

# What "Care" Can Mean for Pharmaceutical Ethics

Warren Thomas Reich

**SUMMARY.** Recent research in the history of the idea of care prior to current feminist literature sheds new light on pharmaceutical care viewed as the point of identity for the profession of pharmacy. This article explores several ideas about care: (a) care as worry and concern; (b) care as attention; (c) the historic clash between care as burden and care as attentive devotion; (d) the nature of attention, a moral component of care; and (e) the modern conflict between taking care of and caring about patients. The explanation incorporates a number of stories, from an ancient myth of Care to modern vignettes of pharmacists. The author indicates some ethical implications for pharmacy ethics and suggests an agenda for future inquiry. [Article copies available from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: [getinfo@haworth.com](mailto:getinfo@haworth.com)]

## INTRODUCTION

Both the topic that I have been assigned and the professional pharmaceutical context in which it will be explored present chal-

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Warren Thomas Reich, S.T.D., is Professor of Bioethics in the Department of Family Medicine, Director of the Division of Health and Humanities in the Center for Clinical Bioethics, and Senior Research Scholar in the Kennedy Institute of Ethics at Georgetown University.

Address correspondence to the author: Center for Clinical Bioethics, Room 234, Building D, Georgetown University Medical Center, Washington, DC 20007.

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lenges of creativity. First, the context of this inquiry is both creative and historically significant: it is a setting in which the profession of pharmacy is seeking to redefine itself around the focal point of "pharmaceutical care." Two authors even speak of "*pharmacy's reprofessionalization*" based on the social and professional responsibility of the pharmacist for patient care (5; italics added).

Second, the assigned topic requires me to explore some of the historically significant—but hitherto unexamined—meanings of care and their possible relevance for the development of an ethic of pharmaceutical care. This, too, presents an unusual challenge, for as recently as 12 years ago and throughout the entire previous history of philosophical and theological ethics one simply does not find a systematic ethic of care. Ethics has generally been based in such virtues as justice, fortitude, and love, and in such principles as beneficence, autonomy, and utility. On the other hand, I have discovered a tradition of the idea of care, virtually unknown in modern ethics, that extends back at least 2,500 years in a variety of cultures (14). Now, for the first time, we are able to compare the history of the moral idea of care with the recently developed ethic of care.

In the early 1980s, the notion of care was "discovered" and quickly exploded in the literature of developmental psychology, then in ethics, bioethics, and the larger disciplines of philosophy and theology. It began when a few women, experts in psychology and education, began examining women's experiences of gaining moral knowledge and making normative judgments. Prior major works on moral development, specifically by Piaget and Kohlberg, had studied only men and boys. Using male attitudes as the norm, they developed explanatory frameworks that, when applied, found women inferior in moral development and, by extension, in moral judgments.

Carol Gilligan (4) and Nel Noddings (12) proposed that women typically (and many men as well) simply have a different moral orientation that had never been taken seriously in moral development studies. That "different" orientation is a "care perspective" whereby they make normative judgments on the basis of what fosters relationships and the dialogue that sustains them. As an outcropping of these writings, an extensive ethic of care has been developed based on caring sentiments; this ethic is attentive to the

values inherent in and the normative implications of the experience of care rather than being so exclusively concerned with universal principles (7,17).

Other participants in this symposium will offer systematic discussions of the contemporary ethics of care and of pharmaceutical care. I wanted to go deeper into the human meaning of care; with that purpose in mind, I will draw on the psychology and history of care—a history that has been almost totally absent from the contemporary, largely gender-oriented discussions of the ethics of care.

### *CARE AS CONCERN AND ATTENTION*

The history of the word “care” reveals that at its most rudimentary level, care means worry or concern (13). This meaning of care is rudimentary in a psychological sense (it is found at the roots of the knowing self); and it is rudimentary historically (it is found in the earliest usages of the word “care”).

The significance of this meaning of care is that if nothing 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. Rollo May, the great humanistic psychologist, insisted that care is at the root of ethics, for the good life depends on what we care about. Only if I care about some thing or person or organization will I be able to transcend my immediate self-oriented desires and take a moral stance regarding the welfare of the other, such as by performing or avoiding certain actions for the benefit of the other (10).

We get an idea of what care means at this level if we ask: “What are you worried about?” “What are your concerns?” “What are you most concerned about?” “Are you avoiding some important concerns?” Furthermore, to worry or be concerned about something entails turning my concerned attention to that thing. Thus, attention is fundamental to the notion of care.

