

# PART I

## Interpretation of the Health Problem and Need for Treatment

The first five chapters of *Social and Behavioral Aspects of Pharmaceutical Care* focus on individuals' interpretations of their health problems and their need for treatment. These five chapters focus on describing health and illness behaviors from both individual and societal perspectives and within the context of both the empirical and theoretical literature on health behavior and behavioral change. Chapter 1 defines health and illness behavior. To obtain a more global perspective on health and illness behavior, Chapter 2 explores the nature and frequencies of illnesses throughout the world. Chapter 3 builds on the first chapter by bringing together multiple theoretical concepts of how individual health and illness behaviors operate within the context of an individual's interaction with the social systems around him or her. Chapter 4 examines how individuals are affected by health and social systems that do not adequately meet their health needs. Chapter 5 investigates models of how individuals and communities can improve health behaviors that ultimately help meet the health needs identified in Chapter 4. These chapters connect with each other as building blocks for thinking about how individuals and social systems react and interact with one another in response to illness. Such multilevel foundations of health and illness behaviors are important for the pharmacy professional as a way to better understand the factors that affect the general experiences and opportunities of patients throughout the world.

## SECTION A

# Concepts of Health and Illness

### CHAPTER 1

Definitions and Meaning of Health and Illness

### CHAPTER 2

Social Epidemiology

## CHAPTER 1

# Definitions and Meaning of Health and Illness

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### THE GENESIS OF SOCIAL PHARMACY

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Arguably, no other health profession has been challenged with changes as profound and momentous as the profession of pharmacy in recent history. A significant transformation involving a professional shift in focus from the product to the patient has occurred, pharmacists have assumed new roles as patient care providers, and pharmacy education has faced formidable challenges subsequent to this evolution, particularly the transition to the doctor of pharmacy as the first professional degree.

A basic understanding of historical events that have shaped contemporary pharmacy education reveals edifying insights into the pharmacist's role in society today. Pharmacy educators formed the Millis Study Commission in 1975 in an attempt to align (or realign) pharmacy education with the contemporary drug-related needs of patients.<sup>1</sup> The commission set out to revise pharmacy curricula that were historically oriented to basic sciences and devise a road map to the profession's future. The Millis Commission, convened by the American Association of Colleges of Pharmacy (AACCP), had a significant impact on contemporary pharmacy education, and many believe that pharmacy education today has been shaped by the numerous recommendations of the commission. The commission was charged with addressing the perceived lack of "insight and foresight" in pharmacy education pertaining to the role of the pharmacist as an integral member of the healthcare team. In addition to the many recommendations related to the need for an outcomes-based pharmacy curriculum, student recruitment, and a six-year doctor of pharmacy degree as a first professional degree, the commission's recommendations were for "curricula with less knowledge of science and more knowledge of patients and well people."<sup>1</sup> De-emphasizing the basic science focus of pharmacy curricula while focusing more on knowledge about

how people make decisions about their health was deemed to be an important early step toward the differentiation of pharmacists while they are still students. Pharmacy education at the time was perceived to be all about drugs and not about people, an emphasis in stark contrast with the need for a qualified practitioner possessing the skills and knowledge necessary to identify, resolve, and prevent patients' drug therapy problems.

The patient-oriented view required pharmacy curricula to include topics such as the social and behavioral aspects of healthcare delivery and communication skills. Discussion about curricular change and the Millis Commission report coincided with the creation of graduate programs and a disciplinary focus area in the social and administrative sciences as they pertain to pharmacy. These social pharmacy programs deal with the full scope of problems of pharmacy and medicines in society.

## DEFINITIONS OF HEALTH AND ILLNESS

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Health and illness are central themes of human existence, with various definitions and interpretations spanning all cultures. Addressing concerns arising from ill health receives much attention in virtually every society around the world, and substantive resources are devoted to the education of health professionals. The *raison d'être* for any healthcare professional to practice in his or her respective field can be found in the very existence of health and illness along a continuum of definitions. In fact, the conceptualization of health and illness delineates the wide-ranging spectrum of practitioner activities across disciplines. Decisions about someone's healthcare needs, irrespective of who makes this determination, drive interventions. In the case of pharmacy, practitioner responsibilities can be found in the identification, resolution, and prevention of drug therapy problems, which should logically coincide with the focus of pharmacy education.

