

Leading Students to Care: The Use of Clinical Simulations in Ethics Reaction Panel

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Question: The thing that came to mind when you pointed out the need to recognize emotions was the fact that we're dealing with relatively young adults. Personally, I feel I've become much more emotional as I grow older, but part of that is because I've experienced more emotional

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situations. Could some of the troubles that students have in these situations have to do with the fact that they're dealing with emotions that they may have never experienced themselves and therefore don't recognize or have any idea how to react to them?

Haddad: I think that's probably true. I think what we're seeing is inexperience. Although some of these students are somewhat older, chronological age isn't always an indication of maturity. If that's true, then we need more opportunities where it's safe for them to experience what interactions with patients are like. If they really mess up, they've not messed up with a real patient.

Buerki (moderator): Each reactor has had an opportunity to reflect on Amy's manuscript before coming to the meeting, so they will be able to respond in some depth. Our first reactor is Bruce A. Berger, Alumni Distinguished Professor and Head of Pharmacy Care Systems at Auburn University's Harrison School of Pharmacy.

Berger: Thank you. I'm going to use my time to present an alternative model to what Dr. Haddad had talked about. It is hard to argue against the use of standardized patients in teaching caring skills, communication skills, patient assessment, and patient counseling. Having a standardized patient means that each student will be presented with the same problems in exactly the same way. This makes assessment and evaluation of student learning and behaviors more objective. It also allows for concentration on specific skill sets that may not be possible with unstandardized patients. Therefore, standardized patients are especially useful when specific skill sets are to be developed. However, standardized patients generally do not allow for continuity of care and the development of skills over time with real patients who have dynamic problems that may change with each visit.

I would like to talk about a program we have developed at Auburn University, the Professional Practice Experience (PPE) program. Janelle Kreuger is the director of this program, and I would like to thank Janelle for sharing the information I am about to present. PPE has been developed at Auburn so that all of our faculty and students participate in a patient-care program. It seems to me that part of the mission of pharmacy education is to develop mature professionals who can render pharmaceutical care. We need to provide students with many opportunities to develop into professionals over time. Certainly, using standard-

ized patients, as described by Dr. Haddad, is one very constructive way to do so. Our program is still evolving. We're still learning as faculty and students about how to do this. Yet it may be the single most important thing we endeavor to do in our School of Pharmacy.

Before I go into the program, I feel obliged to present some information about what caring is to stimulate some thought and discussion. At the most basic level, caring means to attend to the needs of others, to make the concern of others paramount in importance. Nel Noddings has written a great deal about developing caring attitudes and behaviors in K-12 students. She points out that "when we have genuinely received another we often feel our mode of energy flowing towards the needs and projects of the other. We want to help relieve pain, to achieve a goal that is not our own, to actualize a dream. It's a feeling that all caregivers experience when they are in an authentic caring mode. The self is still there with all its ideals and projects but the energy is temporarily put into the service of others' needs" (1). Now, this is a fairly complex concept. It appears that students, from an early age, start learning to recognize the emotions that are involved in caring and the emotions that they feel when they are attempting to care for others. Warren Reich notes that "care means worry or concern. The significance of this meaning of care is that if nothing else matters, if nothing is worth worrying about, ethics is not possible. Any attempt to develop a systematic inquiry into the moral life would be bogged down, for the moral life itself would be mired in apathy" (2). So learning to care, according to Reich and many others, is also part of or moral responsibility as human beings. Put another way, ethics and morality depend upon caring about the welfare of others. In fact, ethical decision-making involves identifying which issues of many are the most salient or important for my attention and concern, what merits my moral caring or concern.

We started the PPE program in 1997 with our entry-level Pharm.D. program students. It fulfills the introductory practice experience component required by ACPE. All students and faculty participate in the program. It consists of six longitudinal one credit-hour semester courses that are graded pass/nonpass; students start the program the day they walk into the school of pharmacy and they are in the program up until they go out in their fourth-year rotations. The PPE program involves direct interaction with patients, is community-based, utilizes a service learning framework for patient access, and allows students opportunities to practice and provide basic pharmaceutical care. There are opportunities for reflection and for personal and professional growth throughout the program. There's also a team component which I'll explain later. It's a

form of experiential education in which students engage in activities that address community needs with structured opportunities to promote student learning and development. It allows the students to use newly acquired skills in a real-world environment, while providing assistance within the community.

As they enter the Harrison School of Pharmacy, each student is assigned a patient. They are then assigned to a group of other students, including second- and third-year students, and all of those students are assigned to two faculty mentors. The entire team is responsible for all of the patients assigned to their team. The PPE program proposes to enhance the quality of life and health care for the community, to involve students in the provision of pharmaceutical care outside the four walls of the pharmacy, to teach that care can be provided outside the four walls of the pharmacy, to promote professional socialization and ability to work within a team, to develop patient caring skills, and to reinforce classroom learning. This is a critical component: the second-year students in the program are mentors to the first-year students, the third-year students are mentors to the second-year students, and the faculty are mentors for all of them. The teams work to develop care plans for patients that are carried out by the students. The PPE program develops reflective thinking and self-directed learning. One aspect of the program we are still working through is standardizing faculty responsibilities. We are also working to develop students into independent learners. For example, a student will go visit a patient, find out that the patient is taking an ACE inhibitor and say, "I'm a P-1 student. I haven't learned anything about that yet." In which case, we reply, "We are never going to be able to teach you everything you're going to have to learn. Go learn about ACE inhibitors and come back to the group and tell us what you've learned. And then we'll add to that information." The response that "I don't know anything about this 'cause you haven't taught me yet" is not a legitimate response.

To instill a sense of caring, citizenship, and community involvement, students are assigned to a patient and to a patient-care team, comprised of first-, second-, and third-year students. Each team is given a roster of sites and/or patients for whom they are responsible. The patients are divided up among the students. Students spend time each week visiting or providing care based upon patient needs and the educational level of the students and the kind of care plans that are developed by the group for that student, given the patient's particular needs. The work is completed concurrently with didactic course work. As students progress and increase their knowledge base, their responsibility for patient outcomes

increases. Third-year students may end up visiting patients with first-year students because they have more information about the particular drugs the patients are using and can add to the interaction with regard to identifying and solving the patients' drug-related problems. The teams are facilitated by two faculty mentors. The teams meet weekly to review and reflect upon the activities of the previous week, provide patient site updates, identify and solve patient problems, and discuss issues related to ethics and professionalism. In addition, each team completes a yearly health and wellness project.

