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Relationships Reconsidered: Reflections on the Pharmacist-Patient Covenant

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Introduction

The pharmacist-patient relationship has changed over the last 30 years from one in the which the focus of pharmacists was filling prescriptions without questioning a physician's order to one in which pharmacists recommend drug therapy to prescribers and offer personalized advice to patients on how to maximize the benefits of medication. A revision of the Code of Ethics for Pharmacists of the American Pharmacists Association was adopted in 1995 and reflects this change of the nature of the pharmacist-patient relationship. The primary purposes of the Code described in the preamble are to "state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists" and to "guide" pharmacists in relationships with patients."[1] The first purpose is important in that any sort of declaration by a profession establishes public expectations. The second purpose, to guide pharmacists in their relationships with patients, is perhaps even more important as the nature of the relationship shapes, consciously or unconsciously, the identity of every pharmacist.

In a very specific way in the first tenet of the Code, the relationship of the pharmacist and patient is described as a covenant – "A pharmacist respects the covenantal relationship between the patient and the pharmacist."[1] The central argument of this lecture is that the symbolic language of covenant, the metaphor used to describe the pharmacist-patient relationship, should be formally acknowledged as an ideal theory or concept. If so, then transitional structures could be developed to move the pharmacy profession toward the ideal of a covenantal relationship. However, before committing to this particular ideal, there should be resonance with the realities of pharmacy practice. I will briefly note here and argue later that the intimate nature of a covenantal relationship does not seem the best fit with most contexts in which pharmacists practice. This disconnection between the ideal of the covenantal relationship and context is important because as the International Federation of Pharmacist's (FIP) Statement of Professional Standards notes, "The code of ethics will therefore apply to pharmacists in all practice settings."[2] FIP does not comment on the nature of the pharmacist-patient relationship.

Why is this type of reflection on the nature of the relationship to the patient important to the profession of pharmacy? There are several reasons but I will offer only two here. The first touches on the basic purpose of pharmacy which is to "optimize medication use and improve patient health."[3] My assumption is that the purpose of pharmacy is achieved through the establishment of a pharmacist-patient relationship. It is the process or means whereby pharmacists carry out the purpose of pharmacy. So, it is important to be clear about the nature of this relationship. As Zlatic notes, "Nomenclature sets up paradigms that govern our thinking, actions and structures."[4] In fact, the words we use to describe the relationship create reality and responsibilities which leads to my second reason that a reflection of this type is important. Since "covenant" is the foundation, touchstone or bedrock for the pharmacist-patient relationship the concept creates obligations, helps identify where those obligations begin and end, and requires certain actions to fulfill such obligations. There are numerous conceptual models to describe the relationship between patients and health professionals and exploring alternative models can offer insights into how the relationship and expectations of those involved differ.

The lecture will proceed in four stages. First, I will briefly sketch the history of the concept of covenant to describe the health professional-patient relationship in general and in pharmacy. Then I will consider the largely unquestioned adoption of covenant as the foundation of the relationship between pharmacist and patient, what it requires of pharmacist and patient in "ideal" terms and contrast it with other types of relationships such as "fiduciary" or "contractual" and why that matters. Third, I will reflect on the impact and influence of context on the ideal relationship between pharmacist and patient using the context of community pharmacy and note the barriers to the covenantal concept. Finally, I propose ways to work toward transitional structures to the ideal of covenant as well as alternate conceptualizations of the pharmacist-patient relationship.

Preludes to the Adoption of Covenant as the Foundation for Pharmaceutical Care

The introduction of the concept of covenant in pharmacy starts with the seminal work of Hepler and Strand in 1990.[5] Prior to that, covenant, as applied to health care, can be traced to two theologians, Paul Ramsey and William F. May. Ramsey noted in his foundational work, "The Patient as Person," in

1970 that "canons of loyalty (such as the pharmacist-patient relationship) are particular manifestations of canons of loyalty of person to person generally"[6] Ramsey then uses the term covenant, a term with biblical roots, stating: "We are born within covenants of life with life" and finally asks "What is the meaning of faithfulness of one human being to another in every one of these relations?"[6]

May followed this train of thought in 1975 and focused this general call to health professionals to be faithful in their relationships with patients to the specific relationship between physicians and patients. In an oft cited article, May contrasted a variety of foundational concepts for such relationships such as code, covenant, contract and philanthropy.[7] May draws a distinction between a professional code and a covenant. Codes are more focused than covenant on shaping behavior through habits and rules of a profession. For example, one should do this, one should not do that. He argues that codes do not "encourage personal involvement with the patient."[7] Covenants, on the other hand, are more internal-oriented. A covenant includes the following elements: "1) an original experience of gift between the soon-to-be covenanted partners; 2) a covenantal promise based on this original or anticipated exchange of gifts, labors or services; and 3) the shaping of subsequent life for each partner by the promissory event."[7] There is a reciprocal sense of indebtedness that helps level the inequities within the relationship, i.e., the neediness of patients vs. the expertise and self-sufficiency of health professionals. If we think about this concept in regards to pharmacy, we can see that some of the elements could apply. It is clear why patients need pharmacists. It is harder to see why pharmacists need patients. Pharmacists need patients to be pharmacists. Pharmacists also learn from patients what it means to be ill, injured, or dependent on medication to survive. The pharmacist is obligated to fulfill the requirements of the covenant regardless if the terms of the relationship are made explicit.[8] It is a promise to every patient.