Given the universality, prevalence, and frequency of illness and disease for both individuals and society, it perhaps seems strange that they are considered to be abnormal conditions. One could argue, as René Dubos has, that disease and sickness are normal, whereas health is the abnormal condition.<sup>2</sup> However, it is socially necessary for each individual within a society to contribute to that society for the society to flourish. Thus, each person has one or more roles that define who that person is, what he or she does, and what is expected of him or her—for example, student, spouse, wage earner, parent. These roles have two characteristics of relevance to this discussion, namely, the societal expectations of an individual occupying a particular role and the reciprocal nature of any role.

A review of the literature reveals that definitions of health and illness vary largely on the basis of cultural background. *Disease* is a medical term, meaning there is a

pathologic change in the structure or function of the body or mind. The World Health Organization's 1947 definition of health, "a state of complete physical, mental, and social well being, not merely the absence of disease or infirmity," reflects this mechanistic view of the body in which ill health is treated as the mechanical failure of some part of one or more systems of the body and the medical task is to repair the damage.<sup>3</sup> At the same time, however, the definition expands the role of healthcare providers beyond the traditional role of treating disease.

*Illness* is the response of the person to a disease; it is an abnormal process in which the person's level of functioning is changed. Talcott Parsons's 1972 definition of *health*, "the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized," expands earlier definitions to address the social needs of individuals—that is, normal role functioning.<sup>4</sup> This shift from an individualistic toward a more collectivistic view of the effects of health and illness had far-reaching consequences for healthcare practitioners because they were no longer limited to treating disease but could engage in preventive measures.

## THE SOCIAL DIMENSION OF PHARMACY

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Just as individual actions collectively form and affect the society in which individuals live, so too society affects the actions of individuals. Sociology is the social science that examines the organization and mores of a society, and sociologists study a variety of issues with which pharmacy is concerned, such as professions and role theory.

Sociology is a social science focused on theory, whereas pharmacy can be viewed as a field of application, taking concepts and facts from other fields and applying them to practice. As stated earlier, pharmacy education has tended to focus on chemical and biological sciences, with little input from the social sciences. It was not until the mid-1960s that the seminal papers on social pharmacy topics were published in the pharmacy literature. Harding and Taylor discussed the social dimensions of pharmacy and pointed out that our actions as healthcare professionals are embedded in a social context. Societal change and increased risk averseness have prompted providers of health care to rethink their professional roles and define their activities as an "exemplar of social action."<sup>5</sup>

A major theme in sociology has been the process of becoming a patient. It has been suggested that the sick role be the focus of medical sociology. Certainly the patient may be considered as a central concept in any discussion of health care, the role of pharmacists, or medication use. Perhaps the best known and most cited characterization of the concept of "patient" is that of Talcott Parsons, a sociologist interested in social systems and the development of societies.<sup>6</sup> To oversimplify, all societies

consist of “actors” with multiple roles, each with a complementary role, adhering to a common or normative set of characteristics, and having reciprocal expectations. Each role has associated rights and obligations. The rights of a particular role are the responsibilities of its complementary role. There is some degree of tolerance for deviance from the norm. However, every society must have some means for enforcement of what Parsons calls the “societal normative order.” As stated earlier, it is socially necessary that each individual within a society contribute to that society for the society to flourish, and illness or sickness is a deviation from what is considered normal. Consequently, the sick role is a method of social control over illness as a deviant behavior. There are two rights inherent in the sick role: the right to not be responsible or blamed for the condition and the right to be excused from normal role responsibilities; the two obligations or responsibilities are to seek competent help and to “want to get well.”

Another sociologist, Edward A. Suchman, formulated illness behavior as consisting of five stages: symptom experience, assumption of the sick role, medical care contact, dependent patient, and recovery or rehabilitation (Table 1-1).<sup>7</sup> Each stage necessitates a decision by the “could-be patient” and illustrates the importance of the “lay referral” system, made up of family and friends, which constitutes the complementary role to the sick role.