Each week students are required to turn in a reflection or SOAP notes, depending on where the students are in the curriculum, and based upon their interaction that week with their patients. We have moved the communication course and the patient assessment course to the first semester, so that students are getting those courses as they begin visiting patients. One of the first things that we do in the communication course is to teach students how to write a reflection. We not only require that students turn in two reflections from their PPE experience as part of the communication course, but three faculty members involved in the course read those reflections, give feedback to the students, grade the reflections, and share that feedback with the faculty mentors of each student. One of our purposes in doing this was to model such feedback for faculty, who may not be used to reading and grading reflections. One thing we noticed was students often didn't do reflections; rather, they made observations. They would say things like, "the patient's house was small and tidy" or "they lived in a run-down neighborhood." We wanted them to start reflecting on the emotional response to those details. For example, we would ask them, "Were you comfortable when you went into this neighborhood? Were you comfortable when you went into the patient's house? During what periods of time with the patient did you feel comfortable? During what periods of time with the patient did you feel uncomfortable? What kind of conversation was taking place when you felt at ease? What kind of conversation was taking place when you started feeling anxious?" Part of what we ask them to reflect on is the meanings that they assigned to the events that had occurred to produce these emotions. Usually what happens right before an emotion is some meaning on the part of the individual that takes place internally. Did students ascribe meanings to the emotions that they later found out were not valid as they got to know their patients? We want them to reflect on those things.

One of the things that I find the most exciting about the PPE program is that it is an opportunity to use literally everything that we have taught

them thus far in their other courses. For example, when we ask students to assess compliance, they often come back and say, "The patient was compliant." Guess what questions we ask? "How do you know? What did you do to determine that? What questions did you ask? What evidence did you gather?" Students are asked to counsel me on one of their patient's medications. One of the student's patients was a 60-year-old male starting the drug Protonix® for GERD. I asked the student to pretend I was the patient and counsel me on Protonix®. The student started off by saying that Protonix® is a proton pump inhibitor. I replied, "I don't know what you're talking about." The student said, "Well, you have proton pumps in your stomach." I responded, "No, I don't. I've never had surgery. They've never put proton pumps in my stomach." This third-year student knew the technical terms, but was really struggling with how to explain what this drug did in lay language. Interestingly, a first-year student who had worked in a pharmacy said, "Talk about acid," then the student was able to explain it. So you find that students at different levels are able to help one another. To me, that is one of the most exciting things about the PPE experience.

One of the changes we are making in the course involves students who are assigned patients who are doing quite well with their therapy. Those patients don't need to be visited every week, so that student might end up going with another student to visit another patient who may be having multiple problems, so that they can work on those problems together. Therefore, students are not "stuck" with a patient who may be doing fine and doesn't need to be visited every single week.

The reflections and SOAPS are submitted electronically to the mentors and a third-year leader is designated to read the reflections and SOAP notes and give feedback for a period of time in the semester. That technique has worked very well in some groups, but not as well in others. We're still learning about how to do that better. The third-year student leader is really supposed to be the person who runs the PPE session when we meet each week with all of the students to talk about what they've done. This has been highly variable with regard to the student leaders really being willing to kind of take over and run that session. We need to do a much better job as faculty at teaching them how to do that and modeling those behaviors first.

There is also a debriefing paper at the end of the semester on various topics related to the students' PPE experiences. Students are required to document weekly patient encounters and team meetings, submit a debriefing paper at the end of each semester, a team health project report at the end of each year, and document their leadership roles. Faculty ex-

Expectations are to participate and facilitate weekly team meetings. We want our students to learn caring skills. We may ask them to do so in simulations. We may ask them to learn to do these things in the PPE program or as a result of learning something in a course, but I'm absolutely convinced if the faculty don't know what these skills are and don't consistently model these skills in their interactions with the students then these skills will not be internalized. Nick Popovich said it very well several years ago about our need for educational care, our need to provide that kind of care to our own students; otherwise, most of our attempts are going to fall short. Faculty need to learn about what this means. Faculty need to review written documentation, to provide feedback, help insure student accountability, submit final grades, and alert the coordinator of problems or successes.

A couple of success stories are in order. The students have developed databases to promote the use of technology. They've established billing procedures to help patients get medication. We've written letters to physicians on behalf of the patient, with the patient's permission, to voice concerns and attach SOAP notes in order to identify drug-related problems, and offer solutions that have been successful on a number of attempts. Several students are working to find lower-cost medication alternatives for patients. A second-year student working with a hospice patient observed that the patient's caregiver crushed all the medications to improve the patient's ability to swallow them. The student realized that one was a medication that was not to be crushed and alerted the hospice staff. When the PPE program first started, I think most of the faculty felt ambivalent about it because the program was fairly amorphous and there were varying degrees of dedication to the program by the faculty. There still is some ambivalence, but we had an honor board case several years ago where a student reported that he went to visit a patient when, in fact, we found out he never did. The student was written up and the honor board, which is composed of four students and three faculty, recommended to the dean that the student simply be required to repeat the experience. When this happened again last year, the student was suspended for a year from the School of Pharmacy. This happened because the faculty and students now believe that this experience is vital to what we're trying to teach about what pharmacists do. I appreciate the opportunity to share with you another model that is still evolving in teaching our students caring skills.

Buerki: Next on our program is William E. Fassett, Dean of Washington State University's College of Pharmacy.

Fassett: My immediate response when I received the paper was that Amy has done yet another great job and contributed to the understanding of ethics instruction. Eventually this will be published and will be part of very rich literature that she has added to over the years, and I always appreciate the opportunity to join her on the dais. I think she makes a strong case for the use of clinical simulations in this arena of giving students' opportunities to practice and opportunities to reflect on their interactions with patients in a larger pharmaceutical care model. I also second her implication that we need to spend careful time in doing classroom research, if you will, in analyzing the utility, the implications and the experience that we have with this model. I've had a chance over the years to participate in the AAHE's [American Association of Higher Education] ongoing discussion on the scholarship of teaching and on classroom research, and I'm convinced that none of us spends as much time in this arena as we should and I think Amy has brought another call to us. My third comment is concerning one of the stronger statements she made in the manuscript—and it echoes something that Bruce commented on and that somebody commented on in the audience to the effect that these are young people learning. Here's the comment: "It's the life work of professionals to recognize these situations and adapt to the emotional responses, particular needs of the patient at that time." It suggests that we have an agenda, not only with our students, but with our practitioners. As we learn from this, it ought to be, in my opinion, a strong agenda for continuing pharmaceutical education to help our existing practitioners and ourselves to also improve these skills. Because the average experience of a person dealing with a health-care practitioner in almost any health profession (even sometimes in nursing) is not what one would expect from people who are expected to demonstrate care. I think that this is a key issue.

