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# Autoethnography as an Instrument for Professional (Trans) Formation in Pharmaceutical Care Practice

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### Abstract

The recent inclusion of pharmacists in primary healthcare in Brazil through the Family Health Support Team has encouraged them to reflect on the need to change from a professional focused on medications to one focused on individuals. This autoethnography allowed a pharmacist to confront her perspectives on clinical practice between 2014 and 2016, a period when she decided to challenge her traditional training as a pharmacist centered on medications. Using pharmaceutical care practice as the theoretical framework that prompted the profession of pharmacy to change its focus to the patient, the authors collaborated to construct a monologue that engages readers in the meanings of becoming patient centered. The research findings also support the versatility of application of the reflective process provided by autoethnography. Through fieldwork, reflective writing and interviews, the pharmacist discovered a new way to relate to "caring" and "patients" in her daily routine.

### Keywords

Autoethnography, Primary Health Care, Practice Change, Comprehensive Medication Management Services, Pharmaceutical Care Practice

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## **Autoethnography as an Instrument for Professional (Trans) Formation in Pharmaceutical Care Practice**

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Nowadays, it is essential that pharmacists participate in knowledge construction as members of multidisciplinary healthcare teams. Their recent inclusion in primary health care in Brazil through the Family Health Support Team in 2008 (Brazil, 2008) has been leading pharmacists to reflect on their own attitudes, behaviors, roles and the need for change: from a professional focused on medications to a professional focused on individuals. These teams provide support to the Family Health Strategy, the foundation of primary care that consists of a doctor, nurse, nursing assistant and community healthcare worker. The multidisciplinary teams are part of an important strategy created in 2008 by the Ministry of Health as an initiative to expand the range and effectiveness of Primary Health Care (PHC) at the municipal level. They function as a specialized, multidisciplinary backup support, taking responsibility for guaranteeing optimal health outcomes and for promoting comprehensive care. Moreover, they assist with interdisciplinary activity and knowledge sharing in health. Thus, the public health system is structured in Brazil in such a way that PHC coordinates care and allows for effective transitions of care (Brazil, 2006, 2008, 2009, 2012).

Pharmacists are among the professionals who frequently comprise the multidisciplinary healthcare teams, being present in about 40% of them (Nakamura & Leite, 2014). They are tasked with dividing their workload between managerial and patient care activities. The former includes the control of the Primary Care Units' medicine inventories. The patient care activities include group activities, individual consultations, and home visits completed individually or along with other professionals. According to PHC guidelines, it is important for patients with complex medication routines to receive some form of pharmacotherapeutic monitoring. However, these guidelines do not specify how this monitoring should be done nor is there any systematization of pharmacists' patient care activities (Brazil, 2009).

Therefore, searching to better adapt to this work reality, two years ago, I (Daniela - Dani) started a journey aiming to challenge what I had learned training for my traditional role as a pharmacist with regards to care. Under the supervision of professors Djenane, Clarice, and Simone, I started learning about pharmaceutical care practice. Following that experience, I was able to reflect on my social role and responsibilities as a health care professional. These professors were my guides in interpreting the data generated throughout the research process and actively influenced my view of the patient care world as represented in this work.

In general, in the health professions, when we refer to technical preparation, we refer to an education that focuses on biomedical knowledge and lacks focus on humanistic skills and attitudes. This means that educational programs usually prepare the professional to treat the body and the disease (with good performance in clinical skills), but not the person. By comparison, in Brazil, the most traditional pharmacy schools are not even preparing pharmacists with the technical knowledge needed to take care of patients, let alone deliver a person-centered education. Pharmacists neither learn to make decisions about drug therapy nor how to perform anamnesis, physical examinations or interpret clinical exams (Freitas, Ramalho-de-Oliveira, & Perini, 2006). This has been my preparation as a pharmacist. As such, my training relied mostly on technicalities associated with the production and quality control of drug products. Thus, acknowledging that professional training was mostly technical has a very different meaning in the pharmacy profession as compared to the other health careers. As a result, the nuances involved in taking direct patient-care responsibilities and the construction of a therapeutic relationship with the patient is overlooked in most pharmacy curricula (Angonesi & Sevalho, 2010; Freitas et al., 2006).

That preparation is part of a heritage, rooted in the decline of the pharmacist traditionally known as the apothecary, who prepared and sold prescription medications and other drugs, but who also had a trusting relationship with his clients. The end of the apothecary era coincided with the birth of the large-scale production of medications by the pharmaceutical industry. This new system of the production of medications incorporated a symbolical meaning in the product, a fusion between a consumer good and a therapeutic tool, and engendered the transformation and predominance of the commercial relationship between the pharmacist and society. This process has consequently demoralized the profession. In Brazil, pharmacists came to apply their knowledge and skills related to chemistry, biology, and the pharmaceutical sciences in several work areas (industry, management, food analysis) not related to patient care. As a result, pharmacy became an essentially technical profession, estranged from the patient and from the healthcare team (Nakamura & Leite, 2014).