At the symptom experience stage, the initial stage of illness behavior, the decision is made that something is wrong, or not normal. There are three aspects to this stage: physical experience, cognitive aspects, and emotional response. The most common physical experience indicating that something is wrong is pain. Cognitively, the experience is interpreted based on what the physical manifestations are, their severity, and the course they take, as well as previous personal experience or knowledge about the

**TABLE 1-1    Suchman’s Model of the Stages of Illness Experience**

1. Symptom experience
2. Assumption of the sick role
3. Medical care contact
4. Dependent patient
5. Recovery or rehabilitation

Adapted from Suchman EA. Stages of illness and medical care. *J Health Hum Behav* 1965;6:114-28.

signs. Symptoms are recognized and defined in terms of their interference with normal role functioning. The emotional response includes fear, concern, or anxiety. When symptoms are extremely severe, felt to be serious, and perceived to interfere with other role responsibilities, the most common first inclination is to seek medical care, with a smaller number considering self-medication. However, even then there is a tendency to delay seeking treatment and engage in self-denial, at least until one has discussed the symptoms with a layperson, typically a relative and most frequently a spouse.

Healthcare practitioners distinguish between signs and symptoms of disease. *Signs* are measurable changes of physiologic functioning and are detectable using diagnostic procedures, often involving medical instruments and diagnostic methods (e.g., stethoscope, glucometer). Many times, signs have little to no meaning to patients and may not even be noticed by them. *Symptoms*, however, are inherently subjective and not easily quantifiable. In most cases, patients will notice symptoms (e.g., pain, fatigue, nausea) as an expression of ill health, and a practitioner will seek to get a sense of the nature of the symptoms by asking the patient to, for example, rate pain during an examination. Healthcare professionals rely on patients reporting symptoms during an examination because they will use both signs and symptoms in formulating a hypothesis of a likely diagnosis.

An acute illness has a rapid onset of symptoms and lasts only a relatively short time, whereas characteristics of chronic disease often include permanent change to the body's functioning. Chronic disease causes, or is caused by, irreversible alterations in normal anatomy and physiology. Although a cure is possible in most cases of acute illness, chronic diseases tend to require special patient education for rehabilitation as well as long periods of care or support.

Symptom experience varies widely from individual to individual, as does the description of symptoms along the continuum of acute versus chronic conditions. A key determining factor is the "return to normal" and the ability to assume normal role functioning without permanent change. In most cases, chronic symptoms result in sustained changes in a person's life. In addition, patients will likely be able to communicate the underlying cause (disease) of which the symptoms are a consequence. This is in contrast to an acute illness, where patients are often unaware of the underlying cause of their symptoms and will in most cases rely on expert practitioners to combine signs and symptoms as evidence for disease.

The assumption of the sick role stage is when the individual makes the decision that he or she is sick. As the individual seeks information and advice and relief of symptoms, the individual's lay referral system is paramount because few individuals are sufficiently confident to decide on their own that they are sick. Also, consistent with Parsons's formulation, sickness excuses them from their normal role obligations

and imposes concurrent obligations on these significant others. Thus, the sick individual seeks permission (technically, “provisional validation” or “provisional legitimization”) from these individuals to be sick and excused from his or her normal responsibilities. In almost all cases, the sick individual follows the advice given by his or her discussant.

At the medical care contact stage, the sick individual contacts a professional within the healthcare system, seeking advice and permission to be sick from a “scientific” rather than a lay source, that is, an authoritative definition or diagnosis of his or her condition, a proposed treatment, and official sanctioning or “legitimization” to be sick. If legitimization is denied, the individual is expected to return to his or her normal role activities. This stage may continue if the sick individual is not satisfied with the initial physician’s diagnosis or recommended treatment; for example, the individual may begin to “doctor shop.” Interestingly, a significant minority of treated individuals indicate that they never received a diagnosis or prognosis from the physician. The most common treatment is medication, with the physician writing one or more prescriptions for the diseased or ill person.

At the dependent patient stage, a decision is made to transfer control to the physician and accept and follow the prescribed treatment. The most important aspects of this stage are that (1) only at this stage does the sick individual become a patient, (2) most patients believe, or claim, that they adhere to the physician’s treatment, and (3) the family and “lay referral system” continue to play an important role. Most patients do not accept the patient role easily because they are reluctant to give up their normal roles, but they may see that the only way to health and a return to these roles is to surrender their autonomy to the professional and lay caregivers. Also significant are the variety of barriers—social, administrative, logistical, psychological—that may easily affect the treatment process.