A third type of relationship that May explores is a social contract which is external to the person and is closer to the elements of informed consent than just putting blind trust into a health professional. May is generally not in favor of a social contract model for health professional-patient relationships, but I think that the model has merits that are worth exploring by the pharmacy profession. Social contracts contain components that respect the dignity of those involved. There is an exchange of information and an

agreement is reached that includes rights, duties, conditions and qualifications.[7] There is legal recourse if something goes wrong. A contract model presupposes that there is self-interest on both sides and so a good contract works to the individual advantage of the parties involved. On the down side, contracts reduce any obligations outside of the stated agreement which can lead to minimalism on the part of the health professional. Since health care is unpredictable, patients would likely be in favor of less stringency in what the health professional will and will not do. Contracts could also lead to defensive practice by following the letter of the law and no more.

A distinction should also be made between a covenantal relationship and a fiduciary one. There is considerable muddling of the terms "fiduciary" and "covenantal" in the pharmacy literature. A fiduciary relationship has legal and business implications. In a fiduciary relationship, "one person places complete confidence in another in regard to a particular transaction or one's general affairs or business. The relationship is not necessarily formally or legally established as in a declaration of trust, but can be one of moral or personal responsibility, due to the superior knowledge and training of the fiduciary as compared to the one whose affairs the fiduciary is handling."[9] There is no mention of an exchange of gifts or mutual benefit. Those with superior knowledge in such relationships have the upper hand and thus bear the obligation to respect the trust placed in them. The one whose affairs are being handled is in the less powerful position.

Hepler and Strand relied on May's work in their definition of pharmaceutical care and only a few years later, the concept appears in the revised Code of Ethics for Pharmacists. There is no direct or indirect statement in the Code as to whether the covenantal relationship is an ideal to which the profession of pharmacy should aspire or a confirmation of fact. The Code of Ethics reads as if affirming the present state that requires pharmacists to respect the "covenantal nature" of the relationship.[1]

In other words, there is a lack of clarity regarding the concept of covenant. Members of the pharmacy profession, or any profession for that matter, should know whether they are aspiring to an ideal or not. Second, if covenant is an ideal, there should be a connection to the lived experience of those who must carry out professional duties and the ideal.

Acceptance of the Covenantal Concept as the Foundation of the Pharmacist-Patient Relationship

There is considerable evidence that the covenantal relationship has been uniformly adopted in textbooks, classrooms and clinical settings in pharmacy education and practice. References to the covenantal relationship are everywhere in the pharmacy literature especially in the areas of professionalism and ethics. For example, almost any reference to the Code of Ethics includes a reminder that the Code "stresses the covenantal relationship with patients"[10] while others include it in the very definition of professionalism as in "the goal of professionalization is to develop the characteristics of being a professional (ie, technical knowledge, accountability, covenantal relationships, etc.)."[11] Some go so far as to say "the covenantal relationship is the essence of all professional relationships. . . "[12] Still others place the covenantal relationship as the hub of professional activities of the pharmacist stating, "If one lacks the core value of the covenantal relationship then all other professional behaviors will lack strength and substance."[13]

There are often references in the pharmacy literature to the Code of Ethics as a source for guidance in the resolution of a practical ethical or professional problem and thereby the ideal of the covenant is also applied. There are many examples in the pharmacy educational literature where students are asked to apply the Code of Ethics to a case or scenario and reason to what course of action should be taken.[14-15]

Despite the number of references to the covenantal concept, there is a paucity of reflection, criticism or questioning in the pharmacy literature on the appropriateness of this ideal concept for pharmacy. Is it prescriptive or descriptive? Fitting or frustrating? It is helpful to recall here that a key requirement of a code and the ideal upon which it is built is that it must apply to all pharmacists in all practice settings. Thus, let us turn to the context of the pharmacist-patient relationship to explore these questions of general applicability and fit.