In the 70s, in several countries, the movement of Clinical Pharmacy gained strength, and, in the United States, it culminated with the advent of Pharmaceutical Care Practice in 1990 (Cipolle, Strand, & Morley, 2012; Ramalho-de-Oliveira, 2011). This movement called for a major transformation in the profession of pharmacy as it positioned the patient at the center of the practice of the pharmacist and caring as his or her main mission.

The work discussed here emerged from my search for a clearer identity as a health professional as well as the desire to systematize my clinical practice as a member of a multidisciplinary healthcare team in PHC. This process occurred as I attempted to deliver Comprehensive Medication Management services (CMM) through face-to-face individual consultations, following the framework of pharmaceutical care practice (McBane et al., 2015; Ramalho-de-Oliveira, 2011). This process of transformation involved my participation in the Pharmaceutical Care course, which is taught by Djenane in the Pharmacy Professional Program, my taking part in patient cases discussions in the “Pharmaceutical Care Study Group” (bimonthly practitioners’ meetings), and reflections about my experiences and about the autoethnographic process. All of these were shared and critically reflected upon with Simone, Maureen, Clarice and Djenane.

The objective of this paper is to describe the first author’s experience of transformation from a technical professional focused on medications to a caring professional focused on people using the theoretical framework of pharmaceutical care practice. Pharmaceutical care is a professional practice that was developed to meet the social need for more effective and safer use of medications. This practice has a philosophy of practice, a patient care process, and a practice management system (Cipolle et al., 2012), components that are also an integral part of any healthcare profession. Following this approach, the pharmacist assumes, along with the patient and the healthcare team, commitments and co-responsibilities related to the patient’s pharmacotherapy. The patient care process involves attending to the patient’s perspective and culture, aiming at comprehensive, coordinated, and holistic care. This process also involves a rational and systematic decision-making process about medications called pharmacotherapy workup, which guides and increases the pharmacist’s effectiveness and efficiency. In this system, the pharmacist will always evaluate the pharmacotherapy of any patient through the same process, starting with the assessment of the need/indication of the medication, then evaluating its effectiveness to reach the patient’s goals of therapy, checking its safety in light of all comorbidities, and finally considering whether it is convenient for the patient to take the medication as professionally recommended (Cipolle et al., 2012; Ramalho-de-Oliveira, 2011; Sorensen, Pestka, Sorge, Wallace & Schommer, 2016). Furthermore, this rational thought process has the potential to increase the reproducibility of the practice and communication among pharmacists and among pharmacists and other health professionals.

It is also the goal of this paper to uncover the role of autoethnography to stimulate reflection, critical thinking, new understandings about oneself and personal transformation. Daniela is the pharmacist living through the reflections and transformation. The other four authors are pharmacists and researchers that accompanied the first author during the entire process and collaborated with data analysis, data interpretation and the construction of an evocative text.

## Method

Autoethnography is a style of autobiographical writing used in qualitative research with the purpose of exploring an individual experience and relating it to a culture (Ellis, Adams & Bochner, 2011). It formalizes a reflexive attitude as a process within a research method, enhancing the development of critical consciousness. The reflexive posture in research and in the field offers more than just a process of verification. It creates, by itself, new understandings and acts of transformation. As a process of reflection, *auto-ethno-graphy* is a way of improving the accuracy of the process of developing critical consciousness (McIlveen, Beccaria, Preez & Patton, 2010). With the objective to understand a process of professional transformation and the resulting changes in work processes, it was necessary to

utilize a qualitative methodology that could promote personal reflection, incite change and generate a product that is meaningful for the professional as well as for others (Ellis, Adams & Bochner, 2015). Thus, autoethnography was considered the most suitable methodological option.

## Data Collection

To fulfill the *autobiographical* aspects of that methodology, the first author kept a field journal starting her very first day attending the Pharmaceutical Care course. This is a course that introduces pharmacy students to the philosophy and patient care process of pharmaceutical care practice and it has only recently been introduced to the curriculum as an elective course. The first author went back to the university, after working as a pharmacist for over 10 years, to take this course as she was looking for possible solutions to improve and systematize her clinical practice. The journal was filled with reflections and insights about her role as a pharmacist; the inherent challenges of the process of transformation and systematization of the process of care; and, finally, the achievements attained with the effort of changing from a technical to a caring professional. These field notes were based on perceptions about patients, about professionals, and about interprofessional relationships as the pharmacist started focusing on caring for each individual person. The objective was to understand a cultural experience (*ethno*) and to relate to that culture (Ellis, Adams & Bochner, 2011; Chang, 2016). The pharmacist continued with these journals for 12 months until the complete transformation of her practice, thereby meeting the term *graphy* of the methodology, that is, systematic registries.