Of course, it is not always desirable to be assigned to the role of patient, or one who suffers from an illness. For example, until relatively recently homosexual individuals in the United States could be diagnosed with a mental illness. It was not until 1973 that the American Psychiatric Association voted to change the diagnostic system to allow homosexuality to be considered normal.<sup>8</sup> Before that time a diagnosed homosexual could be assigned to the sick role and consequently lose social rights and privileges. He or she could be committed to psychiatric institutions, arrested and detained as a “sexual deviant” for engaging in homosexual behavior, and so on.<sup>9</sup>

It is important for the student of pharmacy to recognize that the nature of sexuality did not somehow change in the early 1970s—rather, the social context and values surrounding sexual orientation changed. Homosexual orientation had been medicalized as an illness by Western clinicians for nearly a century, and some historians have argued



that this reflects a pervasive bias within Western medicine against nonconventional sexual expression.<sup>10</sup> This bias may have its origins in moral or religious values about what is “right” and proper, yet the values are expressed in the form of a clinical diagnosis. In this way, diagnoses can be used as a social tool to regulate behavior. The personal values of the clinician may intersect or even conflict with standards of clinical practice, as may be observed in the assertion by some pharmacists that their moral or religious values prohibit them from dispensing certain kinds of contraceptive medications.

The final stage of illness, recovery or rehabilitation, requires a decision to relinquish the patient role. Because of the patient’s desire (and responsibility) to return to health, this decision is generally easy in comparison to the necessary decisions at other stages. Also at this point, either or both the healthcare professional and the lay caregivers withdraw their legitimization of the patient’s right to be excused from normal role responsibilities, and the patient is expected to resume his or her old roles or, in chronic conditions or disability, accept a long period of convalescence or rehabilitation or a new role as an invalid.

Both Suchman’s and Parsons’s formulations have withstood the test of time during the last four to five decades. It must be noted, however, that Suchman validated his formulation based on a well-defined sample of people who had experienced a specific episode of illness and passed through all five stages. There is no requirement that all five stages be involved, nor are specific time frames associated with each phase, which may be brief or lengthy. Suchman pointed out that for the ill person, social concerns seem to predominate over medical or health concerns and that responses to minor illness would seem to be even more likely to be governed by social rather than medical concerns. Additionally, Suchman dealt with people with acute conditions or an acute episode of a chronic condition. However, Suchman also points out that individuals have a natural tendency to underestimate (dismiss, ignore, disregard, or deny) symptoms that are neither severe nor incapacitating. Because many chronic diseases are characterized by a lack of symptoms, or seemingly minor, virtually unrecognizable symptoms, they are more easily denied and people are therefore unlikely to seek early medical care.

Indeed, this same characteristic would appear to be an explanation for some types of nonadherence, together with the natural responsibility to want to return to a healthy status and normal role functioning. The classic example is high blood pressure and patient nonadherence to blood pressure medications that serve as a constant reminder that one is sick, despite the lack of overt symptoms.

The recovery and rehabilitation stage also holds special significance for those with chronic conditions. Because the ill person is expected to do everything possible to return to health, yet chronic conditions by definition mean that there is no cure, special

strain is put upon both the ill person and the lay caregiver. Frequently this seems to be resolved by a redefinition of what is “normal” for the afflicted individual. The classic example is patients with diabetes, who most frequently are able to control the disease with medication and, despite the continued reminders (regular medication, blood glucose readings) and relatively minor lifestyle changes (diet, exercise), generally are able to resume their previous social roles with only minor, if any, restrictions.

The sick role, as formulated by Parsons, carries within it an inherent potential conflict. The ill person has the right to be excused from normal role responsibilities while at the same time has the responsibility to seek competent help and do everything possible to return to health and resume normal role responsibilities. For some people, the care and attention they receive when sick, coupled with being excused from doing things they would normally be expected to do (e.g., in the case of children, going to school when they are unprepared for an upcoming test or have not done the expected homework), is an attractive proposition. These people accept the rights of illness but seek to avoid the responsibility. Thus, these people adopt the “negative sick role.”

