipped with a topnotch education, a sense of humor, and an incision! Of all the various aspects of our service in the past, perhaps our present trend to supply this most important link between patient and physician needs our best efforts and most cautious acceptance. If this is what we call clinical pharmacy, it is also a scientific art and a humanistic science. The art and science must be intermingled, symbiotic, and inseparable. Without the art, the skills, and the tenderness, there can be no data for the physician and only trauma to a patient. Without the science, there can be no reason for the art.

I had only one goal this evening and that was to call your attention to this new facet in the practice of pharmacy today. I hope I have done just that. And if I may be permitted to close with a prayer, I would have that prayer be this:

May we be mindful of the fact that our Creator, who has placed us here on earth to do a work, touches the world mainly through the ministration of human services. We labor in an atmosphere where frequently good must battle evil, where some must suffer and die. May it be our happy task to ease the ways of all those for whom we care. May we be brought to the realization that true happiness is found in the knowledge that a job assigned to us here and at this point in time has been a job well done.

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