

Concept paper

The Future of Clinical Pharmacy: Developing a Holistic Model

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Abstract: This concept paper discusses the untapped promise of often overlooked humanistic skills to advance the practice of pharmacy. It highlights the seminal work that is, increasingly, integrated into medical and nursing education. The work of these educators and the growing empirical evidence that validates the importance of humanistic skills is raising questions for the future of pharmacy education and practice. To potentiate humanistic professional competencies, e.g., compassion, empathy, and emotional intelligence, how do we develop a more holistic model that integrates reflective and affective skills? There are many historical and current transitions in the profession and practice of pharmacy. If our education model is refocused with an emphasis on pharmacy's therapeutic roots, the field has the opportunity to play a vital role in improving health outcomes and patient-centered care. Beyond the metrics of treatment effects, achieving greater patient-centeredness will require transformations that improve care processes and invest in patients' experiences of the treatment and care they receive. Is layering on additional science sufficient to yield better health outcomes if we neglect the power of empathic interactions in the healing process?

Keywords: transformative learning; patient centered care; reflective learning; affective learning; emotional intelligence; empathy; professionalism; empathic concordance; compassionate care; curriculum design; pharmacy education

1. Introduction

Wilson and Perrie, in their editorial for the debut edition of this journal (*Pharmacy*), call attention to the major developments in pharmacy education and practice as our profession becomes more client-centered. While assessment continues to include the fundamental knowledge and skill of traditional pharmacy, the assessment markers for professional competencies are rapidly increasing [1]. This concept paper is allied with a growing body of research that links healthcare providers' competencies for caring with more positive health-related patient outcomes. Healthcare leaders note that the future belongs to people who incorporate "right brain" attributes of empathy and emotional connection with scientific, logical "left brain" processes. Educating a "new professional" requires techniques that foster emotional intelligence as well as cognitive intelligence [2]. Others have noted that to enhance emotional competencies, the spectrum of learning must go well beyond cognitive strategies [3–5]. Strategies that are being proposed to help achieve these holistic functions include emotional learning, sometimes referred to as affective learning and reflective learning, which taps into the learner's personal experience and self awareness. Self awareness, in turn, fosters a stronger sense of connectedness to the life stories of others. This sense of connectedness is thought to stem from a capacity for empathy [5]. Conceptualized as a capacity, rather than a static trait, the quality of empathy may vary both at inter-individual and intra-individual levels. This empathic quality may grow in strength or dissipate and erode over time, depending on the presence or absence of reinforcing experiences, training and circumstances.

In practice, an array of professional skills will be needed with the advent of patient-centered models of care and, particularly in the United States with the growing emphasis on the primary care medical home and related developing models. With these changes the importance of shared decision making will increase between healthcare practitioner and patient, as well as among health care providers as interprofessional team-based care becomes more fully realized as a practice model. Healthcare providers will require humanistic skills to recognize when patient care decisions or preference-sensitive decisions are needed [6]. In fact, these skills when applied in the service of continuity of care and the intention to build longitudinal, therapeutic relationships yield what some have suggested are "high-leverage activities" leading to better clinical outcomes [7–9]. Along this spectrum are efforts to incorporate more training to enhance patient centered communication, an appreciation for "illness narratives" and "appreciative inquiry." Additional activities utilize experience with bio-psycho-social models that have relevance for understanding patients' experiences, translating the meaning each person imputes to illness and disease [10–12].

Survey research, conducted to assess how much compassionate care is valued by patients and physicians found broad, substantial agreement that compassionate care is very important. However, notably fewer respondents indicated that the health care system, in their experience, actually provides compassionate care [13].