Relinquishing the sick role appears to cause most people less difficulty than assuming it.<sup>11</sup> Convalescence, although not enjoyable, proceeds smoothly in most cases and ends with the patient’s return to his or her former well status. Although there may be some concern about picking up where one had left off, this is not a problem for most people.

Succinctly stated, health and illness exist along a continuum, are inherently constrained by interference with social action, and are much less objective than most people recognize.

## **CULTURAL AND CONTEXTUAL FACTORS IN HEALTH AND ILLNESS** \_\_\_\_\_

There is much to be learned about health and illness in the process of becoming a healthcare professional. Even in training programs that last for years, there may be relatively little time devoted to recognizing that definitions of health and illness are subjective in many ways. It may be tempting for students to assume that the diagnoses they learn in training are objective, free from bias, and durable over time. The most common philosophical approach to these issues reflected in medical schools and textbooks has been described as naïve normalism, in which illness connotes abnormal functioning and health is suggestive of “normal” functioning.<sup>12</sup> However, the actual definition of “normal” is hardly clear, and in fact may be largely subjective and influenced by prevailing cultural factors.

For example, what constitutes a disease or illness in one culture may be considered normal and healthy in another. In Germany, low blood pressure is often interpreted as an illness, whereas in the United States it typically is not. An individual in Germany with this condition may be permitted to assume the sick role: he or she may be excused from some social responsibilities and receive treatment from healthcare professionals. Yet if the same individual were part of a different culture, he or she might not be afforded the sick role. Similarly, interpretations of a disease state may vary as well. Students may be surprised to learn that a fairly large proportion of adults (as many as 40%) are colonized by *Helicobacter pylori*, yet relatively few of these individuals develop duodenal and peptic ulceration.<sup>13</sup> Therefore the mere presence of *H. pylori* in a patient does not necessarily mean that he or she is “sick.”

Clinicians are afforded social status and power by virtue of their training and expertise, which means that their personal values are often given great weight—even when those values and opinions are not informed by their professional training or scientific findings. We can expect that when there are significant, widespread changes in social values within a culture, then definitions and standards for health and illness will also be in some way affected.

This may be a humbling point for healthcare professionals to accept: the nature of our role and work is not strictly objective, and our current understandings of health and illness will likely change over time. It is sound advice to new students that one ought to avoid the temptation of being overly confident in one’s knowledge and work. A tragic example from history is the fact that the genocide perpetrated by the Nazis during World War II was to some extent facilitated by healthcare professionals.<sup>14</sup> Physicians and other healthcare professionals were recruited by the Nazi party to medicalize the process of killing socially undesirable people: the sick and feeble were “euthanized” in hospitals, sterilization was forced upon certain social and cultural groups, and physicians routinely evaluated new arrivals to concentration camps to determine their fitness for work (where the alternative to work was execution). By giving the process of genocide a medical façade, the Nazi social and political agendas were more easily disguised and adopted on a large scale. Of course, this was only possible because some healthcare professionals adopted the Nazi value system (and extreme biases) as their own. History warns healthcare professionals that we are not immune to having our expert knowledge swayed and distorted by larger social forces.

This lesson may be especially relevant to today’s pharmacists. There is considerable controversy surrounding the marketing of medications to laypersons, and how advertisements about medications contribute to the social context in which pharmacists practice. Large pharmaceutical companies have been accused by some of either

creating or exaggerating the prevalence of diseases and symptoms to persuade people that they may “need” medication treatment. The controversy has largely focused on psychiatric conditions, such as attention deficit disorder, but also has extended to diagnoses such as restless leg syndrome, irritable bowel syndrome, and the medical treatment of menopause. The argument is that marketing efforts by pharmaceutical companies have perpetuated the widespread belief that “there is a pill for everything” and therefore there has been a proliferation of new disease states and symptoms that merit medication treatment.

It can be observed that there are some common conditions that do not have medication treatments available (e.g., celiac disease), yet these are not as well known within the lay public as diagnoses that carry with them known medication treatments. Also, it is not unusual to group nonmedication treatments collectively as “alternative therapies” even when those treatments (such as psychotherapy, occupational therapy, behavioral modification, etc.) demonstrate equal or better responses. It is also interesting to note that symptoms of an illness (such as “fatigue”) are portrayed in many advertisements as being as “serious” as the illness itself and that associations between symptoms and diseases are overstated—for example, implying that a vaccine for the human papilloma virus is essentially a vaccine for cervical cancer or asserting that depression is a medical condition. Although the diagnosis of major depressive disorder has been substantiated as a disease, the lay use of the term *depression* tends to be situational and usually refers to less severe emotional experiences (e.g., hearing distressing news) that generally do not satisfy the diagnostic criteria.

