Providing Patient-Focused Care Within a Managed Care and Pharmaceutical Care Environment: A Person/Situation Interactionist Model for Community Practitioners

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MANAGED CARE has dramatically changed how health care is delivered, received, and financed. Risk-sharing systems based on capitation, partial fee withholds, efficiency incentives, and other payment methods have revolutionized the whole medical delivery system. As a result of managed care, pharmacy benefit management companies (PBMs) have revolutionized the business of dispensing drugs via their considerable influence over doctors and the prescriptions they write. The community pharmacy has been significantly affected by PBMs, both through fear of a loss of customers if they do not join the network and through the loss of revenue if they do join.

During the past decade or so the pharmacy profession has been experiencing another paradigm change, a transition from a profession that has traditionally emphasized a drug-product focus to one that is more patient-focused. Pharmacare care reflects the transition to a patient-focused profession, and thus these two terms will be used interchangeably in this paper. Pharmacare care is defined as "the provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life." Despite the transition, pharmacare care has not become an integral part of the day-to-day operations of most community pharmacists. Therefore, it might be useful to consider and develop a conceptual framework for studying the potential influences on community pharmacists' patient-focused care.

Previous approaches to the study of workplace behavior in general and clinician performance in particular have tended to emphasize either the individual role or situational variables as determinants of workplace behavior. Such approaches are problematic because neither captures the important interaction between individual and situational variables. Stated differently, workplace behavior is a function of both the person and the environment. Typical of this theory is a laboratory experiment by Monson et al., who attempted to predict talkativeness by placing extraverts and introverts in either a strong or weak work setting. A strong situation is one in which most organizational members respond to organizational expectations to perform in particular ways. For example, a pharmacy may give bonuses for prescription volume. As a result, a majority of...
pharmacists may believe prescription volume is more important to the pharmacy than unrewarded behavior such as counseling patients. The authors concluded that only when the situation was weak did extroversion predict talkativeness. When the situation was strong, extroverts were not significantly more talkative than introverts. Thus, predictions of talkativeness based on either individual factors (extroversion or introversion) or situational factors (strong or weak work settings) would result in fewer precise predictions of behavior than would examining both simultaneously.

The study of community workplace behavior may be incomplete without an examination of the simultaneous effects of both individual and situational factors. For example, although a community pharmacist is often guided by the profession's code of ethics, the behaviors deemed most important by the pharmacy may take precedence when a conflict arises. If a conflict arises between the time required for counseling patients and the time required for prescription dispensing, prescription dispensing may be emphasized by the pharmacist at the expense of counseling simply because the pharmacy rewards that behavior.

This paper proposes an interactionist approach to the study of how community pharmacists make decisions in patient-focused care. It recognizes that both situational and individual factors play critical roles in decision-making behavior, and it offers a conceptual framework and a model using an interactionist approach to the study of community pharmacists' patient-focused care.

A major component of the proposed model is Kohlberg's cognitive moral development (CMD) theory, which has been pragmatically and significantly linked to health professionals' clinical performance.14-18 Moral-reasoning assessment is an assessment of conceptual adequacy of moral thinking that attempts to tap the basic conceptual frameworks that individuals use to analyze social/moral problems and judge the proper course of action.19 Simply stated, when tasks are nonstandard-ized and ill-defined (as the situations faced by community pharmacists often are), individuals who are more advanced in their moral reasoning skills seem predisposed to behave in a more professional manner.15-18

Based on empirical evidence, the proposed model suggests that moral reasoning is significantly and pragmatically associated with the patient-focused care activities of community pharmacists.16 Because behavior does not take place in a vacuum, however, other variables, both individual and situational, are expected to influence community pharmacists' patient-focused care and thus moderate the relationship between moral reasoning and this care. Situational factors would include the pharmacy organization's reward system, pharmacists' perceptions of significant others approving the provision of patient-focused care, and workload pressures. In addition, three individual factors are proposed to influence patient-focused care: self-efficacy, ego strength, and locus of control.

The proposed interactionist model of community pharmacists' pharmaceutical care decision-making behavior assumes that moral reasoning plays a major role in this behavior (see Figure 1). First, the pharmacist is confronted with a patient-focused care decision. The pharmacist's moral reasoning level determines the process of deciding the appropriate level of patient care to provide. Moral reasoning skills are not enough to predict and explain actual patient-focused care behavior. Both situational (e.g., organizational climate) and individual (e.g.,
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self-efficacy) factors are expected to interact with the moral reasoning of community pharmacists before arriving at the actual patient-focused care behavior.