I don't know the details of Amy's course, although I know that it involves didactic instruction and discussions. Knowing Amy, I'd guess it involves lots of active learning. However, I'd like to take my time and talk a little bit about how we set the context in which some experiences like these patient simulations would be used. Let's talk about how we set the stage in the didactic portion of our courses for practice with standardized patients. I'd like to share some ideas about a bit of an ongoing debate comparing what has been called the "principles approach" to ethics to the care perspective. Bruce referred to the work of Nel Noddings, and her writing is really accessible on this topic. It's aimed at educators, so it's really good for us to learn from. Ten or fifteen years ago,

there was a considerable argument that these approaches were incompatible. As you will see, I think the general view is that both approaches have a place in our dialog on ethics. Then I'm going to emphasize something that Dr. Haddad has indicated, that her use of these exercises are formative; they are not summative. I'm going to suggest for the purposes of continuing discussion—I'm going to sound stronger on this issue than I actually feel, but I'd like to be a little bit provocative—that there are good reasons why we should make sure that we don't misuse this technique in summative evaluations. Not very long ago I was at a meeting where faculty who are using videotaped interactions with patients have suggested that those interactions ought to be done as part of the admissions process for a college of pharmacy and that we could use them to expand what we do in interviews. The extension of their thinking was that if admissions committees could judge whether individuals exhibited caring behaviors, that this could help the committee determine whether they got into a college of pharmacy. I'm going to suggest that that's unethical behavior at our current state of knowledge.

To set the stage, I will be talking about the use of didactic material relating to pharmaceutical care and ethical decision-making. I argue that this material needs to provide a framework for the student's analysis of the case in these settings that will guide their decisions and actions. When Amy's students are given that five minutes of preparation, they have to begin to pull together therapeutic knowledge and some understanding of the ethical processes, ethical decision-making, the ethical principles involved, their responsibilities, and the responsibilities of others. They're being asked to pull this together fairly quickly. So it's obvious that Amy isn't throwing them to the wolves in this situation. She's actually had some discussions about some of these things with them and has assigned readings and other exercises. I wish us to consider how we build the context leading to the student's behavior in the simulation.

I'm a strong advocate that we must build progressively on the skills that students have obtained from other disciplines. We know, for instance, that by the time they get to pharmacy school, the students will come to almost any decision-making setting with a sound grounding in scientific method. They are going to look for evidence that leads to yes or no answers. That's going to be part of their tool kit and background. We can try to overcome that or we can take advantage of it. By the time they have gained a certain amount of tenure in their third year, they've probably learned a lot about SOAP notes and clinical decision-making processes. I believe that the easiest thing to do is to make sure that they

understand how ethical reasoning parallels, supplements, and complements the logic and reasoning that they've developed in these other settings. So, I think linking ethical and clinical decision-making to the pharmaceutical care process is the final piece that we need to undertake.

We have a really rich literature and considerable conversation has developed concerning pharmaceutical care. Doug Hepler and Linda Strand, and I think particularly Hepler, saw this whole notion of developing pharmaceutical care as developing a moral and ethical model, a philosophical model for practice, so it's important that we link our decision processes to that model. Therefore, one of the things that I often do is start the students is start with readings such as the Principles of Practice for Pharmaceutical Care from APhA to simply remind them that there is a process for providing care. They should be familiar with this process, which details a series of steps pharmacists should follow to provide pharmaceutical care: establish a professional relationship with the patient, collect patient information, evaluate medical information, insure that the patient has all supplies, information, and knowledge necessary to implement therapy, and review, modify, and monitor the plan as necessary and appropriate in concert with the patient and the health-care team. These are the five steps that APhA has defined as being a process that pharmacists should be following in every setting. The process isn't sufficient; it is necessary. I generally then take my students through some of the other literature where we look at the drug-related needs of patients and how those translate into a list of seven or eight problems related to drug therapy, depending on how you define them.

Many of us teach this process as part of an Introduction to Pharmaceutical Care course. Most of us around the country now seem to be using SOAP notes as our principal way of organizing the data and analysis of drug therapy. Some colleges are teaching different formats, but SOAP is such a common approach that this has become a default structure for therapeutic decision-making, so we might as well live with that. If what our students are doing is using SOAP notes, then we're going to have to build their ability to ethically reason on that structure.

In my illustration, I've skipped over the "S" and the "O" portion because when we actually get down to clinical decision-making, we're getting into assessment and planning. Regarding the assessment mode, I discuss with my students why, when physicians write a SOAP note, they may or may not be identifying therapy-related problems. To deliver pharmaceutical care we need to do that: for each problem one must identify a desired outcome. This concept is straight from the core literature concerning the delivery of pharmaceutical care. For each problem

or outcome one must list the alternatives and then rank the alternatives in terms of outcome.

One organizing model students have the grounding to use is the understanding that there are economic, clinical, and humanistic outcomes. Most of us in this room are very much involved in teaching students how to assess those outcomes in the economic and humanistic areas and some of us are involved in the clinical areas as well. I teach that we can't just be concerned with improvement in a patient's quality of life, but with other humanistic outcomes as well, including adherence to our moral and ethical values and standards. We must assess each outcome or alternative in terms of how well that outcome or alternative delivers a moral and ethical outcome. This approach is actually fairly simplistic, but I think it's a useful approach, particularly in the early stage of our students' careers.

When discussing the implementation of therapy in the ethical realm, it's very important that we stress that our patients understand and accept the therapeutic alternatives we present to them, that is, we must obtain their informed consent. Based on my conversations with others who teach law, ethics, and therapeutic decision-making, we need to talk with the students in greater detail about the process and methods for truly obtaining informed consent. With some 35 states authorizing prescriptive authority for pharmacists, we can no longer just simply say, "This stage is up to the doctor." We should now say, "This stage is up to the pharmacist." Every Doctor of Pharmacy anticipating having prescriptive authority should have training that includes a very clear understanding of how to effectively obtain informed consent from patients. We need to teach, not only the theory, but the skill of obtaining valid informed consent.

Students must also learn the art of preparing the patient to comply with therapy. It requires providing the patient with the attitude favoring compliance, as well as the knowledge, skills, supplies, and tools necessary for compliance. As I was watching the vignettes today, I wanted to ask the students if were they really effective in preparing their patient to comply with their therapy. I think that would be one of the practical or technical issues to assess.