Impact and Influence of Context on Relationship

Pharmaceutical care grew out of academic medical centers and academic pharmacy so it follows the covenantal concept fits best in this practice setting as it would in contemporary free-standing

pharmacies that focus on medication therapy management (MTM). The context in which pharmacists are best equipped to provide MTM brings us closer to realizing covenant because there is access to broader and consistent information about the patient's health status that extends beyond medications, the opportunity for multiple interactions with the team to gain more knowledge about aspects of a patient's life that will have implications for MTM, and time to build trust. However, most pharmacists practice in community settings. What does the pharmacist-patient relationship look like in the community pharmacy setting? Consider a standard pharmacy ethics case that describes an interaction in a community pharmacy:

Mary Phillips, Pharm.D., prided herself on her ability to keep in touch with her patients. Dr. Phillips had known Cora Jackson for many years. Mrs. Jackson picked up the prescriptions for herself and her husband, Jake, on a regular basis. Dr. Phillips noticed that this past month Mrs. Jackson asked for the refill only of her husband's antihypertensive drug, furosemide. Dr. Phillips asked Mrs. Jackson if her prescription for chlorthalidone had been discontinued or changed by Mrs. Jackson's physician. The patient replied, "Oh no, I haven't been to see Dr. Williams. We, that is Jake and I, just decided to cut some corners. You know how expensive these drugs are, especially mine. So, we decided to just get one blood pressure prescription filled, and we'd share. Jake's was less expensive, and one pill is as good as another. I just split the pills in half. We don't have enough money to get both prescriptions filled and still pay the heating bills."

Dr. Phillips knew that her own heating bills had risen substantially in the subzero weather. She also knew that Mr. and Mrs. Jackson were literally on a fixed income. Dr. Phillips felt that she should try and persuade Mrs. Jackson to give higher priority to health. As a pharmacist, she also knew that splitting pills in half was not appropriate and would probably not do any more good than not taking any medication at all. Yet, Dr. Phillips recognized that the health and comfort of Mr. and Mrs. Jackson depended on adequate heating.[16]

Chambers argues that "Stories of moral dilemmas, like all narratives, are constructed from a specific point of view, which persuades us to see the events in a particular manner."[17] Consider the various aspects

of the case that frame the nature of the relationship of the patient and the pharmacist in light of covenant. In this instance, the point of view in the case is the pharmacist's. We are seeing the world through Mary Phillip's eyes and she is someone who "takes pride" in keeping in touch with her patients. She knows things about them and their lives that can and do have an impact on MTM and their overall well-being. She knows their drug history; she notices a change and asks about it. Mrs. Jackson trusts Dr. Phillips enough to tell her about their scheme to save needed money and why. Dr. Phillips is concerned about this risky plan and begins to weigh the benefits and harms in the situation, a clinical and ethical calculus. Dr. Phillips might or might not have been prompted by the pharmacy's computer to ask about Mr. Jackson's refill, but it is the trusting relationship that has already been established that causes Mrs. Jackson to answer candidly. Most of the elements of a covenantal relationship are here. There is an exchange of gifts of trust and confidence from the patient and in return the competence and care from the pharmacist. The case affirms through its choice of words and "back story" that Mary Phillips is a "good" pharmacist who cares enough about her patients to get to know them, maintain an open and trusting relationship over time, takes time, a precious commodity, to talk to them when they are in the pharmacy and asks questions that are specific to the needs of this patient now. She also understands about the high cost of heating bills as she too must pay more to heat her own home, an insight that speaks to mutuality. This case is a good example of how perspective and voice affects the reader's vision of the pharmacist-patient relationship.

In contrast, the real world of community pharmacy practice is different in several ways from the one in which Dr. Phillips and Mrs. Jackson engage. Real community pharmacies are full of barriers to the ideal of covenant such as lack of consistent and complete patient information, lack of patient understanding of the expertise of the pharmacist, and lack of privacy and time for exchange of personal and professional information. It is also confusing in a community setting as to which obligations take priority when there are conflicting duties to one's employer and prescribers. Patients often don't make this any clearer or easier in that they use several pharmacies and see multiple physicians. Pharmacists must also deal with a variety of payers and regulations. Pharmacists spend considerable time navigating

these multiple barriers to just get the right drug to the right patient with appropriate payer approval. Is there any way, given these impediments, for pharmacists to know patients well enough to attain the ideal in which patients "exchange the gifts of information about their health with the expertise of the pharmacist?"

The next ethics case regarding a common interaction between a patient and pharmacist highlights the challenges to the development of a covenantal relationship in community pharmacy practice.

Dan Mac, Pharm.D., the manager of a community pharmacy, sighed when Nancy Roeggenbach handed him a manufacturer's "coupon" for a $4 co-pay for Drug X. Right away he knew that filling Ms. Roeggenbach's prescription would take more time in an already busy day and that this new prescription would cost her more. The small print on the back of the card confirmed the way it worked: Dr. Mac would run the prescription through Ms. Roeggenbach's insurance to find out how much her cost would be, then he would run it through with the coupon code, which should take $126 off her $130 co-pay. Dr. Mac had seen this before; most insurance plans did not cover brand-name Drug X, and it was going to cost Ms. Roeggenbach more than the stated $4 co-pay if she wanted it today.