Trends reported in the research literature that focus on empathy are not encouraging. For example, the troubling conclusion of a recent study by a team of social scientists is that American college students have been scoring lower and lower on standardized empathy tests over the past three decades. In fact, researchers report that since 1980 self-reported scores have dropped 34 percent on "perspective taking" (the ability to imagine others' points of view) and 48 percent on "empathic concern" (the

tendency to feel and respond to others' emotions) among USA college students [14]. Yet, there is evidence that empathy can be fostered and nurtured; as quoted in [15] "The ability to empathize is like a muscle capable of growth, atrophy, disability, and even regeneration". To that end, researchers have emphasized that teaching communication skills is not sufficient and that deterioration in empathy is observed as early as the first year of training and especially during clinical rotations. This observation should inform our strategies to institute a more systematic and consistently reinforcing approach to fostering the basis of compassionate care [13,16,17]. Likewise, relying on role modeling by faculty, mentors and preceptors to instill enduring empathic professional capabilities is probably insufficient. Implications of the historical underpinnings of clinical empathy, defined as "detached concern," have been discussed elsewhere [18]. Crandall and Marion, 2009 refer to a "hidden curriculum" marked by mixed messages and a failure to impart communication skills, provide practice opportunities, and employ constructive, consistent feedback [19]. These limitations appear to lead to erosion of empathic, humanistic approaches to patient care [17]. Influences of a hidden curriculum that shape the attitudes, values and behaviors of future health care providers require a more explicit and intentioned systematic approach to empathy training which could produce a resilient foundation that endures through clinical training and has the capability to transform patient care.

Goleman reports that emotional intelligence may be a better predictor of educational and professional performance than academic grades. Four types of abilities are proposed as foundational to emotional intelligence [20]. These are: emotional self-awareness, self-management, social awareness, and relationship management. Questions remain about how to impart these competencies. Some have contended that of the six general competencies used by the Accreditation Council for Graduate Medical Education in the USA, persistent challenges are most associated with defining and teaching the competency of professionalism [21].

2. Review of Training Methods

There is a growing body of research that links health care providers' greater capacity for empathy and compassionate care with more positive health related patient outcomes, better patient compliance, and patient reported improvement in quality of life [13]. Are we lagging in our efforts to address the training implications for future pharmacists?

A survey of pharmacy professors and administrators regarding outcomes important to lifelong learning found self-reflection to be an important outcome that most schools could teach and evaluate [22]. As pharmacy practice models evolve in the future, it is anticipated that fulfilling professional roles in patient centered care will entail going well beyond storage and retrieval of accurate information, requiring a much greater reliance on professional judgment and responsibility for medication related patient outcomes. As pharmacy curricula evolve, changes would ideally be driven by the imperative to achieve a set of competencies that are directly linked to delivery of optimal patient care.

How do we deliver on the promise of the healing arts? How do we bridge from the science of medicine to the delivery of care that helps our patients achieve health and healing? Taking note of some of the best strategies and techniques currently being used to foster affective learning for physicians and nurses, questions arise regarding the feasibility and receptivity within pharmacy to integrate these techniques into educational curricula, for both students and practicing professionals.

On a positive note, there is a growing consensus among pharmacy faculty that emotional intelligence is an important, albeit intangible characteristic [23]. Those advancing the use of reflective and affective learning techniques are working to bring these processes into patient care as integral, rather than peripheral, as ways to achieve better patient outcomes and potentially reshape the medical treatment model. In academic pharmacy do we have the courage to teach this level of caring?

The following examples are representative of the emerging interest in reclaiming humanism within medical and nursing education and the creative instructional strategies currently in use.

2.1. Medicine

Annually more than 70 medical schools around the world teach *The Healer's Art* course, a reflective inquiry into the very human elements of healing developed in 1991 by Rachel Remen, M.D. *The Healer's Art* is an inquiry into empathy and compassion utilizing a discovery model curriculum and is designed for first and second year medical students. The goals of the course are: “(1) to provide support for medical students in recognizing, valuing, enhancing and preserving the human dimension of their work; (2) to enable students and physicians to experience and affiliate with the core values of the Hippocratic Oath: compassion, service, harmlessness, love, and justice as a way of life; (3) to enable students and physicians to experience the support of an egalitarian and collegial relationship that is nonjudgmental, noncompetitive, and harmless; and (4) to enable students and faculty to explore the concept of healing in Medicine and participate in relationships that promote healing” [24]. Rabow *et al.* report from their study of 582 students in USA and Canadian medical schools that the most common themes expressed by students participating in this course were a “definition of professionalism in medicine” and “legitimizing humanism in medicine” [25].