Now, as to actually teaching students approaches to ethical analysis, there are a number of models that utilize a principles approach. I will recommend to you, if you haven't seen it, the model that Jonsen, Siegler, and Winslade use in their book entitled *Clinical Ethics* (3). This text is primarily directed at physicians in clinical practice, helping the practitioner identify key decision-making variables in every complex

case.¹ The authors propose a four-quadrant model: The quadrants are labeled as “indications” for medical interventions, “preferences of patients,” “quality of life,” and “contextual features.” They provide some really wonderful examples to show how to analyze the case in each of these four areas. “Indications for medical interventions” represent therapeutic issues: Is there a need? Is there a therapy-related problem? Is there a treatment that has some hope of efficacy? They discuss the duty to provide futile or inefficacious treatment, a long-standing area of discussion in medical ethics. They specifically advise not overlooking palliative or hope providing care and they devote quite a bit of discussion to the relief of pain.

The second quadrant regards preferences of patients. While these quadrants are not hierarchal, the authors do treat them in the order in which I’m presenting them. It turns out that if there is no indication for therapy or if there is no therapy, then the preference of the patient to be treated is overridden. In this quadrant, the authors consider whether the patient is competent and whether the patient’s consent to treatment is informed.

When reviewing the quality of life quadrant, they obviously consider it in terms important to patients. For medical ethicists in particular, this is the area where those big time nasty problems of substituted judgment, advanced directives, and pulling the plug on respirators occur, so this is an arena of great interest. These kinds of quandaries are not so important to pharmacists in most situations; a possible exception is when the pharmacist participates in the delivery of drugs intended to allow a patient to end his or her life, or when pharmacists are directly involved in the use of abortifacients. However, quality of life issues are important to pharmacists, often in relationship to decisions to use drugs with significant side effects or costs.

The contextual features quadrant provides an arena for consideration of laws, interests of third parties, and health-care system issues. A classic set of principles (beneficence, nonmaleficence, respect for autonomy, justice) set forth by writers such as Beauchamp and Childress (4) maps nicely into these quadrants and so people who are used to working with that other model or have used related readings will find the model easy to use.

I’d like now to briefly talk about the principles approach versus the care perspective. The principles approach is based on a hierarchy of principles, with four or five in particular most commonly cited. These principles are said to convey meaning on more specific rules, and then those more specific rules are applied to individual cases. This is a logi-

cal hierarchal framework for starting at rule levels and moving down to the case, and then deciding what you should do in the case. This has been called “the ethics of the father,” that is, the way the father reasons with the family: “Son, you can’t take the car out if you don’t have your homework done. That’s our principle. Do you have your homework done?” “No, I don’t,” he replies. “Then you can’t take the car out, I’m sorry. That’s it. I don’t care how important this game is to you tonight. That’s it. Okay?” The alternative, as it was once presented, is a care perspective. And for those of you that know this in greater detail, you’ll recognize I’m skipping over a lot here. But in general, the care perspective understands that responsibilities arise out of relationships and it involves a preparation, if you will, to receive the other as a cared-for person. Decisions are made in light of the impact on the other. It is arguably highly situational, and it’s sometimes called “the ethics of the mother.” Its proponents would characterize a father’s decision as “I will not issue you a ‘stay-away-from school-today-because-you-don’t-feel-like-going’ permit because that’s just wrong. It’s against principles. I’m not going to write a false note to your teacher.” These proponents would assert, however, that a mother says, “I know how concerned you are about what’s going to happen today, and I know that you don’t want to have to do this. And I feel for what you’re feeling, and on this one occasion I’m going to write you this note, even though it’s a lie. But I’ll lie for my child because of what it means for my child at this moment to do that.” So these perspectives have been seen as polar opposites. Now, you have to remember a little bit about a nice academic argument that went on between Lawrence Kohlberg (who I think is no longer with us) and his student, Carol Gilligan. I can remember when I was coming up in the teaching profession that Kohlberg’s model of the stages of moral development was considered very important and was taught as dogma. You started in childhood reasoning according to a cause-and-effect relationship: Touch the hot stove your finger gets burned. And mom says no, and the next time mom says no, you don’t do it because of cause and effect. By the time you’re a teenager it’s the relationships and the norms and your peer group that determine the rightness and wrongness of your behaviors, and by the time you become an adult, you are able to apply rules and reason, and if you’re really good, you become a professor of ethics and you can argue the principles at their highest level. Now, Kohlberg did all of his work with boys and he had a graduate student, a very bright person, named Carol Gilligan. Gilligan tried to replicate Kohlberg’s work in young women. Her early studies dealt in real, not hypothetical, situations. She studied women

who had faced the prospect of having an abortion. She asked them about how they made that decision, and what she found was that overwhelmingly, the decision was made in terms of the child or the non-child, and the effect of the decision on relationships with other people. Almost all her subjects made their decision based on relationships; they considered the norms of people they cared about. Try as she might, Gilligan could not find women reasoning by principles in most cases. This seemed to imply that women were locked in permanent moral adolescence because they choose to reason by relationships, and that was not acceptable to Dr. Gilligan and to most of us if we think about it. Now, Gilligan did quite a bit of work and there have been a number of subsequent descriptive studies with both men and women. Over the past ten years, researchers have moved on to other things, but during the descriptive study era Gilligan and others asserted that, by and large, if you give men a chance to reason through a problem, they will choose a principles approach. The good news, from their perspective, is that men can be taught. It takes a long time and constant reinforcement. If you don't keep teaching us, we'll forget. Let us out of your sight for six months and we'll regress. But we can be taught to apply the care perspective. By the same token, women preferentially use a care perspective, but as evidenced by the great number of women professors of ethics who teach a principles approach, they can learn to understand and apply and examine students about the approach. Gilligan asserts that the care perspective, once it's been implemented in a decision, in an actual situation, is universally seen by the people who use it as being superior to the principles approach.

There is little work that I'm aware of studying whether there are cultural differences which determine whether persons adopt one approach or another, but it seems to me one way of looking at these gender-based differences in the United States and in Europe, is to not see them as sort of sex linked, but to see them as cultural. This raises the question whether there are other cultural differences which determine how people choose to approach ethical decisions. I suspect from my experience that there are such cultural differences.