Data collection was conducted through the following techniques: (a) 66 field notes entries (journal) and reflections after the workdays that included direct patient care, which usually happened twice a week; (b) 12 field notes entries and reflections after each practitioners' meeting at the Pharmaceutical Care Study Group; (c) semi-structured interviews with other 5 (five) pharmacists living through similar experiences of professional transformation and reflection on those encounters; and (d) 12 reflective meetings with all the co-authors to discuss the first author's perceptions, feelings and learning's jotted down in the field notes. All interviews were transcribed verbatim into Microsoft Word 2013 documents and all data, interview transcriptions and journal entries, transferred to the program NVivo 10 for analysis.

## Participants

Ellis, Adams, and Bochner (2011) as well as Anderson (2006) understand that the data must be transcended and, the best way to accomplish this end is through the viewing of the data by other people, guaranteeing rigor and validity. The five interviewees were intentionally recruited, being chosen as pharmacists who understood the theoretical basis of pharmaceutical care practice, had the same working context, and were also engaged with direct patient care. These interviews had the objective to unveil the meanings other pharmacists ascribe to their experiences with patients and as members of the health care team.

## Data Analysis

Data were collected and analyzed simultaneously following the processes proposed by Ellis (2004) and Chang (2008), and utilizing the Software NVivo version 10. The data was read multiple times and a line-by-line codification was carried out creating labels or units of

meaning that represented the meanings that emerged from the text. Line-by-line coding was conducted for each new data collected, comparing data within the same interview, between interviews, and comparing interviews against data drawn from the first author's observations and reflections and registered in her journal. As the data analysis progressed, several initial codes were reexamined and renamed to better fit the data and enable a greater level of abstraction. Throughout this process, reflexive memos were also created to register all the researcher's analytical process and data interpretation. These memos were utilized to better understand the themes, regroup or rename them, and interpret the findings (Chang, 2008; Ellis, 2004).

Moreover, several meetings were carried out for collaborative analysis of the research team. These meetings were used in this study to systematize the reflective and deductive process necessary in an autoethnographic study. As a result of these meetings, the first author's understandings of her lived experience and of the culture in which she was immersed in were broadened. These new learnings redirected her focus as an observer, shaped her next interviews and assisted with subsequent data analysis.

Initially, 23 themes (nodes) were identified, which were subsequently rearranged into five major themes. After further analysis by the research team, two main themes were consensually identified, which will be presented and discussed below. The three remaining themes will not be discussed in this work. These two major themes were considered the main discoveries of the full research process: (1) Caring: Is it a matter of choice? (2) The Patient: Encountering the person behind the medication. As a group, we understood that the best way to convey the change in Daniela's professional experiences would be to build a dialogue between Dani in 2014, before becoming aware of the principles of pharmaceutical care practice and applying it into daily practice, and Dani in 2016, a time when she experienced the process of transformation and systematization of her work practice. Therefore, the two major themes that emerged from the full data analysis, and were checked and compared within and between interviews, will be presented as a text that mix original data and creative writing based on these same data, as proposed by Caulley (2008).

All presented dialogues are derived from the data, be they field notes, interviews, reflections, or post-interview reflections.

The study was approved by the Ethics Committee at the Federal University of Minas Gerais and by the institution where the study was conducted. All interviews were recorded and all the interviewees signed an informed consent form. The audio files were destroyed after the transcriptions were completed. The data are in the possession of the first author. Pseudonyms were used to refer to the interviewees.

## **Results**

Influenced by the work of Vries (2012), the results of this autoethnography were structured as a monologue between the perceptions of the first author in 2014 and after she experienced a significant professional transformation in 2016 (Vries, 2012). As described in the methodology session, two major themes were codified into the two great discoveries of this autoethnography, which were "Caring: Is it a matter of choice?" and "The Patient: Encountering the person behind the medication." These themes will be described evocatively by using excerpts from the full body of data. By using excerpts from the diary, reflections, and interviews, we constructed an interactive fictional monologue that evolves overtime and simultaneously discuss the data.

We chose to use evocative writing, a new writing practice in qualitative research, where we hope to offer a new opportunity for the reader to think about a topic and engage the audience through a creative text. It is not the data speaking for themselves; rather, we see as

the evolution of a narrated perception in a process of self-reflection. In “Autoethnography and Narratives of Self: Reflections on Criteria in Action,” Sparkes (2000) cites Charmaz and Mitchell (1997) who observe that “silent authorship comes to mark mature scholarship. The proper voice is no voice at all.” Thus, we chose to keep the active voice of the first author and walk by her side during her new discoveries. We are also influenced by the work of Diversi (1998), who went beyond the boundaries of traditional forms of writing qualitative research to produce a rich text on the lived experiences of kids living in the streets of Campinas, Brazil.