**Barriers to Community Pharmacists’ Adopting Pharmaceutical Care**

Partly because of the individual and situational barriers to positive patient-focused care, pharmaceutical care has not yet become a reality for community pharmacy practice. Penna has identified several situational barriers to providing patient-focused care. These include a drug-product focus, the lack of a service orientation, and a lack of pecuniary incentives. Additional situational factors have been identified as barriers to comprehensive patient care. Raisch reported that excessive workload, lack of privacy, patient attitudes, and store layout are the biggest impediments to pharmacists’ providing counseling services to their patients.

Embracing a patient-focused paradigm may be particularly challenging for community pharmacists because often the pharmacy organization’s climate is incongruent with the provision of pharmaceutical care. Organizational climate refers to how organizations indicate to their members the behaviors that are important for organizational effectiveness. According to Schneider et al., an organization’s climate is reflected in two primary areas: how the organization goes about its daily business (is it flexible, innovative, stodgy?); and what goals the organization pursues (quantity, cost containment, patient satisfaction, market share).

Because the primary revenue source of a community pharmacy is dispensing, a conflict may arise if the time needed to provide a high level of patient care takes away from the time needed to dispense prescriptions. Consequently, the pharmacy organization is rewarded for prescription volume, and various situational pressures may dictate that dispensing prescriptions takes precedence over the provision of pharmaceutical care. Factors such as individual differences have been shown to potentially attenuate community pharmacists’ embracing pharmaceutical care. For example, Berger et al. reported in a national study that one in five pharmacy students experiences a phenomenon known as communication apprehension, which indicates a level of extreme fear or anxiety associated with either real or anticipated communication. A pharmacist who is apprehensive about communicating with others may have difficulty embracing the profession of pharmaceutical care because it requires verbal interaction. Other individual difference barriers include the pharmacist’s resistance to change and the ability (perceived or real) to provide comprehensive patient care, as well as the motivation to do so.

Ocifina et al., using a Theory of Reasoned Behavior Action framework, reported that although community pharmacists had high intentions to provide pharmaceutical care, they generally reported a low provision of care. Suggested explanations of the discrepancy between intention and actual behavior include low perceived social norm by physicians, low perceived behavioral control, and low self-efficacies regarding the provision of pharmaceutical care. Despite the barriers to its attainment, pharmaceutical care has been incorporated into the mission statements of all pharmacy associations, including the Joint Commission of Pharmacy Practitioners. Thus, it has become the hallmark of the patient-focused care paradigm.

**Interactionist Approach to Workplace Behavior**

A debate has endured over the past 60–70 years as to which is a stronger influence on workplace behavior—the person or the situation. Presently, many behavioral scientists acknowledge that both personal and situational factors influence behavior. The degree of influence of each factor in the production of workplace behavior continues to be the subject of debate.

In recent years, most research on workplace attitudes and behavior has been situation-based. The situationist approach proposes that an individual’s workplace behavior can be best predicted and explained by assessing the characteristics of his or her situation. For example, job-design researchers have posited that job characteristics are the major determinants of work attitudes and behavior. These researchers hypothesized that in order to increase employee job satisfaction, employee job-enrichment interventions must take place.

Other situational-based researchers have taken a social information-processing perspective. They have argued that job attitudes and behavior can be transformed by social influence and contextual cues. This line of inquiry leads to emphasizing subjective factors that can condition work attitudes, which results in more contingency-based models of workplace behavior.

In an insightful critique of the situationist position, Bowers analyzed 11 studies that assessed the relative variance attributed to situations, to individual differences, and to Situations X Individual Difference interactions. He concluded that, in 11 of 19 comparisons, individual differences contributed more to behavior explanation than did situations (x=12.71% versus x=10.17%). However, the mean percentage of the variance attributable to the Situations X Individual Difference interaction was 20.77%.

The individual-differences, or dispositional, approach to workplace behavior argues that a person’s behavior can best be predicted and explained by measuring his or her personality traits, values, motives, abilities, and affect, because these variables are stable and are reflected in behavior. Because these individual differences are not readily observable, they are inferred from temporal consistencies in observable behaviors. Staw and Ross, for example, reported significant stability of job attitudes and consistency across many situations. The authors used the National Longitudinal Survey of Mature Males and found that a person’s job satisfaction in 1966 was a significant
predictor of his job satisfaction in 1971, even after controlling for pay, occupation, and employer. Gerhart used a younger sample of males and replicated the Staw and Ross study. Gerhart controlled for job complexity and reported results similar to Staw and Ross.