I think the best interpretation now is that each perspective constitutes one of two "lenses through which we view the world." Al Jonsen has at one point contrasted the principles approach with the case-based analysis as analogous to a traveler in a balloon versus a traveler on a bicycle—the balloonist flies overhead looking down on the terrain whereas the bicyclist goes up and down and through the curves of a particular path. Both are viewing the same terrain but from a different degree of

particularity. Likewise, you could say that the principles approach and the care perspective are two alternative ways of seeing. The fact that both men and women can effectively use either lens despite different initial preferences supports this notion. Different ways of viewing the world will be more productive in some settings than they will in others. My experience in spending quite a bit of time in doing case-based analysis while trying to use the principles approach to analyzing the cases and then trying to adopt a care perspective is that the principles approach very often explains to me what I thought was actually going wrong or what was objectively bad about the decision, but that the care perspective explains my moral indignity concerning bad behaviors. The best case is a lawsuit, from a number of years ago, involving a 300-pound nursing student who was hounded out of nursing school because she was too fat. The faculty got this notion in their head that one can't be a fat nurse, that somehow her obesity would interfere with patient care. They forced her into a contract to go to Weight Watchers and lose two pounds a week. She went regularly to Weight Watchers but she never lost the weight; the net result was that she sued, and she won (5). This case gained some notoriety on 60 Minutes because she subsequently did complete her nursing studies at another college and became a highly valued nursing supervisor at a pediatric hospital. This was a big case; they did all sorts of things that were wrong: They violated her autonomy, they violated her trust. Their decisions were not beneficent, their decisions were actually harmful. They violated everything on my list of ethical principles. But why do I feel moral outrage at the faculty's reported behavior? Not because they violated ethical principles. What bothers me is that this was a nursing school, a place that teaches people to enter a health profession, a caring profession, but the faculty absolutely failed to demonstrate care. It's that perspective, to use some words of Al Jonsen again, that energizes my "springs of moral action" (6). What really makes me outraged is considering how I would act if I were in Sharon Russell's shoes. I think it's useful to use both of these perspectives in our teaching, and I find it helpful.

My last comment argues that formative assessment provides the instructor and the student with insight, supplements the educational process, and is very valuable; we probably don't do enough of it. But let me suggest that, if these exercises are used or contribute to a summative measure, that signals that we've made a judgment about a particular skill set or a particular approach to interaction that must be demonstrated. If we can't say it must be demonstrated, then we aren't entitled to grade on it, and that's what a summative assessment is. I think there's

a danger that SP [standardized patient] exercises might enforce a bias favoring a particular interaction style that is rooted in gender orientation or cultural antecedents. Until we know much more about some of the questions Amy raised in her presentation today, how will we know the real meaning of these interactions? Can we really tell caring from watching the behavior or are we just seeing a communication style that could be improved? Until we can really do that we have to be very careful. I think it's likely that these exercises will enhance students' understanding and development of the skills. They are very likely to provide a formative basis for improving our pedagogy. I think that's really a key point. Moreover, it's important that our didactic material build on all of the other skill sets. I think it's important to link general medical ethics concept to specific pharmaceutical care concepts, and we must recognize that cultural or gender antecedents may be operating as we try to judge the content of peoples' ethical and moral motives from their behaviors.

Buerki: Thank you for that very delightful response, Bill. Let me introduce our final reactor, Paul L. Ranelli, Professor in the Department of Pharmacy Practice and Pharmaceutical Sciences at the University of Minnesota College of Pharmacy, Duluth.²

Ranelli: I am interested to hear more from Bill about "the ethics of the father." I have three daughters and I'm trying to fit my ethics of the father with my three daughters. I'll have to work on that a little bit, but it is nice to know that men can be taught. Thank you for inviting me to be a member of the reactor panel.

I'll take a different approach to Amy's paper. I had prepared an outline with notes beforehand, then I scratched some other thoughts while Amy, Bruce, and Bill were talking. My time here will be in reaction to Amy's paper and to the three presentations we have just heard.

One point Amy made in her presentation is the crux of the matter, and I'm going to discuss it in a slightly different way. The crux of the matter is this: Amy mentioned that the students could go look up whatever drug information they needed before the encounter and they could also bring into the room whatever they wanted to. For me, that's the key. What are the students bringing into the room where these encounters take place? What are they truly bringing into the room? It's not drug information that I'm talking about. What "baggage" or social, psychological, or personal issues are behind them as they enter the room? That's

the way I was trying to think about my task today as a way to think through Amy's paper. For me, the drug information is a vehicle, an important vehicle, but not as important as what the students are truly bringing into the room? I'll get back to this in a minute.

Let me address the scholarship of teaching. Amy mentioned Lee Schulman and his work with the scholarship of teaching and learning. Schulman says, and I'm paraphrasing, we as faculty serve students by teaching them and pharmacists serve patients by treating them. Clinical research is a common research mechanism in medicine and pharmacy; we regularly do clinical research. Bill mentioned this, too. Yet the equivalent to clinical research, classroom research, remains rare in a university setting. The scholarship of teaching and learning is an initiative to foster that classroom research.

Another point that Amy mentioned is the idea of an emotions list, a list of positive and negative emotions. I have done this with what I call "empathic words." I ask students to reflect back with an empathic phrase. Empathy is like learning a new language for many people. And I get weary of hearing, "You sound frustrated." So I give students a list of words that illustrates that "frustrated" is one of many choices. I also say, "Have fun with that list at a party and see how many words you can use appropriately from the list of empathic words."

Stepping off this point about words of emotion, here are others that come to mind after reading Amy's work and listening to her. One is self-reflection. Another is a sense of loss or wound. Another is the word journey versus the word destination. Another is the word question versus answer. I'm happy with the journey Amy is taking with this work. I believe that she has an interesting approach to teaching students. It's the journey that the students are on that is important, not the destination. What you may believe is your final destination ignites future journeys within. It is the question you ask that becomes important, not so much the answer you receive. I started to think about some questions that I would ask students about caring and how we teach caring to pharmacy students. Do pharmacy students care? Do pharmacists care? If they care, what do they care about? What does it take to care and be influential?

Consider these questions. Can a marriage counselor who is divorced be a good marriage counselor? Can a celibate priest be a marriage counselor? Can a sportswriter discuss baseball without having played the game? Can a pharmacy student be a caring student? Does caring have anything to do with being a pharmacy student? Can a non-pharmacy student be as caring or more so than a pharmacy student in those situa-

tions that we just saw? No matter how you would respond to these questions, the questions focus on orientation. In other words, what is the orientation that the student brings into the room and how can we help shape that orientation and help the students with their journeys?