Reactions to a confidence-inspiring tale are used to establish various criteria that may be most relevant to social transformation (Denison & Rinehart, 2000; Richardson, 2000; Sparkes, 2000). By using strategies of arts-based qualitative research, we hope to open up the text for multiple interpretations and invite the reader to connect with the human dimensions of Daniela’s experiences, perceptions, and feelings about her professional transformation.

### *Initial thoughts*

Dani (2016): I have just come to a conclusion, and I have got to share it.

Dani (2014): Surely you do...

Dani (2016): It happened when I was reading this: Can autoethnography be considered a research methodology that promotes transformation? The answer is encouragingly positive!

According to Diana Raab (2013), “... the transpersonal relevance of an auto ethnographical study comprises the idea of promoting self-awareness and self-discovery, which can lead to transformation” (cited in Custer, 2014, p. 11). Custer goes on to state that:

The transformation occurs in a dramatic way to the individual who is brave enough to reveal himself to the world and promptly board on a fantastic journey. This also happens with those who share the process of introspection, reflection, and contemplation with the researcher (such as, readers, public and other researchers). Autoethnography is a transformational research method because it changes time, demands vulnerability, promotes empathy, incorporates creativity and innovation, eliminates borders, regards subjectivity, and brings therapeutic benefits. (Custer, 2014, p. 11)

Dani (2014): And what have you discovered?

Dani (2016): That doing autoethnography catalyzed my entire process of professional transformation!

Dani (2014): But was not that the idea? To experience the change of a pharmacist from a traditional technical professional to a caring one and to construct a report about this experience? Isn’t that what my master’s project was? Being a provider of Comprehensive Medication Management (CMM) services in primary care as a pharmacist of the Family Health Support Team: an autoethnography of professional transformation.

Dani (2016): Well, certainly... However, I was struggling to find the path of transformation from a technical to a caring professional in my data. Trying to find the elements of my understanding of Pharmaceutical Care Practice. However, I see that the best part of the experience is the path itself. I wanted to describe what to expect after the transformation (in terms of my place as a health professional, my self-confidence, and sense of empowerment) and how the resulting knowledge has become part of me. I guess I was searching for something more specific.



Dani (2014): Hum... Like what?

Dani (2016): Maybe I was looking for the elements to teach a process of transformation, do you understand?

Dani (2014): Vaguely... Are you looking for a step-by-step process that could be taught to pharmacists?

Dani (2016): Exactly! But, I have come to see it was not going to be like that. The answer I was looking for is: reflection. It seems that the answer was there all the time. I was not considering the methodology as part of my process of transformation to a professional who takes care of patients and is accountable for that. I was using it only as a way of collecting data. Actually, the methodology was a way to achieve the main result: the transformation itself! It was then that I really understood that autoethnography fulfills both roles: the process and the product (Ellis et al., 2011).

Dani (2014): And what did that reflection bring?

Dani (2016): In the analysis of my field journals and interviews, two major themes emerged: (1) Caring: is it a matter of choice? and (2) The Patient: encountering the person behind the medication. I will discuss them further.

### *Caring: Is it a matter of choice?*

Dani (2014): I have returned to the university to take an elective course in the pharmacy professional program, the same course I previously chose not to take during my years in pharmacy school. The course is about taking care of patients. At that time, that is, during pharmacy school, I did not understand how the marketplace could absorb that kind of knowledge. I thought it was some sort of a new “fad” in pharmacy.

Dani (2016): That’s true. At that time, it was not easy to understand that pharmaceutical care should not be seen as a choice or something optional in the profession of pharmacy. You will understand what I mean later on. So, going back to the university to take that particular course was the trigger of all the work being done here. But tell me the feeling at the beginning of your participation in the class.

Dani (2014): It is the first day of pharmaceutical care class. I enter the classroom full of students from the second through the seventh semester of pharmacy school. I am in the class, me and my humongous and disorganized baggage of 10 years working as a pharmacist and all the jobs that a traditional pharmacist is exposed to after graduation. In that first class, the teacher draws a triangle on the blackboard. Each side of the triangle is filled with these terms: philosophy of practice (the base), patient care process and practice management system (sides). A simple and, at the same time, bold representation of a profession.

Dani (2016): Yes. Today I see that the purpose of the triangle was to “discuss how the practice with the patient works and which values are inserted in the encounter between the pharmacist and the person who uses medications” (Ramalho-de-Oliveira, 2011).

Dani (2014): Well, the class begins, and students need to answer the question of what caring means. Everyone babbles simplistic definitions, such as taking care of a person and treating someone gently or giving attention to someone. I realize that I do not know what caring is. Rather, I do not know what care means in the healthcare context; neither do my younger classmates. I am quite distressed by this discovery.