An anonymous correspondent wrote a letter to newspaper columnist Ann Landers to tell her about a woman who thinks it is perfectly all right to take her shoes off during church services attended by the letter writer. The correspondent then asked Ms. Landers, “What do you have to say about this?” Ann Landers replied, “Dear

Du: I say the poor woman's feet probably hurt. Be thankful that yours don't" (9).

In so many words, Ann Landers is saying, "What are you worried about? Yes, I know you are worried about the inappropriateness of the barefoot woman's offending practice of taking her shoes off in church. And you expect me to comment decisively on her outward behavior. But I'm telling you what *I'm* worried about: I'm concerned that the poor woman's feet probably hurt." Landers is giving an instruction on what it is worth *caring about*.

Furthermore, Landers's reply illustrates the meaning of care as attention. Her reply stuns, because it unexpectedly turns Du's and the readers' attention away from the shoeless woman's nonstandard behavior to her subjective feeling of pain. Landers did not imply that Du's question was absurd; she simply set aside Du's vision of things by turning Du's and her own readers' attention away from the rightness or wrongness of the action involving socially offensive feet to the need to be attentive to the great discomfort that the lady is possibly experiencing in her feet. We show what we care about when we turn our attention—our interested and empathic attention—to a person or idea or task or group.

It is the irony in Landers's reply that so effectively refocuses the reader's attentive moral concern. In her humorous reply, one notes an ironic clash between the apparent meaning of her statement (that the shoeless woman's discomfort is worthy of our attentive concern) and her intended meaning (that being attentive to the woman's discomfort is far more important than being concerned about the rules of etiquette entailed in removing shoes in church).

As this analysis indicates, care as concern pushes us in the direction of establishing a ranking of what we should care about. In Plato's *Apology*, Socrates exhorted his hearers not to care for their bodies or for money more than for their souls and the welfare of their souls. He argued that the cultivation of the soul is the first concern (11). Whoever would live the good life has to discern what he or she should care about above all else.

The rhetorical effect of Landers's ironic reply is a pointed revelation of nothing less than the starting point of all ethics. Intentionally or not, we approach the task of forming normative ethical judgments about behaviors and attitudes by first judging what is salient

for our moral attention. Landers's ironic statement illustrated that kind of judgment; as such, it manifested both of the basic elements of care. First, it urges the reader to ask: What matters most here? What do we need to be concerned about? Second, it is an exercise in attention or attentive care: What is really going on around me, and of the several things going on, which deserves my primary moral attention? Landers answered those questions, and in so doing, focused our interpretive attention on a person and her individual experience—a focus that might never have entered into an ethical discussion solely of the worshipping woman's external behavior.

The entire task of discerning what merits our moral concern and turning our attention to it—a task that is suggested by the most rudimentary elements of a morality of care—is a major, largely neglected element of ethics. Instead, ethics seems more preoccupied with identifying the most dramatic quandaries, assuming without much further inquiry that they constitute the canon of ethical issues for health care, and solving them intellectually through the application of principles. While this dominant approach to ethics serves the good purpose of developing intellectual skills of analysis and assists certain stages of policy development, it can create blinders that limit our vision of what calls out for our attentive care in the first place. For example, the woman with sore feet is emblematic of the numberless individual patients whose anguish goes unheeded because the concern of both the health professional and the bioethicist is not sufficiently trained to be attentive to that sort of thing. At this turning point in the philosophy and ethics of pharmacy, it would be important to be attentive to the rudimentary activity of listening to the concerned voices from the past and present that speak of those things that merit attentive concern.

We will return to the notion of attention after reflecting on an ancient narrative of care that establishes a vision for all of ethics and in particular for the ethics of the caring professions.

### ***CARE AS BURDEN, CARE AS DEVOTION: AN ANCIENT MYTH***

Much of the history of care is embedded in story; one of the most ancient stories of care is a myth that was published in Rome in the

second century of our era. The myth itself is enigmatic: It is scarcely ever commented on or published by mythologists; yet it has had a strong influence through the centuries on some major literary writers, philosophers, and psychologists. The myth is a creation account that is available only in the following abbreviated form.