In further support of the proposition that individual differences account for a majority of the variance associated with behavior is the fact that much of the empirical evidence supporting the situational side of the behavioral equation is based on experimental studies conducted in laboratory settings.

Bowers cogently argued that two problems are associated with using laboratory experiments as a way of studying the relative contribution of traits and situations to behavior. First, researchers often manipulate the experimental treatment conditions until the different conditions have their desired effect. Bowers stated that setting up conditions to have an effect and then arguing for the dominance of situations over traits is an inferential leap. The problem is that when laboratory studies do what they are supposed to do—demonstrate a main effect—it places constraints on the display of individual differences. The result is often the appearance that traits are irrelevant in the study of workplace behavior.

Second, Bowers noted that the major component of the laboratory experiment—random assignment of subjects to treatments—violates a basic tenet of human behavior in organizations: that humans select themselves into and out of workplace settings. An interactionist theory of workplace behavior advanced by Lewin posits that behavior is a function of the person and the environment. This theory states that both situational and dispositional factors influence workplace behavior. Stated differently, interactionism argues that an individual's workplace behavior is as much a function of the situation as the situation is a function of the person. Because workplace behavior does not take place in a vacuum, more accurate information concerning outcome behavior can be obtained by examining both situational and dispositional factors. Bowers summed up the interactionist approach by stating that: "The situation is a function of the observer in the sense that the observer's cognitive schemas filter and organize the environment in a fashion that makes it impossible to ever completely separate the environment from the person observing it." A relevant example using the interactionist approach to the study of community pharmacists' clinical performance is depicted in the following example. A consultant to a large chain pharmacy organization has been asked to determine the reasons that some of the chain's pharmacists provide patient-focused care while others do not. The consultant, while examining the environmental half of the behavioral equation, concludes that a significant barrier to a pharmacist's emphasizing patient-focused care is an organizational climate that does not foster this behavior.

In other words, the climate of the pharmacy organization is incongruent with the basic tenets of patient-focused care: preventing, identifying, and resolving patients' drug therapy problems. Assume that upon further examination, the consultant to the chain pharmacy organization discovers that the chain's reward system is not conducive to the provision of patient-focused care. It rewards, or at least is perceived by its pharmacists as rewarding, prescription volume over patient care. This may result in a lower level of patient-focused care. According to Kerr, the organizational reward system is often used as a way of encouraging behaviors that the organization deems important to its effectiveness. Kerr states that employees of organizations "seek information concerning what activities are rewarded, and then seek to do (or at least pretend to do) those things, often to the virtual exclusion of activities not rewarded." Thus, based on an examination of the environmental side of the interactionist approach, the consultant may report to the chain pharmacy organization that the organizational reward system and climate are barriers to their pharmacists' provision of comprehensive patient care.

The other half of Lewin's interactionist theory of workplace behavior focuses on dispositional determinants. Because behavior is a function of the person and the environment, individual differences can be expected to play a significant role in pharmacists' clinical performance. Individual differences may significantly influence workplace behavior in a profession such as pharmacy for two reasons: First, because the cornerstone of a profession is autonomy, individual pharmacists can be expected to exert more influence over their behavior than nonprofessional employees. For example, because of their knowledge of drugs, pharmacists may be given a great deal of latitude in recommending or not recommending drug therapy regimens. Nonprofessional employees, such as assembly-line workers at a car factory, probably are not afforded the same latitude in making assembly-line work decisions.

Second, research indicates that individual differences are less predictive of behavior in "strong" situations in which intense situational pressures to behave in a particular manner are present. Although a community pharmacy setting may be classified as a "strong" situation, dispositional factors can be expected to play a major role in the production of professionals' workplace behavior because many professional behaviors are conditioned by the beliefs and values of the individual. For example, those pharmacists at higher moral-reasoning levels may exhibit greater degrees of consistency between clinical decision making and actual behaviors, regardless of the inherent situational pressures.