Dani (2016): I remember that day. I started to follow up on my professional activities daily by writing reflections about caring as the foundation of my journal. I came to understand that the practice of care is associated with all health professions and it involves comprehensive care and the development of inter-relations (professionals-people-institutions) in a respectful, resourceful, and reliable way. All professionals who treat patients have an

ethical obligation to take responsibility for the decisions and actions taken and for the results achieved with them.

Dani (2014): I begin to develop awareness that care is not optional in the context of my work in primary care in the public health system. Thus, it seems important to me to take some time to reflect on my practice, as I am meeting patients daily. All of my readings about pharmaceutical care practice make so much sense since they become answers to my longing to know how to take care of the patient. I start to comprehend the issue of choice. As a pharmacist, can I choose to be or not to be a healthcare professional? Is it my responsibility to take care of patients? Where is that assumption within the Pharmacy profession?

Dani (2016): Indeed. At that moment, I was linking theory to practice. At every consultation and journal entry, I would ponder the meanings associated with the process of care, just as the professional practice of pharmaceutical care proposes: “it is expected that all healthcare professionals treat their patients using a rational decision-making process. Besides, it is not possible to really take care of the patient if we do not follow up with him to evaluate the results of the decisions we made” (Ramalho-de Oliveira, 2011, p. 87).

Dani (2014): Gosh! It is unbelievable. I become aware of my lack of knowledge about patient care itself, something that seems so obvious in the healthcare arena. I see how fragile my knowledge is. There is no point in knowing, or possessing knowledge, without applying that knowledge somewhere: in the patient’s life, in monitoring the progress of disease states, in the identification of drug therapy problems (DTP) – a type of knowledge that I am starting to learn how to apply in my work process. My knowledge is too dispersed... It feels like I am chasing ideas floating in my head without any order. I know. I know a lot... and nothing at the same time. As I look at the prescription presented by the patient, several mechanisms of action come to mind. Maximum doses, potentially dangerous combinations... It is useful knowledge, definitely, but I do not know what to do with it. Pharmacology seems loose and pathetic when facing a life, a person that needs help. I do not know anything about human experiences, clinical work, or decision-making processes. Honestly, my feeling is that the patient may be wasting time with me. Impotence becomes a usual feeling for me.

Dani (2016): I remember that! Today I look at the technical knowledge I learned, knowledge without a face, disconnected from the health context, and compare it with the pillars of education proposed by UNESCO: learning to know, learning to do, learning to be, and learning to live together (Brazil, 2012). It was from this feeling of frustration that I went in search of something that could connect the technical information I already possessed with a logical clinical reasoning process. I was seeking a better preparation as a health professional. Where should I start? How to approach the patient? How to evaluate the individual, physically and clinically, in order to generate knowledge for rational decision making in pharmacotherapy? Please, remind me how my work process was like at that time.

Dani (2014): I confess that at some point I wonder whether the Community Health Workers should be the one professional in charge of organizing the medications for every patient that the health team suspected was not using their medication properly. Why should a pharmacist be utilizing her time to do that when someone else could do it well after getting training? Was that the best way to use the potential of a pharmacist? After all, that is the main reason most professionals refer patients to me! They expect me to make sure patients take their medications as prescribed.

Dani (2016): I did that with plenty of patients: I educated them to accept and follow the prescribed treatments. I did that without first assessing whether the pharmaceutical products were or would be effective and safe for that particular person within the unique context of their lives. Today I call that approach compliance-based practice. That is, intervention without a comprehensive care process, without accountability, without a

systematic form of decision-making and, therefore, with uncertain and possibly risky results (Sorensen, Pestka, Brummel, Rehrauer, & Ekstrand, 2016).

Dani (2014): I realize there is something wrong. What is my field of knowledge? Would any training prepare me to solve the problem I was designated to solve as a pharmacist (Campos, 2000)? My sense that something is wrong seems to me to be a sign that I am not using the same tools that other healthcare professionals use (or should use) when they are called upon to solve a problem. Besides that, I detect my lack of clarity about my own responsibilities when I am communicating or giving recommendations to the health team. I am afraid I am taking all kinds of professional roles, except the one I should be taking. What is my role anyway? I try to organize my thoughts.

The need to understand my practice through autoethnography forces me to interact with who I was in the past, and to confront the new professional I am becoming in the process of learning a professional clinical practice (Custer, 2014). My overly technical preparation, with no notion of care in the healthcare field, is constantly highlighted in my thoughts. My role with the patient is not clear. I am confronted, challenged, moved, and becoming transformed by what I am learning.