Ms. Roeggenbach had been taking delayed-release diclofenac and was doing well on that regimen when he last spoke to her. Delayed-release diclofenac was on the pharmacy's $4 list, so she was only paying $4 per month for her medication now. He wondered why there had been a change to Drug X. Dr. Mac now had to submit a claim to her insurer and another one to the drug manufacturer.

As he ran the prescription for Ms. Roeggenbach through the computer, Dr. Mac saw that despite the advertised $4 co-pay, her cost was going to be over $450 if she wanted it today. This was a great deal more than $4. Her insurance required preapproval because of the availability of generics.[16]

Dr. Mac is faced with opposing obligations here to the patient, the prescriber, the pharmacy, the manufacturer, and the insurer. It is no wonder that Dr. Mac sighs at the outset of the case. The context and facts of the case place Dr. Mac in a situation where it is difficult to discern what it means to do what is best for this patient. In this case, the pharmacist knows the patient somewhat, but doesn't know why the

drug has been changed. He might assume that the patient thought she was getting a newer, better drug for no more than what she had been paying. Maybe she found a coupon on-line or a friend told her about the drug or she saw an ad on television. We also don't know why the physician changed the prescription of if he or she knows anything about the cost of the drug, coupons, or any of this complicated structure to shift patients to newer, more expensive products. Clearly it is more work for the pharmacist which takes time away from other beneficial activities. Additionally, the movement to more direct patient care such as immunizations, lab work, and chronic disease monitoring brings pharmacists in closer proximity to patients. The increasing intimacy of pharmacist and patient is yet another reason to be clear about the nature of that relationship.

As we move to other settings in which pharmacists practice, we can start to see how the concept of covenant is further stressed or stretched when context is considered. For example, specialty pharmacies and other types of settings often include interactions that occur at a distance with patients and prescribers. What sort of compensatory skills must a pharmacist possess for the lack of face-to-face interaction to build trust and establish relationships? In some of these settings, the need for a trust-based relationship is perhaps higher given that specialty pharmacies, for example, were developed to deliver generally expensive, difficult to administer drugs or drugs with serious side effects and adherence problems.

Possible Ways to Work Toward a Clearer Understanding of the Pharmacist-Patient Relationship

One needs the ideal theory so one has a clear vision of what the ideal outcome should look like. In other words, the ideal should have "logical priority" but not "temporal priority."[18] If the pharmacy profession hopes to reach the ideal of the covenantal relationship over the long term, then the profession should focus first on recognizing and evaluating changes that may be achievable under the current contextual realities of pharmacy practice.[18] To that end, we can turn to non-ideal theory that envisions mechanisms for moving pharmacists and their clinical circumstances toward a practice environment and structures characteristic of the ideal. Think about the ideal theory or concept as the summit of a very tall mountain and the non-ideal theory as the camps placed strategically at the base and up the mountain. In

that manner, the mountain climbers can measure their progress toward their goal of attaining the summit. Also, they have a place to return to if the distance between camps is too far. Another aspect of this metaphor that is very helpful is that you should be as certain as you can that this is the mountain you want to climb.

Briefly, here are some ideas for transitional mechanisms that could affirm the ideal and support the move toward it. Any work of this type should be undertaken by representatives of the profession from a broad array of pharmacy settings. Additionally, the involvement of students and patients, perhaps patients who commonly use the services of specialty pharmacies, in such an endeavor would shed some light from the perspective of future pharmacists and recipients of care. Such a task force or blue-ribbon panel could start by launching an effort to identify the concrete features of the actual relationship of the pharmacist and patient in representative settings. This would allow us to see commonalities. Such data would help determine the gap between the ideal and the real. Perhaps a set of fundamental obligations could be established as the basis for the relationship that grows more complex with the involvement of the pharmacist in direct patient care, i.e., more will be expected of the pharmacist in relationship with the patient as the stakes escalate. Finally, changes to the structural environment in which pharmacists work and its impact on movement toward the ideal relationship should be explored. As Dikun et al. note, pharmacy should consider "the importance of the pharmacists' environment to the successful provision of advanced patient care. This lack of attention to the work environment may stem from 'individual blame bias' wherein all the responsibility for not providing advanced patient care falls on pharmacists, rather than on the system of which they are a part."[19]

A totally different approach is for the profession to choose another mountain to climb. In this approach, alternative ideal theories or conceptual models could be explored such as social contract as previously described or a therapeutic alliance that inspires trust, encourages open communication, and values the patient as an equal partner in therapeutic decisions.[20] The pharmacist's role could also be envisioned as a mediator,[21] protector, or advocate all rich metaphors that offer promising alternatives to describe the complex nature of the pharmacist-patient relationship.

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