As a result of examining pharmacists' behavior from an interactionist perspective, the consultant to the chain may report that, while the reward system and organizational climate are barriers to pharmacists' providing patient-focused care, some pharmacists who are predisposed to a high level of patient...
care may ignore the inherent situational pressures of the pharmacy and thus provide a high level of patient care despite these pressures. However, most community pharmacists are influenced, either positively or negatively, by the pharmacy organization’s climate. Thus, the provision of pharmaceutical care has the best chance of becoming an integral part of pharmacists’ day-to-day activities if the climate fosters patient-focused care.

### Interactionist Model of Pharmacists’ Patient-Focused Care Decision Making

Based on the premise that workplace behavior is a function of the person and the situation, the proposed model of community pharmacists’ patient-focused care posits that clinician decisions are explained by an interaction of individual and situational components. It implicitly assumes that neglecting to provide a high level of patient-focused care violates the ethical covenant embodied in the pharmaceutical care concept. The proposed model is based on Trevino’s interactionist model of ethical decision making in organizations. An integral component of the model includes pharmacists’ moral reasoning skills, which have been empirically shown to positively influence clinical performance.

Moral reasoning emanates from the field of cognitive development and provides a theory that explains the human decision-making process prior to behavior. Rather than being concerned with what is socially or morally right or wrong, moral reasoning is concerned with the processes individuals go through to arrive at decisions. Moral reasoning is based on Kohlberg’s CMD theory, which is a stage theory of moral development. Through extensive interviewing and observation of adolescents, Kohlberg derived a model that conceptualized ethical judgment based on a series of developmental stages. Kohlberg’s theory of moral development posits that individuals advance along a stage-sequence continuum that represents a series of cognitive levels akin to the rungs of a ladder. Most individuals move upward through these developmental levels, beginning with “preconventional morality” up to “conventional morality” and sometimes to the highest level, “postconventional morality.” Each level has two developmental stages, and individuals progress upward in an invariant sequence. In other words, an individual progresses from stage to stage in a logical sequence. Theoretically, stages cannot be skipped. Table 1 provides highlights of the six stages.

Both theoretical and empirical evidence support the proposition that higher moral reasoners will put the patients’ concerns above personal or company interests and, as a result, may provide patients with a high level of care regardless of the situational pressures encountered.

The psychology of moral reasoning provides a useful theoretical framework for understanding how pharmacists arrive at decisions. It provides the basis for a number of propositions that may be tested in future research.

Prior theoretical and empirical research lead one to expect community pharmacists to reason at the conventional level of cognitive moral development. Thus, most pharmacists are greatly influenced by the organizational climate of the pharmacy when determining the appropriate level of patient-focused care.

**Proposition one.** A majority of community pharmacists reason at the conventional level of cognitive moral development (stages 3 and 4). On the other hand, community pharmacists who do reason at the postconventional level of cognitive moral development are expected to behave consistently with their internally held beliefs.

**Proposition two.** Community pharmacists at the postconventional level of moral reasoning (stages 5 and 6) will be more likely to exhibit consistency between patient-focused care judgment and behavior than those pharmacists at lower stages.

**Proposition three.** Community pharmacists who participate in ethics-training programs based on cognitive moral-reasoning teaching strategies will significantly increase their moral-reasoning scores.

Empirical research suggests that specific training interventions can increase the cognitive moral development scores of participants.

**Proposition four.** Community pharmacists who score high on the self-efficacy scale will be more likely to exhibit consistency between patient-focused care judgment and behavior than those pharmacists who score low on that scale. Individual differences are also expected to affect the provision of patient-focused care. Three dispositional factors are

### Table 1: Six Stages in the Concept of Cooperation

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td>Stage 1</td>
<td>The morality of obedience: Do what you’re told.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>The morality of instrumental egoism and simple exchange: Let’s make a deal.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>The morality of interpersonal concordance: Be considerate, nice, and kind, and you’ll make friends.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>The morality of law and duty to the social order: Everyone in society is obligated to and protected by the law.</td>
</tr>
<tr>
<td>Stage 5</td>
<td>The morality of consensus-building procedures: You are obligated by the arrangements that are agreed to by due-process procedures.</td>
</tr>
<tr>
<td>Stage 6</td>
<td>The morality of nonarbitrary social cooperation: Morality is defined by how rational and impartial people would ideally organize cooperation.</td>
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proposed to influence this behavior: self-efficacy, ego-strength, and locus of control. Self-efficacy is a construct that expects better performance for individuals who think they can perform well on tasks.6 Self-efficacy is associated with work-related performance in adaptability to new technology, faculty research productivity, and behavioral modeling.6,47 Odedina reported that those community pharmacists who ranked high on the self-efficacy scale were more likely to provide a high level of pharmaceutical care than those scoring low on the construct.6

Proposition five. Conventional community pharmacists with high ego strength are more likely to exhibit consistency between patient-focused care judgments and behavior than conventional pharmacists with low ego strength.

