

Communication in Pharmaceutical Care: Strategies for a Dialogue

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Abstract

Given a new philosophy of practice, pharmaceutical care regains a more social role for the pharmacist, breaking with the traditional model focused on the medication and instead focusing on the patient. A greater inclusion of the professional in the collective scenario of health care is thus attained. However, various barriers impede the full implementation of this new professional practice in the Brazilian health system. It has been noticed that professionals need to rethink their practice, admitting the importance of others (the patients) in the co-construction of health care. To this end, the pharmacists need strive for professional development (especially in the relational context) to help them take on this new type of care. In this respect, social constructionism figures as a strategic tool for realizing care and a relationship more inclusive and participatory through the creation of relational environments.

Key words: *pharmaceutical care, communication in health, social constructionism, health care, pharmacist, Brazil.*

Context

Pharmaceutical care is a practice in which the professional assumes responsibility for each patient's specific health care needs. Developed within the pharmaceutical profession, the philosophy of pharmaceutical care describes a patient-centered method with the objective of taking care of all of his or her necessities with regard to drugs in order to guarantee reaching the pharmacotherapeutic purposes and obtaining positive results (Cipolle, Strand and Morley 2006).

In the 80s, there arose a new technological model for pharmaceutical services, which aims at offering a direction and extending the pharmaceutical professional's work to a philosophy of practice that is professionally committed to the patient's care. In 1990, this discussion solidified with the publication of the article "Opportunities and Responsibilities in Pharmaceutical Care," in which Hepler and Strand (1990) defined pharmaceutical care as: "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patients' quality of life."

In Brazil, discussions about this new professional practice culminated with the publication of a consensus proposal for pharmaceutical care (Organização Pan-Americana da Saúde and Organização Mundial da Saúde 2002), where a number of compatible concepts were brought together in order to consolidate this practice. According to this document, pharmaceutical care must be developed within the context of pharmaceutical assistance, with a view to the overall integrity of health care.

Under this new practice, the focus of care has been shifted from the medication to the patient. This change demands great challenges, and innumerable obstacles are faced by pharmacists who view pharmaceutical care as the principal element of their professional life.

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As the pharmaceutical care proposal implies social practice, it is exactly in the construction of these relations (therapeutic and human) that pharmaceuticals meet their biggest challenge. Despite the various advances in the curricular syllabuses of pharmacy courses, we still find gaps in the humanistic education of pharmacists. Therefore, professionals must

constantly search for the development of such abilities for the consolidation of social practice and not just an individual one.

The Obstacles to Pharmaceutical Care

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development of pharmacists more committed to drugs than to patients.

Furthermore, in spite of the current recognition and prominence that pharmaceutical care receives, the paradigm change, in practice, still requires some planning. The initial impasse is found in the very education of the professional. The current pharmaceutical curricula

and the marketplace itself are not ready for this new clinical and humanistic pattern.

In Brazil, the pharmacist's clinical practice does not stand out, be it in pharmacotherapeutic assistance, prevention, or care-giving. And receives little professional recognition in the field, neither by the health-care community, nor by society at large (Organização Pan-Americana da Saúde/Organização Mundial da Saúde 2002).

Pharmacists consider themselves inexperienced, little stimulated to develop this approach (Oliveira et al. 2005). According to Araújo (Araújo and Freitas 2006), pharmacists are conscious of their (re)positioning as health professionals and of the redefinition of the objects with which they work. However, it has been noticed that there is still a great deal of intention and precious little practice. Despite the situation, still incipient, of pharmaceutical care in Brazil, great strides have already been made. But there is still a lot to be done.

One of the main barriers is the positivist emphasis on the knowledge and health-illness process that some pharmacists maintain (Williams, 2007). The ideal context for pharmaceutical care requires an environment sustained by shared knowledge and commitment to solidarity (Cipolle, Strand and Morley 2006). The proposed approach does not anticipate highly specialized knowledge, but a social practice. In this sense, no one knows more or less than anyone else. Faced with this truth, neither pharmacist nor patient should fear the new possibilities since they won't be built or based on the knowledge possessed by either one. Knowledge must emerge from the professional-patient relationship based on the contribution that each makes.