### *The Patient: Encountering the person behind the medication*

Dani (2014): The reflections go on and on. And, now, I ask myself the function and the importance of the philosophy (the base of the triangle) of Pharmaceutical Care Practice. Just as I wonder about the meaning of care in health, I do not understand what a professional practice philosophy is. Actually, I realize that no one in the class does. I remember my student years. Would these students manage to fit that knowledge in the routine of the compulsory curriculum proposed by the college of pharmacy? A curriculum that honors fragmented knowledge and is unaware, or ignores, the role pharmacists should play in healthcare? A curriculum that does not include the person as part of its subject matter?

Dani (2016): Today I understand that for me it all started making sense only because I had the opportunity to reflect on those concepts along with my practice. Therefore, I could engage in critical thinking and make use of tools such as a theoretical framework and a community of practice to help me achieve the desired change in my professional practice. As Paulo Freire (1987) explains in *Pedagogy of the Oppressed*:

...if men are made of “what to do” it is exactly because their doing is action and reflection. It is praxis. It is the world transformation. Moreover, just as every “whattodo” is praxis, everything that is done of that “whattodo” must have a theory to guide it. The “whattodo” is theory and practice. Reflection and action. (Freire, 1987, p.70)

An environment supportive to care, Primary Health Care, surrounded me. From there, I started searching for new concepts about professional practice. I have understood that, as Rios (2008) points out, professional expertise articulates four dimensions as inseparable components: a technical dimension, which refers to the gathering of knowledge in that particular field of work; an aesthetic dimension, which relates to the sensibility of individuals in interpersonal relations that occur in their work, that is, being sensitive to events that exist in your relationship with your practice; a political dimension, as the work is done in a social context that determines it; and an ethical dimension, which is the dimension that underlies competence, since the other dimensions will earn their full meaning when guided by ethical principles, such as respect, justice and solidarity.

Dani (2014): Interesting! Those dimensions are in accordance with the philosophy of Pharmaceutical Care, which defines the professional's values and responsibilities and provides the basis for this professional practice. This philosophy determines the performance expectations for each professional, in their practice with each patient (Ramalho-de-Oliveira, 2011).

Dani (2016): Yes, nowadays I am able to understand what that professional philosophy, as a mission, provides: it responds to a social demand, describes the pharmacist's responsibilities, defines a practice that is holistic and centered on the patient and promotes care through a therapeutic relationship (Ramalho-de-Oliveira, 2011).

Dani (2014): The pharmacist's responsibility, which I begin to incorporate in my daily practice, is to meet all pharmacotherapeutic needs of the patient, through the identification, prevention and resolution of problems – experienced or potential – related to the use of medication (Ramalho-de-Oliveira, 2011). Based on the premise of my responsibility with the patient, I articulate the care process. In my work context, I realize that as pharmacists we constantly try to solve problems without understanding what the individual, who is the focus of our attention, has to say and what he or she considers to be a problem. We tend to ignore the entire path they have walked in life until getting to the chair where they are seated in front of us.

Dani (2016): Exactly! You will soon realize that the analysis of my reflections from the time you describe revealed interesting aspects of my professional practice during that period, the period before my encounter with pharmaceutical care. At that time, my practice was focused on the technical aspects of medicines and the lack of definition of my professional responsibility was apparent. It was unclear for me and for my colleagues what kind of problem our profession was responsible for solving and how we should make consistent and rational decisions. Today I understand that not considering the patient's life context can be associated with medical errors. This means that I was putting the patient at risk (Weiner et al., 2010).

Dani (2014): These terms ring a bell. Now I am starting to see that when I tell the patient that he or she should be compliant with a prescription, I am patronizing if I consider that compliance should happen unilaterally and without dialogue. I am beginning to understand that just because patients have a prescription; it does not mean that they should follow it without questioning. I usually do not consider the patient to be the person in the best position to make a decision that will affect his or her life; therefore, I do not see him/her, I do not understand him/her.

Dani (2016): Yes. You bring to mind how I used to see myself: as a medication specialist. I now realize that underneath that narrow attitude lays the lack of responsibility for the patient's pharmacotherapy, which has been due to the absence of clinical reasoning and skills to intervene in the patient's life as a health professional. I did not have the ability to perform a physical examination, or to recognize signs and symptoms, or to direct my questions according to the pharmacotherapy in use. I was not aware of the patient's medication experience nor had knowledge of the therapeutic goals for the patient's health problems. I knew what a dosage form was. I could teach about dosage units and about what should be fractioned or not. However, what are the essential types of knowledge for the pharmacist who cares for patients and takes responsibility for that care?

Dani (2014): On second thought, my contact with patients until now has been superficial: managing medication in a drugstore was the only job that presented that kind of contact. My practice today still involves specific yet fragmented activities, with the inherent assumption that I will not see the patient again. My practice involves mostly technical guidance on understanding the prescription. Nevertheless, patients do come back. How to help them? How can I become part of the care process in a meaningful way? What should I

assess this patient? Should I only do so if he or she is compliant to his medications? Should the patient adapt to a prescription or should the prescription adapt to the patient?!