Ego strength refers to strength of conviction or self-regulating skills. Individuals with high ego strength ratings are expected to be less vulnerable to situational pressures and more likely to follow their convictions than those low on the scale. Rest and Naveez demonstrated that Stage 4 individuals with high ego strength were more likely to resist the temptation to cheat than those Stage 4 individuals with low ego strength.41

Proposition six. Conventional internal locus-of-control community pharmacists are more likely to exhibit consistency between patient-focused judgment and behavior than conventional external locus-of-control pharmacists.

Rotter's internal/external scale measures perceptions of control over life's events. An "internal" believes that outcomes are the result of one's own efforts, while an "external" believes outside forces such as luck or destiny account for outcomes.68

Proposition seven. Conventional and preconventional high-prescription-volume pharmacists will exhibit less consistency between patient-focused care judgment and behavior than postconventional high-prescription-volume pharmacists.

Because workplace behavior is a function of both dispositional and situational factors, certain work-related pressures are expected to influence community pharmacists' patient-focused care behavior.20,69 For example, pharmacists who experience high workload pressures, such as routinely dispensing a high volume of prescriptions per day, may provide their patients with levels of patient care that differs from that of pharmacists who dispense a lower volume.

Proposition eight. Conventional and preconventional community pharmacists are more likely to be influenced by significant referent others concerning their patient-focused care behavior than postconventional pharmacists.

Pressures exerted by patients, supervisors, and physicians are expected to influence community pharmacists' patient-focused care behavior. Some patients may be more receptive to the provision of pharmaceutical care than others. Supervisors may feel pressure to increase short-term profitability through increased prescription volume. In addition, pressure may be exerted by the physician on the pharmacist to dispense a particular prescription for a particular condition, even if an alternative drug therapy is more effective. These situational factors are expected to moderate or interact with dispositional factors in the production of community pharmacists' patient-focused care.

Proposition nine. Conventional and preconventional community pharmacists are more likely to be influenced by the pharmacy organization's reward system concerning their patient-focused care than are postconventional pharmacists.

The pharmacy organization's climate and culture are expected to influence community pharmacists' patient-focused care. The reward system, in particular, is expected to shape the pharmacy's climate and culture. Whereas an organization's climate is readily observable by the policies, practices, and rewards of the organization, its culture is not so directly visible. Culture may be defined as the shared beliefs, values, and assumptions existing within an organization.40 An organization's culture can be inferred from its climate. For example, if a community pharmacy rewards prescription volume and not pharmaceutical care activities (climate), its pharmacists may come to believe that management values prescription volume over pharmaceutical care (culture). Therefore, depending on how reward systems are developed, administered, and managed, they can help shape culture specifically because of their influence on worker motivation, satisfaction, and membership. If community pharmacists are rewarded for prescription volume, this pay-and-performance link can dramatically influence the pharmacy's culture through its clear communication of the performance norms of the organization.

Conclusions and Future Research

The proposed interactionist model of community pharmacists' patient-focused decision making may be useful in predicting changes, not only in pharmacists' values and behavior but in organizational values and norms as well.68 Consider, for example, what happens when a new pharmacy school graduate, whose primary reason for becoming a pharmacist was to help prevent, identify, and resolve his patients' drug therapy problems, enters a community pharmacy. If the members of the pharmacy cohesively and intensely value dispensing more than patient care, will the new pharmacist's values change, and patient care become a lower priority? Will his/her behavior change—that is, will he or she begin to spend more time on distributive functions than initially anticipated? Or will the new pharmacist inspire his or her colleagues to emphasize patient care and, eventually, recruit more patient-oriented pharmacists?

The goal of this paper has been to illuminate the need for and propose an interactionist model for community pharmacists' patient-focused decision-making behavior within the present paradigm changes resulting from managed care and pharmaceutical care. Future research on predicting and explaining pharmacists' pharmaceutical care performance can benefit from a consideration of both dispositional and environmental factors.
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