

# Pharmacist's perspective on providing care when patients engage in unhealthy behaviors

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## Abstract

**Objective:** To assess the association between unhealthy lifestyle-related behaviors in patients and the pharmacist's professional obligation for providing care.

**Design:** Surveys with repeated measures ANOVA.

**Setting:** Four live continuing education programs on law and management conducted in the state of Florida.

**Participants:** 488 Florida pharmacists were surveyed with 65% completing the survey.

**Main outcome measures:** Pharmacists' opinions based on lifestyle-related diseases classified as follows: low lifestyle-related disease (low LD): nonsmoker with asthma who is adherent with asthma medications; moderate (mod) LD: nonsmoker with asthma who is nonadherent with asthma medications; high LD: smoker with asthma who is adherent with asthma medications.

**Results:** The difference between the scales for measuring professional obligation for low and mod LD was significant, with pharmacists reporting greater professional obligation for low versus mod LD. The difference between professional obligation for low and high LD was significant, with pharmacists reporting greater professional obligation for low than high LD. The difference between professional obligation for mod and high LD was significant, with pharmacists reporting a higher professional obligation for mod than high LD.

**Conclusion:** The differences in professional obligation between the three patient scenarios were small but statistically significant. The findings suggest that certain patient behaviors, such as smoking or medication non-adherence, can have a negative effect on pharmacists' sense of professional obligation to the patient.

**Keywords:** Professionalism, professional obligation, lifestyle disease, pharmaceutical care, nonadherence.

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Society may argue that health care professionals have a Hippocratic duty to their patients and that this responsibility shall focus solely on what is best for the patient regardless of the consequences to the interests of others. The covenantal relationship between the health care professional and the patient is the essence of professionalism. This view is supported by the Code of Ethics ("the Code") of American Pharmacists Association, which states in part that "a pharmacist promotes the good of every patient in a caring, compassionate and confidential manner." Although developed not to be a rigid prescription of behavior, the Code conveys that pharmacists have an ethical obligation to do whatever they deem necessary in the interest of their patients, and, specifically, that the "pharmacist serves individual, community and societal need."

However, in practice, the pharmacist's ethical obligation to patients may be different than those prescribed in the Code. Some pharmacists, as a matter of conscience, may hold a view that pharmacists should not be ethically obligated to provide care to certain patients, such as those who choose to engage in unhealthy behaviors (e.g., smoking tobacco or not being adherent to medications). Thus, we are faced with the question of whether it is ethically permissible for a provider of health care to refuse or provide less care to patients with lifestyle-related diseases.

For the purpose of this paper, lifestyle-related diseases are defined as diseases in which the patient has engaged in behaviors directly or indirectly leading to worsening of a disease or condition.

## Objective

The primary goal of this study was to assess whether the presence of a lifestyle-related behavior that may contrib-

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ute to disease in patients is negatively associated with the pharmacist's professional obligation for providing care to those patients.

### Methods

The study was approved by the University of Florida's Institutional Review Board.

A survey was administered to pharmacists attending four live continuing pharmacy education programs on law and management in the state of Florida.

The survey (see Appendices 1 and 2, supplemental content available on JAPhA.org) consisted of three scenarios in which patient experiences with a drug-related morbidity were described. Each scenario consisted of specific information about a patient, including diagnosis, prescription medication, and refill history. The patient scenarios were developed with the assistance of an expert panel and were pilot tested to show that they represented different levels of lifestyle-related disease. The scenarios were designed to simulate realistic situations in which pharmacists would find themselves and in which they would be faced with decisions regarding identifying, resolving, or preventing a drug therapy problem (a full description is provided elsewhere).<sup>1</sup> Each scenario was presented as a hectic day in the pharmacy in which the pharmacist had limited time.

For the purposes of this study, the study variables were defined and operationalized as described below. Lifestyle-related diseases were classified as follows: low lifestyle-related disease (low LD): nonsmoker with asthma who is adherent with asthma medications; moderate (mod) LD: nonsmoker with asthma who is nonadherent with asthma medications; high LD: smoker with asthma who is adherent with asthma medications.

### Situational factor

This variable was defined as the extent of the severity of lifestyle disease. The level of lifestyle disease was presented within patient scenarios that varied from low lifestyle disease (adherent with medications, nonsmoker with asthma) to moderate lifestyle disease (nonadherent with medications, nonsmoker with asthma) to high lifestyle disease (adherent with medications but a smoker with asthma).

### Professional obligation

This variable was defined as the extent to which pharmacists perceived they had a professional obligation to identify, resolve, or prevent a drug therapy problem. Professional obligation was measured on a 4-point scale (strongly agree, somewhat agree, somewhat disagree, strongly disagree) with the following items: "As a pharmacist, I have a professional obligation to help resolve the patient's drug therapy problem(s)."; "I will feel guilty if the patient's drug therapy problems interfere with her/his asthma therapy outcomes."; "As a phar-

macist, I am professionally obligated to ensure that the patient's drug therapy problem(s) is (are) resolved."

These three items were used to create a summated measure for professional obligation for each scenario. Possible range of the summated scores ranged from 4 to 12.

Variables such as time pressure and work environment were noted in the scenarios as to reflect a very busy day in the pharmacy (Appendix 2, supplemental content available on JAPhA.org).

### Data Analysis

The study tested whether increasing severity of lifestyle disease had a negative effect on professional obligation. Repeated measures ANOVA was used to examine the effect of severity of lifestyle disease on professional obligation. The alpha level was set at  $\alpha = 0.05$ . The model showed normality with a slight skew to the right. As such, the normality of the data for the models was adequate for the statistical models analyzed.

To determine the necessary sample size for repeated measures ANOVA comparing the means of three groups, an effect size of 0.25 was chosen, and a power of 0.8.<sup>2</sup> The minimum sample size needed was calculated as 128. An effect size of 0.25 was chosen based on consideration of recommendations by Cohen.<sup>1</sup> Cohen considers an effect size of 0.2 as typical in new areas of research inquiry.

### Results

A full description of the establishment of the pretest and reliability and validity of the survey instrument is reported elsewhere.<sup>1</sup> For testing the hypothesis that increasing severity of lifestyle disease has a negative effect on the pharmacist's professional obligation, a total of 488 pharmacists were surveyed at the four Florida continuing education programs. A total of 318 surveys were returned for a response rate of 65%<sup>a</sup> (Table 1). The repeated measures ANOVA results of testing the hypothesis are shown in Table 2.

The difference between the mean of the summated scale for scenario low LD and scenario mod LD was significant at 0.245 (10.898 and 10.653, respectively;  $P = 0.009$ ). The difference between the mean of low LD and high LD was significant at 0.570 (10.898 and 10.328, respectively;  $P < 0.0001$ ). The difference between mod LD and high LD was significant at 0.325 (10.653 and 10.328, respectively;  $P < 0.0001$ ).

As such, there were statistically significant differences between the pharmacists' sense of professional obligation when presented with patients with the same disease (asthma) but varying levels of lifestyle-related conditions. Pharmacists had the highest sense of professional obligation for the patient with asthma who was a nonsmoker and was adherent with therapy. Pharmacists had the lowest sense of professional obligation for

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