Look at my face for a moment; I have two weeks of beard growth. I was on a family camping trip and I'm trying to see if I want to keep a beard. Now, I'm looking at what I need to bring into the room. What do I bring into the bathroom to shave? What tools do I need to shape the beard and get whiskers off from under my chin and my neck? I bring in the right tools, a razor and shaving cream, but I cannot see well without my glasses. If I take off my bifocals I can't see where I need to shave, so I am also bringing bad eyes into the room. Even if I put on my glasses it's a big learning experience for me, because I have progressive bifocals, so if I look up to try to focus, it's useless; the glasses have little value. So I have to redirect my glasses off my ears so I can at least try to see what I am doing. Remember, what you take into the room along with your tools is very important.

One of the details I saw from Lowell's video is how he established boundary markers. We all do it. Students do this, faculty do it, and it's good to hear Bill talk about faculty involvement and what faculty believe caring is. Identifying boundary markers will provide us insight. What is a boundary marker? Let's say we are members of a group; pharmacy faculty could be a group. That group seizes a boundary marker. Boundary markers are opportunities to reinforce a false sense of superiority and the markers are established with an intent to exclude others. So for Lowell, is it a need for security or for a sense of superiority that makes him withhold drug information that the patient asks about? Or is it Lowell's anger with the patient's caregiver that causes him to set up a boundary marker by excluding others and even excluding the patient in this case.

Another main point from Amy's writings is the issue of transformation, which Bruce mentioned in his presentation. The issue of transformation is really about hope. It's the idea of being transformed. A counter argument to transformation is the notion of pseudotransformation; there's great danger in pseudotransformation. That is, if we don't change from the inside out, if we don't "morph" like the popular Power Rangers from days gone by, we'll be tempted to find some external method to satisfy our need that signifies that we are different from those outside of us. If we cannot be transformed, we will settle for being informed, which only involves facts, or we will settle for being conformed. So this issue of transformation, I believe, is something that we

can share with students. How can we get that point across to students? Maybe by going through a longitudinal approach through the curriculum, as Bruce mentioned. That may be helpful. This idea of pseudo-transformation, how do we know if we settle for it? As a start, ask yourself three questions to help you decide. Am I becoming judgmental, exclusive, or proud? Am I becoming more approachable or less approachable? Am I growing weary of pursuing growth? Most likely, there are more questions that could be asked. But these will be useful in helping look at how you are viewing transformation within yourself, as a faculty member and within your students.

Buerki: Now we have a chance for some sharing from the audience. Perhaps you'd like to share some of the things that you are doing at your schools to enhance care. Or perhaps you'd like to focus on some of the responses to Dr. Haddad's paper.

Question: I have a comment and then a question pertaining to some of the things that were presented here. Someone briefly mentioned the issue of culture. From my experience, pharmacy students' ethical values are in part largely based on their cultural upbringing, so I find it imperative that if you're going to talk about ethics, you have to look at culture as well. The patient population that we immediately care for is not representative of our students; the majority of our students are foreign students. In terms of ethical issues and teaching empathy and caring for patients, this goes beyond pharmacy. This is something that the medical and the nursing professions are dealing with, at least in Washington, D.C., where practitioners often have different backgrounds than their patients. I'd like to know, Dr. Haddad, was there an ethical issue if the students were from a different culture?

Haddad: Yes, culture and ethnicity play a role in ethical issue. First of all, there's six different patients played people of different races, different genders, and different cultural backgrounds. Then when the students watch each other's interactions in their groups, they can see the same case played out with different patients. They can hear different values and attitudes from the different patients. In ethics in general, culture is one of those issues that is supposed to not matter in making ethical decisions. We all come to a level playing field in ethics, right? The principles apply in all circumstances to all people, so it shouldn't matter whether we are male, female, black, or white, because this is one human being relating to another and so what does it matter? I think it matters a

great deal. I'm going to be more explicit about looking at race and gender issues this coming semester. I think I need to make it more explicit. I need to ask the students how this impacts their interaction with their patients and the way they look at the ethical problem.

Fassett: To cite Amy's presentation, it's the life project of a professional to continually learn how to respond to clients more effectively over time. It's very difficult for a faculty member to do more than explore issues about which we know very little; we actually know very little about each other's cultures. In one of yesterday's sessions, someone raised an issue of leadership related to cultural diversity; some schools have been very successful in gaining diversity on their campus, but that diversity is layered as in a parfait. The diverse student groups don't interact well, so even though you have diversity the students don't learn from each other very much. I'm sensitive to making sure that we don't make bad decisions about students who are influenced by our lack of understanding of their culture. I'm at a loss as to how to deal with some of these issues myself because I don't know enough about which techniques work and which don't in the classroom. My sense is that the best way for people to learn how to be capable of dealing with people of other cultures is through increased sharing and exposure. I think that these patient simulations, followed by a planned opportunity for the students to share with each other their own reactions arising from their cultures, is probably our best hope for expanding the understanding that we each have of how others are perceiving us.

Question: Each of you talked at one point or another about the role that faculty play in this whole process of students learning how to care. Bruce, you commented that you think your faculty may not be doing the best job but there is an area for growth; that's great. I'm curious what your thoughts are about how faculty can communicate that they care. If we're talking about role modeling and mentoring as some of the potential ways to assist students in their development, what are the kinds of things that you might think about as desired behaviors? What are the kinds of things that we should be focusing more on? How do we give feedback to students about the behaviors that we observe? I often say my relationship to my students in the classroom is really no different from the relationship of the pharmacist to the patient. If we're trying to have students become pharmacists who respond empathically in a caring manner to their patients, how are we teaching them about that in our teacher roles? What thoughts do you have about things that we might be

doing or questions we should be thinking about more to help us role model effectively?

Berger: I guess what I would say is that faculty need training in this just like students do in many cases. I think the idea of faculty truly being servant leaders is really new to some people. I was talking to some faculty listening to the leadership presentations that we heard and the colonel talking about needing to serve his crew. That was really a new concept to some of the faculty in the audience. Or, the idea of what it means to respond with civility to students. Sometimes in higher education, being as bright as we are, we might be sarcastic with students publicly. What are the impacts of that? What does that do in terms of the students feeling there is a safety net in their environment, feeling free and comfortable about asking questions and failing sometimes. I don't think this happens by osmosis. I think it's a question of training the faculty also to think differently. It's also part of what Paul was talking about in terms of the transformation has to take place internally; that internal transformation has to be a completely different orientation about who you are in relationship to your students. The absolute power that we have can be used corruptly, and we must be aware of that and how that plays out also.