Kumagai observes that the increasing use of narratives in medicine (both physician and patient stories) calls for an overarching conceptual framework grounded in empathy and moral development theory which serves to validate the educational value that story telling (narratives) can bring to medical education. He points out that “at its core, medicine is a type of applied humanism, that is, the application of science in recognition of human values and in the service of human needs” ([11], p. 653). The use of narrative medicine was utilized in the University of Michigan Medical Schools' Family Centered Experience program in 2003 which included family visits and discussions among all care givers, patients and their families. Kumagai concludes that the use of narratives is fundamentally different than teaching the biomedical sciences, concluding that it is fundamentally a transformational process capable of changing one's perspective—“a wholly different way of seeing oneself” ([11], p. 656).

Columbia University School of Medicine offers a Masters in Science for physicians in Narrative Medicine. The school says that “the care of the sick unfolds in stories. The effective practice of healthcare requires the ability to recognize, absorb, interpret and act on the stories and plights of others. Medicine practiced with narrative competence is a model for humane and effective medical practice.” [26]. The Master Scholars Program in Humanistic Medicine at New York University School of Medicine is dedicated to promoting humanistic values in medical education among young physician scholars [27]. In addition, there are foundations devoted to promoting humanism in medicine such as the Arnold P. Gold Foundation and the Healthcare Foundation Center for Humanism and Medicine at the New Jersey School of Medicine at Rutgers University [28,29]. The evidence continues to grow that

medicine education recognizes the critical need to attend to the humanistic needs of both the patient and the healthcare provider.

2.2. Nursing

A similar commitment to humanism has historically been an essential component of nursing preparation and continuing education. Florence Nightingale asserted “that the essence of nursing rested on the nurse’s capacity to provide humane, sensitive care to the sick, which she believed would allow healing” [30]. United Kingdom nurse educators, Freshwater and Stickley observe that the concept of emotional intelligence has been growing over the past two decades and now nursing curricula reference the notion of an “emotionally intelligent practitioner,” wherein theory, practice and research are “inextricably bound” with experiential knowledge. Freshwater and Stickley say that emotional intelligence needs to be an essential part of nursing’s core curriculum and is interdependent with rational intelligence. The authors note that the complicating challenge here is to develop curricula that promote and sustain reflective (emotional) learning and practice in a time where nursing role models are “highly stressed, often underpaid and disillusioned teachers” who often “find their own working environment uncaring” [31].

McQueen’s literature review reinforces the concept that emotional intelligence is a key factor in establishing therapeutic-patient relationships and that the current demands of nursing need to draw on emotional intelligence skills to meet both patient care needs as well as the “co-operative negotiations” within the multidisciplinary team. McQueen concludes that these skills need to be recognized in nurse education [32]. Zimmerman and Phillips describe using affective teaching strategies in a senior nursing course to “awaken in students both an understanding of the healing aspects of caring and providing holistic care” particularly when dealing with chronic illness ([33], p. 422). The authors believe that the affective and reflective activities help the students begin “to examine the meaning of caring” ([33], p. 424). They conclude that this is a critical learning experience for nursing students, especially with current technological advances in science and medicine, the easy access to information and communication via the World Wide Web, and the brevity of patients’ encounters with their health care providers when seeking and receiving care ([33], p. 425).

Another example of nursing educators helping to create a balance between the scientific/technical approaches to care with the “ever-important human-centered aspects” is Susan Kleiman’s Humanistic Teaching Model, developed and tested at a large university in New York City. “The Humanistic Teaching Model [34] integrates humanism with an existential understanding of the patient’s and nurse’s lived-in world experiences and the meanings that they ascribe to their experiences ([34], p. 210). The author reports that this Humanistic Teaching Method is available as a template and can be used to improve the quality of patient care while also promoting professional growth and work satisfaction ([34], p. 214).