The controversy about pharmaceutical marketing is ongoing, and we certainly cannot offer the reader any firm conclusions about it, yet we can point out that the existence of this controversy demonstrates that definitions of health and illness do not exist in a vacuum. Even business and economic forces influence our interpretations of what is healthy and what is pathologic.

It is interesting that people may define health and illness in ways that are different from clinicians. For example, it has been found that older adults who have multiple health problems may still describe themselves as “healthy.” On the other hand, some people define themselves as suffering from a medical condition in which the nature of the “illness” is poorly defined or subjectively understood. This is best observed in the ubiquity of the word *addiction* in Western society, where addiction implies a biological or medical condition or both. When one is “addicted” to something, he or she may be afforded the sick role and thereby be partially or fully excused from responsibility for his or her actions because of uncontrollable biological forces. Addiction has been applied to alcohol and other substances, but more recently has also been used to explain behaviors that do not involve a known substance, such as addictions to shop-

ping, television, the Internet, sexual behaviors and pornography, gambling, and so on. Such definitions of addictions are controversial among clinicians and researchers, yet it is not at all unusual to encounter laypersons who use these terms to explain their own or someone else's behavior.

Body image is another area in which the medicalization of common problems and concerns may be observed. Standards of beauty change over time; several centuries ago, women with large ("Rubenesque") physiques were considered more attractive than slender women. In modern Western civilization that standard for beauty has essentially reversed, and perhaps it is no coincidence that drugs and medical procedures that alter physical appearance have become increasingly popular. Elective surgery (such as liposuction) and other cosmetic procedures are rendered largely within a medical context: procedures are performed by professional clinicians, and recipients of elective cosmetic procedures may undergo surgery, receive prescription medications, and even be identified by clinicians as "patients"—yet they typically are not defined as "ill," "sick," or being "in need of treatment." There is literature suggesting that most people are in some way disappointed with their physical appearance (it is normal to be dissatisfied with some feature of one's own appearance), but whether or not this constitutes a medical problem has yet to be substantiated.

Nonetheless, modern pharmacists will recognize that concerns about body image pervade Western culture, and that increasingly people are turning to either medical or pseudomedical solutions. A new term in the pharmacy lexicon is *lifestyle drugs*, which are not always medically necessary yet may be prescribed for other (e.g., cosmetic) reasons. Lifestyle drugs may include those that decrease wrinkles in skin, promote hair growth, and so forth. Examples of pseudomedical solutions include advertisements for "nutritional supplements" that look surprisingly like advertisements for prescription medications and offer guarantees of weight loss and increased sexual performance.

Thus, it can be seen that individuals interact with healthcare professionals for diverse reasons, and the nature of those interactions is shaped by numerous external forces, such as culture, society, morality, and economics. Further, definitions of health and illness are not limited to clinical interactions: an individual can define himself or herself as "sick" without any formal clinical diagnosis or can define himself or herself as "healthy" even in the presence of a formal diagnosis. Suffice it to say that objectively understanding health and illness is remarkably complicated, even though clinicians routinely interact with patients as though there were little or no subjectivity involved in the process.

We have been building up to a point that by now should make intuitive sense: as a pharmacist, it is both prudent and necessary to consider clinical interactions of all kinds as a type of social experience. Social experiences are not strictly objective, and consequently even the most skilled and competent pharmacist is susceptible to

making errors during clinical interactions. Being mindful of the social context in the practice of pharmacy can help one reduce the risk of errors and thereby enhance the quality of treatment.

In this sense of the word, *errors* are not limited to medical errors. Rather, the concept refers to the universal problem that human perception is not reliably objective: nobody is perfect. Sociologists, social psychologists, and other social scientists can tell us much about the ways in which we are prone to perceiving social experiences inaccurately. Although the list of perceptual errors and distortions that all of us are susceptible to is quite long, we can benefit from focusing upon a few.