Ranelli: I'll echo what Bruce said. Transformation is really the essence of hope; that is one way of using it. One of the more toxic situations that can happen to a relationship is when you think that the other person cannot change. This situation would influence teacher-student relationships, pharmacist-patient relationships, and student-patient relationships, any relationships. This is something that I am challenged with daily and I bet I am not alone.

Berger: I don't know how it is at your school; I've observed some things at other schools. Part of this transformation is a transformation from thinking of students as undergraduates to thinking of them as colleagues, and I don't mean friends. I mean in terms of thinking that we admitted these students, we now have a commitment to do everything we can to help them grow in this profession. They certainly have responsibilities they must also assume, but it's the difference between really being committed to help these people get where we need them to go versus the bell-shaped curve. The mentality that somebody's got to fail has to stop; that's an undergraduate rather than a professional school mentality.

Fassett: I can think of a couple of things. First, we need to have some explicit discussions about the role of faculty. One of the most interesting cases in medical ethics that has informed my thinking about ethics of teaching was the Tuskegee trials. This provided one of the early recognitions of how inhumanly physicians could act when they were focused solely on being researchers. They saw themselves as researchers, committed to the principles of the clinical trial that they were conducting. They never, ever saw themselves as physicians treating patients. In the world that we operate in, we are sometimes researchers, we are sometimes administrators of a series of policies designed to protect the public against ill-prepared students, and we are also teachers. I believe we need to have a real discussion about assuming the teaching role, and then what that means. I must confess that I have failed to carry forward some of the things I began exploring regarding the ideas of educational care and presenting in publications, but it's a starting point for a discussion of the teacher's role that Nick Popovich recognized very early on. It's so obvious we should be embarrassed that it doesn't just jump out at us all the time. If you take Hepler's and Strand's definition of pharmaceutical care as the responsible provision of pharmaceutical services for the achievement of desired therapeutic outcomes that improve the patient's quality of life, you can see that a simple transformation suggests that educational care is the responsible provision of educational interventions to achieve desired educational outcomes which improve the student's quality of life. It's as simple as that. Then we have to ask ourselves, how good are we at identifying educationally related problems, identifying and ranking alternative educational strategies, measuring educational outcomes, and delivering those outcomes in the context of things that will improve the student's quality of life? That's our commitment, if you will: a simple transformation of pharmaceutical care to educational care. We need to have a continuing conversation. U. E. Reinhardt has taken one approach that I find is really nice. He likes to ask defining questions. Should the child of a gas station attendant who was in a car accident have the same chance at survival as the child of a bank president? If we all agree that the answer is "yes," then we look at what we're actually doing to see if we're achieving that, and then we find out that in this country the answer is really "no" (7). We have decided by allocation of resources that the child of the gas station attendant should not have an equal chance to survival; we could ask the same thing in our classes. One issue that's actually emerging I will bring to my faculty because we recently have had some disagreements among our faculty about this question. It relates to how we select and retain stu-

dents to study pharmacy, given limited resources and rapidly increasing applicant pools, and I'll state the question in the very personal terms of my institution. Should Washington State University College of Pharmacy be a place where it is our goal to help every student that comes to us become an effective, capable pharmacist or is it our goal to attract and graduate only the very brightest people we can find through dint of their own effort? This debate may be going on in other places around the country: some faculty that believe that the most important thing we can do is to hold to very high standards, and any students that fail to completely adhere to those standards is given three strikes and they're out. The institution that I'm at has a hundred-year history of the prior commitment. It has had a history of making sure that everybody who can be successful will be successful. Our faculty needs to revisit that discussion and we will. I think those are some of the discussions that maybe need to go on in your institutions because I think there's a division of opinion, and it's not just between disciplines, it's within disciplines. We have some faculty who are Theory X faculty and some that are Theory Y. Some seem to assume that students don't want to work, don't want to read, don't want to do study. "If I fail 20 percent of the students in my class, it's because they're not willing to work. Okay?" That's one extreme position. I'll bet that every faculty in the country has at least one person who at least secretly holds to that belief model. The other position is one which I once challenged the faculty at Drake. If we're really good teachers and we're in a private university, we shouldn't admit only the best students we can find. We should admit those students who are not well motivated but are capable and we will turn them into successes; we will become the Sylvan College of Pharmacy. If we can turn these little sow's ears into silk purses at a private school, there will be great demand for our services. Anyway, I think we have to ask some of those questions and have a clear discussion among our faculty about what do we really think. Are we, as teachers, really responsible for the outcomes of our students?

Question: I think if we are going to model caring for students, we need to be human and to demonstrate that. A few years ago, about ten minutes before I went into class, I got a note from several students saying there was cheating going on in my class. It upset me so much that when I got to class and I stopped and said, "There's something that is really wrong today." I talked about what was going on and my voice started to crack; I couldn't even speak about it. The sense was how much I cared about what was going on in that class; there was not a

sound. Sometimes I think we just need to model being humans, and that's kind of how we teach. I think that was an awful experience, but I think both I and the students learned something.

Ranelli: I'll talk to this briefly. On September 11, 2001, on my campus and on campuses across the country, faculty, students, and staff had a national tragedy to deal with; many of us had personal issues as well. University-wide, the students remarked that there were a number of faculty who made no mention of the incident at all that day, even after it just happened. Some faculty suspended classes during their 50-minute hour or talked about it a little bit and then went on with their material. Some faculty said, "I can't handle class today" and gave an explanation. What the perplexed students wanted was some reaction-any reaction-from faculty, and they were taken aback that some professors could go on as usual and not say anything.

Question: I have a couple of comments and then more of a technical question. First of all, I want to thank the panel, because this has been very informative and very interesting. I'd also like to posit that we can measure these kinds of behaviors outside of structured simulations, which relates a little bit to the work that I've done with trying to measure professional behaviors. I think we can observe these behaviors if you have specific criteria; if you have enough interaction with your students on a day-to-day or week-to-week basis, you can make observations of their naturally caring behaviors in other environments. My question is for Amy. Even though we just saw brief snippets of your student interactions, it occurred to me that the patient's behaviors elicited different responses from the students; the example that was most striking was the patient who was crying. I have a strong feeling that the other students may have reacted differently if their patient may have cried as well. I would like you to comment on that.

Haddad: Yes, students do react differently. I try and keep the standardized patients to the script but they do what they want to do when it starts. The ethical cases are not like cases that involve medical problems. The standardized patient who cried, cried with every one of the students. So all the students that went through that room got that experience. Mr. Banyon was the only male. He stood and paced and he told me, "I have a friend who has Alzheimer's disease and this is what he does. I think that's what I should do." So the patients have some latitude in how they play the role. What's helpful, then, is when they watch each

other's work in groups of five. The students will say, "Oh, your patient cried? Mine didn't cry. I'm glad mine didn't cry." Then they have an opportunity to talk about what would it be like if they did cry. Or, "Your patient was hard on you. Mine didn't ask those questions." They gain from watching their peers; they can see that the same case may play itself out differently.