Dani (2016): Yes, that started making me very uncomfortable, and I began to question my role. I was always executing the decisions of other professionals, and not my own. My activity always started with the prescription, an understanding that today I see as outdated (Freitas, 2005). I was there to supervise, to execute an order from above, and was not free to assume a professional identity. What identity? Getting the patient to be able to take his/her prescribed medication, in the right manner, at the appropriate times, in the appropriate dosages. “Enable him to use,” as Freitas (2005) notes. Should I not question whether that medication was suitable for that particular patient, for his/her life context, and consider his/her characteristics and expectations?

Dani (2014): Agreed. At first, even after these discoveries, I still am not able to make a break away from a position of distance from the patient. I finalize my encounters as usual in a technical fashion, with the provision of information on medication schedules. However, I am aware that this is not a responsible clinical approach, focused on the person, and I am still working out a way to better understand the person and use this knowledge in my decision-making process.

Dani (2016): The overly technical preparation of pharmacists immobilizes the individual. I did not expect to deal with the fears, the expectations and the being-in-the-world of the person I was trying to help (Ramalho-de-Oliveira, 2011). It is clearer today, as you will realize soon. Help me remember how these encounters with patients were at the time.

Dani (2014): Well, when on a home visit, I measure the patient’s blood glucose, organize his medicines, and note what medications the patient is taking, besides the ones in the prescription. That is, my thinking is not trained enough, which leads me to do what is most comfortable to me: promote adherence. I feel helpless, stupid, and lost. I notice that I must think along with the patient, instead of acting in a mechanical way. I do not want to repeat the labels that health professionals sometimes give patients: “unbearable”, “never satisfied with anything,” or “we give, and they just want more.”

Dani (2016): Well, we understand that the premise of the philosophy of pharmaceutical care is that the primary responsibility of the pharmacist is to ensure that every medication in use is appropriately indicated to treat the patient’s health problems; that they are the most effective available, the safest possible; and that the patient is willing and able to use them as recommended. This will not happen if the practical approach does not focus on the patient, if he or she is not the beneficiary of the pharmacist’s actions and if he or she is not seen as a person with knowledge, experience, and principles — those are completely essential to the professional responsibility to be met (Angonesi & Sevalho, 2010; Freitas et al., 2006).

Dani (2014): How do you experience this process nowadays? What has happened after attending the pharmaceutical care class?

Dani (2016): What happens next is still ongoing because I never left the field. I am still reflecting, reconsidering, and using this material to transform my practice. However, I finally understand my role, and it may be the time to inspire others to take up the challenge to locate themselves in the role that best serves the people (Nakamura & Leite, 2014). Take a look at my field journal excerpts toward the end of the data collection, carried out between October 2014 and October 2015:

*Promoting adherence has its time in my practice, and may even happen in my first contact with the patient. However, there is a responsibility involved in this approach now. That is it! You might have made the decision to promote adherence based on information that supports it. You have data to support the*

*understanding that the medication is indicated, effective and safe for the patient. This is different from before, when I thought that making the patient compliant was what I had to do, necessarily. Now I am empowered and aware of my role. It is as if everything I knew had withdrawn to make room for new knowledge, but not only new knowledge, a whole architectural project (Comprehensive Medication Management). Then, when this old knowledge (technical information on pharmacotherapy and its effects on laboratory test results, for instance) should be placed somewhere, it went to several compartments suitable for it, such as answering the questions about indication, effectiveness, safety, and convenience of a medication for a patient. These compartments now communicate with each other! As a result, I am less stressed, finally. The theoretical framework of pharmaceutical care allows for an efficient exchange of knowledge. Starting the care cycle through an initial evaluation and the negotiation of strategies with patients, I can bring to the family health strategy program a real contribution that will have an impact on the patient's life. Besides being more viable for the patient, which I believe to be the most important point.*

Dani (2014): I see. Has this systematization of reasoning been completely filled with knowledge to generate a decision-making process that is more focused on the patient?

Dani (2016): Not yet. There are knowledge gaps needed to complement our transformation. These relate mainly to the humanities and social sciences. It is necessary to consider the intersection between the clinical reasoning of the health professional and the patient's biography and cultural background. To be effective, pharmacists need to use knowledge about the medication and illness experience. This represents the knowledge of the patient. The power of the decision-making of the pharmacist that provides CMM services can be limited if the professional does not reach for these other types of knowledge.

Dani (2014): And has this process been lonely up to this point? I have been feeling alone as I begin to take this path.