2.3. Pharmacy

Maine and Vogt observe that the key messages from recent keynote presentations at the annual meetings of the American Association of Colleges of Pharmacy (AACP) are raising critical questions about student pharmacist preparation. In the 2005 keynote, physician and author, Rachel Remen shared her insights on compassion in medicine and the critical importance of caregivers to listen with their

hearts in establishing a human connection. In 2007, author and journalist Dan Pink predicted that the future of the world will belong to those people who can function holistically and that healthcare is urgently looking for practitioners who can deliver empathetic and compassionate care. In his 2008 keynote address, senior futurist, Jonathan Peck, also challenged pharmacy educators to produce “holistically oriented healers, knowledgeable about the whole person with whom they soon will be establishing healing relationships” [4].

Inspired by the humanistic work emerging in medicine and nursing education, Vogt and Finley at the University of California at San Francisco (UCSF) School of Pharmacy developed an elective course that utilizes stories and reflective techniques to create exploratory experiences for students centered on basic elements of compassionate care. Introduced in 2006, the course was designed to reach beyond the biological aspects of the traditional curriculum to explore the complex, psychosocial human issues encountered in clinical pharmacy practice and patient care. The session topics are: (1) Tending to Patients (listening with heart); (2) Tending to Ourselves (care of the practitioner); (3) Tending to Life Changes (loss of control, illness, and death); and (4) Tending to Meaning (in life and work). In the course assessment three themes emerged from both the instructors’ observations and student feedback: (1) Increased recognition for the value of communal support (among students and faculty); (2) An experientially grounded basis for personal growth and professional formation; and (3) Deeper insight into and experience with the pharmacist’s role as compassionate listener and caregiver [35]. Other innovative elective courses in pharmacy education are being introduced that incorporate a greater emphasis on patients’ illness experiences, including course delivery via online media, online class chat sessions and asynchronous discussions, while drawing content from literature in the humanities, film, drama and television [36].

As experiential learning opportunities within pharmacy curricula increase in the United States, there is an emerging interest in utilizing reflective learning to optimize both introductory and advanced student experiences, in accord with the guidelines of the Accreditation Council on Pharmacy Education. The panel producing the 2013 Educational Outcomes report from the Center for the Advancement of Pharmaceutical Education (CAPE) notes that the updated outcomes were “intentionally expanded” beyond knowledge and skills to include the affective domain, to reflect and validate the significance of these professional skills and personal attributes, bridging foundational science with essential skills for patient care [37].

Further evidence of this interest in affective learning to prepare student pharmacists for an increased humanistic/compassionate approach to patient care could be found at the 2013 AACP Annual Meeting which held a well-attended Special Session on “Developing Reflective Practitioners through Reflective Learning.” The session featured faculty from several schools sharing their approach to this developing knowledge base in pharmacy education [38].

3. Discussion

Integrating humanistic skills into pharmacy education and designing curricula for compassionate patient care raises timely questions for pharmacy educators.

- Is it possible to reclaim the therapeutic roots of pharmaceutical care and rediscover the skills that confer the ability to fully attend to our patients?

- Beyond delivery of the compendium of current knowledge and information in educating future pharmacists, how do we frame, and legitimize the humanistic ways of knowing?
- And finally, how do we engender and nurture these humanistic skills in our students so that they are able to listen empathically and attend to their future patients with compassion? Further, how do we engender these skills in our faculty who will role model these practices for their students?

4. Conclusions

As in medical and nursing learning models, instructional techniques in structured reflective learning incorporated into pharmacy curricula can catalyze global change throughout pharmacy practice and support interprofessional education. By constructing curricula that integrate techniques and learning experiences into the training of our future health care professionals, our professional schools can function as the incubators for reinvesting in healing, and a better understanding of the healing process. To achieve diffusion, by integrating these instructional techniques into the current pharmacy curricula, the change is catalyzed for future pharmacists. Students exposed to more empathic, compassionate, holistic care recognize that pharmacists are “the medicine” too.

We ask, what would serve as the best incubator for advancing studies that push the boundaries of the current medical model to incorporate the humanistic elements of healing and well-being? In a world wedded to evidence and science, why does research related to these critical aspects of health care delivery and education remain largely on the periphery? More to the point, what are the barriers preventing us—as pharmacy educators—from aggressively moving forward with integrating effective learning using reflection, compassion and a holistic approach to patient care? We propose that these questions deserve our urgent consideration.

Conflicts of Interest

The authors declare no conflict of interest.

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