Berger: I want to add something. I want to go back to what Paul said about what you bring into the room. Because so much of my Ph.D. training was in psychology, I'm very much interested in the relationship between meaning and emotions. If you're a pharmacy student, what you might bring into the room is that crying is weakness. If that's so, then the emotions that result from the patient crying are very different than if you're somebody for whom crying means "I need to care for this person." I spent a lot of time talking to students about what meanings came up before their emotions took place, because that's how they start learning about who they are and what's going inside. As humans, we rarely respond to reality; we react to our own reactions, to our own history. And until we start learning about our own history, which has to do with meaning, we're going to keep doing those same reactions over and over again. So I spend a lot of time talking to my students about what meanings come up: When you walked into that patient's house and they were lower income and they weren't the same race, and you felt frightened and apprehensive, what was the meaning? And does that meaning work? Is it accurate? Was this patient somebody you really needed to fear after you got acquainted and what have you learned from that? That's part of what I think has to happen as part of the transformation.

Question: Bruce's comments were a good preview for what I wanted to ask. When Paul asked, "What are you bringing into the room?" I wanted to ask Amy if the students who are in your class have the opportunity to reflect on how they have reacted emotionally to previous occasions or do they just get a self-awareness of their emotional capabilities before they do these exercises, and then later on see how they've grown or how they've changed throughout the course?

Haddad: I hadn't thought to ask them about the emotional impact initially. So, in the fall semester I only asked the last two times and then I was kind of sad that I hadn't done it all four times. In the spring, I did it all four times. Each time I asked the same question, "What emotions were evoked in the simulation?" They really did move from not being

able to say anything about their emotions to identifying themselves and those of their patients.

Fassett: I would like to ask a question to the audience or to Bruce, Amy, or Paul. We know that at any given point in time, our adult students reflect the range of emotional, psychological, physical problems of the general population. We also know that some percentage of them is clinically depressed at any given time, and that it's undiagnosed. We know that some percentage of them have undiagnosed diabetes, hypertension, or any of these other conditions that we know about general populations. Those conditions affect them as human beings. It's part of what they bring into the room. Paul, that's almost the best question that I've heard in a long time. It's going to keep me awake at nights, thinking about what my students are bringing into the room. I'd just like to ask a question arising from this reality, and this again, from my logic, argues very strongly for being very careful about how we determine students' futures based on these kinds of interactions-to make sure that we're not being judgmental based on these interactions, but that we use them appropriately and carefully until we learn a lot more about them. How do you approach the student who, the day before this event, has had somebody die? Think about it. They may have a parent or grandparent who has Alzheimer's and they bring that with them to this setting. As caregivers in this setting, think of the skill set we need. I think there's room for a lot of workshops on building our own skill set once we get into these areas.

Haddad: The students will say that it's not fair that they don't have more information and more time to think about what they should say to work through all of this. I did have a few students who actually do have grandparents who have Alzheimer's disease and so this case was especially difficult for them. But they said, "Boy, this is a lot better that I'm doing this now in this kind of setting, because it never occurred to me that people I would meet would set off this kind of reaction." So it's an opportunity for the students to face their personal reaction in a safe environment where they can reflect on it. In real life, they're not going to have this warning before seeing a patient.

Berger: I also wanted to make sure that I was being clear. When I ask about meaning and emotions, it's not my job to do analysis of our students. It's not my job to analyze our students, nor to judge them at all. It's my job to pose the questions, the kinds of questions so they can do

the internal work, so they can start engaging in the journey. I'm not even that interested in the answer to the question, "What was your meaning?" I'm interested in them starting to ask themselves those things so that they can start taking that internal journey and that's part of the transformation process.

Question: First of all, I found everyone's presentation outstanding; I really appreciate your comments. As a career clinician, and somebody who's been involved in drug development, there are a couple of things that I feel I really need to comment on. I also have to say, after being almost a twenty-year member of AACCP, this the first meeting that I've attended, and if this is the quality of programming that goes on, I'll continue coming back for a long time. What I have to say has to do not just with the issues discussed here, because I found your method for teaching students outstanding. I really hope people use this method. I think it's a great means of communicating a lot of things that have to do with differences among people with whom we interact. I'm very sensitive to issues that have to do with culture, genomics, drug metabolism, and the global development of drugs, making sure that our students, as drug experts, know how to best advise people. I was really struck, looking at the specific example having to do with somebody with Alzheimer's and trying to explain those things and bringing it back into your personal life, how everybody chose how to respond and how the students responded. I think this is a great exercise, but it brought to mind for me all the things about people that are really different, gender differences and ethical principles that they use in decision making, which I think is outstanding. There are age and developmental issues that need to be addressed. We usually think about working with developmental capabilities of individuals of a specific age. I've worked with people with developmental disorders over the years trying to determine if an individual has the capability of giving true informed consent; this is a critical issue and an ethical concern for all of us. There are huge communication barriers, not just racial differences, but differences in cultures around the world. I think about students from other countries coming here and learning how to practice: Their value systems are different, their morals are different, the way they perceive it appropriate to interact with people is different, and then they become practitioners. The next time you go to a hospital or an ER and a medical student or resident is working there from another country, study the way they approach you to communicate and figure out what is wrong with you and how they determine what your needs are. The other thing I wanted to

say had to do with behavior. What I saw demonstrated was a couple of students bringing out specific target symptoms associated with Alzheimer's disease; let me give you a word of caution about the behavior you actually observe. The behavior you observe on the surface in somebody who is ill or under stress or duress is very different from the way they behave normally. All those morals and values that are under the surface and suppressed come up to the surface, and these patients behave differently than you would see when they were in good control. How we teach all those things to students in the short time we have, I don't know. I don't have the answer; I think all these issues that are incredibly important and I hope that people walk away from this session and think about those clinically related issues and how we can impart this kind of knowledge to students, so we can figure out a better way to communicate that information.

Buerki: I want to thank you very much for participating in our session this afternoon.

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NOTES

1. Readers who wish a copy of Dr. Fassett's PowerPoint presentation may contact him at fassett@wsu.edu.
2. At the time of this presentation, Dr. Ranelli was Dean and Professor of Social Pharmacy at the University of Wyoming School of Pharmacy.

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