Dani (2016): It is a lonely process in a certain way. However, soon you will be able to count on the support of a group of pharmacists that is aware of its professional responsibilities and that will influence your preparation as a CMM provider. It was essential to our progress to "live through" the philosophy of practice with a group of colleagues that meet regularly at the University (Pharmaceutical Care Study Group). This group has been helping not just with the development of the clinical knowledge needed to take care of patients, but also with our identification with the philosophy of practice and the acceptance of our new professional identities. I understand that this is what has consolidated this transformation. One cannot become a patient care provider alone!

Dani (2014): That notion of transformation is very important. It also means that I am reflecting on issues like the medicalization of society, which bothers me greatly.

Dani (2016): Exactly! Throughout the incorporation of the philosophy of practice and my professional transformation, I realized that I have been naïve by concentrating so much on the power of medications. So, the next stride should be to consider patient care both within each person's immediate context as well as to examine pharmacotherapy in a broader, sociocultural context. This might be my future project!

## **Final Remarks**

Dani (2014): Have you ever thought about how this new understanding of the professional can make a difference in our environment? Would it be possible to foster a new level of awareness for an entire professional category?

Dani (2016): I do not know yet how to extend this level of awareness to an entire professional class. I do not have the answer yet simply because, for now, the effort depends on each one of us. A formal preparation with this level of criticality is still incipient in Brazil, within the traditional curricula of pharmacy schools. These curricula do not question the pharmacist's role with the patient. This questioning and focus on patient care is still optional and can be seen only in a marginal curricula, a kind of counter-culture within the pharmacy profession (Ramalho-de-Oliveira, 2006). However, recently, several national organizations are proposing to reform the Pharmacy curricula to focus on patient care (Brazil, 2002). The National Policy of Permanent Education in Health "proposes that the health workers education process be shaped by the questioning of the work process, and considers that the preparation and development of these professionals must be focused on the health needs of people and of populations" (Brazil, 2009).

Dani (2014): Does that mean, from our experience and consequent findings that the current working logic of the pharmacist inserted in primary care, in what is referred to as care, can and must go through a re-evaluation? Are there subsidies that support this practice transformation?

Dani (2016): Precisely. The National Policy of Permanent Education in Health's premise is a rupture with the logic of purchasing goods and the educational processes oriented only in the provision of these commercial services. The policy highlights the demands for changes and institutional improvement, based on the analysis of work processes, their problems, and their challenges. It also explains the relationship of its proposal with the principles and guidelines of the Brazilian Universal Health System, an integral healthcare system and the making of a progressive healthcare chain. We must rethink our working process in relation to patient care and ways to reinvent pharmacy and its role in primary care. We can start where we are at, our city, our clinic, our first patient. Shall we?

## **Limitations**

The time spent in the field and the number of participants can be considered a limitation of the study. Because this is the result of a master's thesis, fieldwork had to be limited to two years. Regarding the number of participants, it should be noted that very few pharmacists were attempting to use pharmaceutical care practice as the guide for their work with patients in the studied scenario, which limited the number of pharmacists that could be interviewed for this study.

## **Discussion**

When Daniela started systematizing her practice with patients in her work context, she did not expect the philosophical component of a profession to be so impactful in her life. It was through the reflections promoted by autoethnography that she started developing a critical consciousness of her professional being-in-the-world. Autoethnography is still a young qualitative methodology and we could not find any study utilizing this approach in Pharmacy.

We must judge success by changes in culture, by self-definitions that characterize communities, and by meanings that influence and shape the day-to-day. With increased self-

understanding, we can provide a faster and more successful route for social change than by the amendment of laws or other macro policy structures (Ellis, 2002). To be more specific, empowerment brings change to the environment in which we live in.

The process of sharing stories and insights provided by reflective writing has the potential to inspire and encourage readers to critically examine their own experiences. In this study, autoethnography was a means for emancipating an identity focused on medications, which was culturally familiar, and to scrutinize a pharmacist's perspectives as a professional and as a human being. It is as if the autoethnographic methodology opened a forum for self-reflection and discussion, one that may serve as a strategy to promote the professional transformation wherever one is located. We believe that our objective was achieved, since the chosen methodology allowed and enriched a learning process and the transformation of a professional practice. Moreover, it is hoped that the experiences and reflections described here can serve as a window to visualize the culture of Pharmacy as a profession, still distant from the people who use medications.

Finally, we would like this work to function as an invitation to other professional pharmacists to join in new investigations about their practice and their role as health professionals in our society.

It is our understanding that the reflections presented here could be transferable to other contexts and be utilized by pharmacists and pharmacy educators to assist those individuals that envision the reinvention of Pharmacy as a patient-centered profession. Medications are the most prevalent technology in our health systems and a patient-centered approach to the assessment of their daily use has the potential to dramatically change the lives of patients for better.

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