Pharmacists have to rethink their knowledge and practices with the objective of rediscovering themselves professionally. The concept of pharmaceutical care must be expanded not to a mere relationship of exchange with mutual benefits in which the patient delegates authority to the pharmacist and he or she provides competence and commitment to the user, but rather provides health care based on the "relational space" built between the two of them.

Social Constructionism and its Contribution to Pharmaceutical Care

In terms of knowledge production, the constructionist proposal is to produce theoretical constructs that support human-action coordination based on socially legitimate values and conventions, as well as promote various criticisms to social conventions, either through criticism of scientific practice or of other cultural practices, or even criticism that leads to a general break with the conventional. Thus, social constructionism invites us to try new possibilities of social interaction and emphasizes the relational responsibility of researchers, questioning their rhetoric concerning “the truth,” and the authority they intend (McNamee and Gergen 1999, Rasera and Japur 2005).

The rise of social constructionism dates from 1973 with the publication of the article “Social Psychology as History,” by Kenneth Gergen (Rasera and Japur, 2007). The creation of this movement is corroborated by criticisms of mainstream scientific approaches, along with an alternative conception of the presuppositions by which individuals attain knowledge (Rasera and Japur 2005). The social constructionist perspective visualizes knowledge and research activity itself as a social practice, a product of history and dialog, centered on language and its related processes (Camargo-Borges and Japur 2005).

Rasera and Japur (2005) reports great difficulty in determining a singular group of ideas that postulate all constructionist premises, yet still the authors describes an ideological consensus found around four central descriptions presented below:

- (1) The cultural and historic specificity of ways of knowing the world.
- (2) The priority of human relations in the production and sustaining of knowledge.
- (3) The interconnection between knowledge and action.
- (4) The valuation of a critical and reflective posture (Gergen 1985, Rasera and Japur 2005, Rasera and Japur 2007).

These constructionist descriptions have a number of implications, some of which we can highlight here: anti-essentialism, anti-realism, language as a form of social expression, focus on interaction and on social practices, and focus on the process. Constructionist research does not describe what things are, but the process through which they are built. By according privilege to social interactions, knowledge is generated by social processes that build new realities.

Thus, social constructionism does not stand for just a theory that proposes techniques or methods for practical application, but something closer to a relational practice, a way to create conceptions of the world that are built up through dialog. For McNamee (2004), constructionism proposes specific therapeutic practices focusing not on the self, but on creating relational environments. With this in mind, constructionist theory’s articulation and practice of care are more of an invitation to *dialog* rather than a declaration of how things must be.

We come face to face with the weight and importance of social relations. We have observed in the practice of pharmaceutical care that it is not enough just offer a service with good technical quality in order to satisfy a numbers requirement and reach some desired results. The challenge, therefore, is bigger than expected: not only the advance in care, from drug-centered to patient-centered, but also the consolidation of a mutual and integrated pharmacist-patient work relationship that befit social and cultural specifications.

For social constructionism, production of meaning stands on different social practices in which people take part. And these practices are sustained by concrete relationships which people experience along the time (Camargo-Borges and Japur 2005). Therefore, the pharmacist-patient relation must strive for equalization and co-construction. The knowledge “brought to the table” by the pharmacist is not

hierarchically superior to that brought by the patient. The former does not possess superior knowledge over the latter, but simply holds different ways of being, of seeing health and the medications, and of describing situations. Setting their relationship in hierarchical stone leads to distorted visions between pharmacists and patients. It is not a matter of denying the differences and specificities of each one's knowledge, but taking into account the relational environment in which their knowledge becomes action.

Final Considerations

Taking this speech as a strategy for creating a relational space in pharmaceutical care, we propose an escape from a sort of oppression and a quest for healthy contradiction and reflection.

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care in general.

The construction of meaning for this new professional practice demands a new order. The emphasis is not only on effecting changes, but principally on creating a space for dialogue. To this end, there needs to be a relationship that transforms, a relationship in which new understandings are negotiated, as well as novel premises for pharmacists, patients, and pharmaceutical

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Endnotes

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