The fundamental attribution error (FAE) is also known as either personality over-attribution or correspondence bias.<sup>15,16</sup> It has been defined in different ways, but essentially the FAE is the tendency to overlook situational factors in favor of more durable personality traits when explaining human behaviors. In short, the FAE is the tendency to believe that someone's observed behavior is entirely representative or descriptive of who they are as a whole person. The problem with such sweeping conclusions is that behavior changes significantly according to its context, and in reality, most people are very complex and their behaviors are determined by multiple factors.

For example, imagine that you are working in a community pharmacy and are confronted with a frustrated patient. The patient complains about the costs of his pain medications and about having to wait for the prescription to be filled. The FAE may lead you to conclude, "This is the kind of person who complains about everything—he's just an irritable person and nothing will satisfy him." These are attributions about the patient's personality, which is durable and unlikely to change. The reality may be that this patient is actually very reasonable and likeable in most other contexts—it's just that right now, he is in pain and distress. These are situational factors. You might not fully appreciate the FAE until a time when you are in pain and distress while waiting for treatment, at which point you become frustrated and demanding toward your caregivers. The FAE might lead you to believe that you are normally a patient, calm individual, except that now you are in a frustrating situation.

Practically everyone is susceptible to the FAE, and it has a clear implication for clinicians. As a pharmacist, you will be interacting with patients when they are sick, and being sick commonly induces distress. That is, being sick is a situational factor that may influence behavior, yet the behavior you observe among your patients may not be at all descriptive of their entire personalities. The individual who presents to you as irritable and demanding at the pharmacy counter may, under most other contexts, be quite calm and patient.

Similar to the FAE is confirmatory bias, in which one's attention is focused upon supporting initial impressions about someone else—even to the exclusion of

disconfirming evidence. There was a case in which a patient attempted to fill a prescription that the pharmacy did not have on hand; when informed of the problem, the patient complained and demanded to speak to the pharmacy manager. The pharmacy manager first met with her staff, who advised her that “this patient is slurring his words and is probably drunk.” Upon meeting with the disgruntled patient, the pharmacy manager fell victim to the confirmatory bias: she operated from the first impression that this patient was intoxicated, and disregarded the patient’s assertions to the contrary. It turned out that the patient was dysarthric due to a cerebral vascular accident and was not intoxicated at all. This part of the patient’s medical history might have been revealed had the pharmacy manager assessed him more objectively. Another way of expressing the thinking behind the confirmatory bias is “Don’t confuse me with the facts—my mind is made up.” The lesson here is to be wary of operating too strongly from first impressions.

Other sources of bias frequently come into play as clinicians interact with patients, and so it is not surprising to learn that clinicians are often more confident in their assessments of patients than they are accurate in those assessments.

## SUMMARY

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Both Parsons’s concept of the sick role and Suchman’s theory of illness behavior have stood the test of time. But times have changed, and patient–pharmacist interactions are increasingly influenced by social forces. Because future roles are expected to expand and direct patient care is predicted to increase, an understanding of the patient as well as of social and behavioral aspects of pharmaceutical care is highly pertinent to today’s practicing pharmacist. It is important to acknowledge the inherently subjective nature of health care and healthcare delivery despite the presumed objectivity that is implied in today’s science-driven approach. As pharmacists provide direct patient care, there is a responsibility of the profession to recognize the dynamic social context of healthcare practices.

Culture and norms have changed and become more complex over time. Major changes include the following: the recognition of the patient’s right to make decisions about his or her treatment; an emphasis on preventive medicine and wellness; recognition of nonadherence; acknowledgment that traditional Western medicine is only one choice for the ill person, and that people tend to use both conventional medicine and alternative therapies concurrently or in a complementary fashion; an increase in the use of health insurance, including federal and state programs; the emphasis on cost containment by third parties, including health maintenance organizations and managed care; the change from a preponderance of acute conditions to chronic conditions; emphasis



on self care; direct-to-consumer advertising; lifestyle drugs; the proliferation of allied health professionals and paraprofessionals; and demographic changes, including the aging of America. Each of these changes is associated with a social dimension relative to pharmacy practice and will be addressed in subsequent chapters of this text.

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