One day, while Care (the Latin word is *Cura*) was crossing a river, she paused, pondered, picked up some mud, and began to fashion a human being. While she was reflecting on what she had accomplished, Jupiter came along and Care asked him to give the spirit of life to the human being. Jupiter willingly did as she requested. Then Care decided that she wanted to name the human after herself; but Jupiter insisted that the human be given his name. While Care and Jupiter were arguing, Terra (the goddess Earth or Mother Earth) arose and said that her name should be bestowed on the human being, since she had given her own body to fashion the human. Finally, all three parties to the dispute agreed to accept Saturn as their arbiter. (He was known for his fairness.) Saturn resolved the dispute with this decision: Jupiter, who gave spirit or soul to the human, would take the soul back after death, and that should be enough for Jupiter. Since Terra had given her body for the human, she would receive it back after death, and that should suffice for her. "But," said Saturn, "Since Care first fashioned the human being, let her have and hold it as long as it lives—from birth to death." Finally, as to naming the human, Saturn decided: let it be called *homo* (Latin for "human being"), since it seems to be made from *humus* (Latin for "earth") (14,6).

The word *cura* (care) in Latin had a deeply ambivalent meaning. On the one hand, it meant a heavy burden—the burden of the cares of life—so much so that these cares were personified. For example, the vengeful Cares stood at the gate of Hades in the mythology of Virgil. But Seneca placed emphasis on care as uplifting, a power that places humans on a level with God. He said that God perfects his good through his own nature, but in humans the good is perfected by care (16).

The myth suggests some profound insights regarding the nature of care. Care, in the myth, is a primordial model of healing: She is achieving the wholeness and goodness of humans, for she is holding them together from birth until death. The myth tells us that the

body is directed toward the earth to which it will return, while the soul is directed upward. Thus, while humans are threatened with an internal sundering of the self, Care is holding them together in wholeness while cherishing them.

This is a positive, uplifting notion of care; but its positive quality is known only as a counterpoint to the inherent threat to the unity of the individual. There is a profoundly dialectic element in this ancient notion of care. This element could be very instructive for an ethic of care today, where we tend to think of care as altruism: an idealistic dedication of the self to compassionate service of the other on the basis of gentle, fine feelings. Such a vision of care blinds our view of the dark side of care. There is only one care in this myth: it is burdensome care that requires being transformed into a more uplifting kind.

The imagery and narrative setting of care in this myth is highly significant for ethics. One of the major functions of myths is to offer an ancient narrative in which it is possible for humans to understand basic truths about human nature as reflected in the gods and goddesses or other characters in the myth. Myths actually change reality for their listeners: it causes them to view the world differently and to form communities accordingly. The myth of Care conveys an understanding of how care is central to what it means to be human and to live out a human life. It also provides a genealogy in light of which we can rethink the value of care in human life.

The myth of Care has strong political implications. Care created and held together not only the first human being regarded as an individual, but through it the beginnings of all humankind. Thus, care is the glue of society. This could have important implications for bioethics. The great political philosophers used creation myths or myths of origin to explain the human condition and justify certain political structures and principles to deal with the adversarialism of citizens in a pluralistic society. The myth of Care suggests a radically different image of society and the social order. The image is one in which all are cared for from birth to death simply because they are human; and the myth presents this image of care as one that is a pervasive and creative presence in our world.

The imagery of this myth also suggests something about power that we know from modern psychology: that the power to be nurtur-

ing to others and to care about others depends on being cared for, especially in early childhood. The strong social and political elements of the myth, together with its implications for a psychology of growth and power, offer a corrective to the dominant contemporary view of care, which regards care as having only an individual and interpersonal significance. This, in turn, suggests that the moral responsibility to care for the health of the public or of large cohorts of the public could be articulated in terms of an ethic of care.

### ETHICAL IMPLICATIONS OF ATTENTION

The mythical character Care (*Cura*) suggests the human importance of devoting one's concern or caring attention to the other—themes that were established early in this paper. A closer examination of the theme of attentive care is warranted by the ethical challenge found in pharmacy today.

Although the pharmaceutical profession is currently appealing to the idea of pharmaceutical *care* and patient *care* as central to the definition of pharmacy, it is not clear that this appeal includes a substantive, empathic attention to, let us say, the plight, the anguish, or the suffering of the individual patient. For example, when Hepler and Strand argue for patient care as central to the definition of pharmacy, they are speaking principally of the social and professional responsibility of the pharmacist to prevent drug-related morbidity and mortality (5). An argument of this sort—based on the need to achieve the greatest aggregate benefit for consumers of medications while avoiding harming them—is relevant to the meaning of care as expressed in the phrase “taking (technical-beneficent) care of”; but it easily overlooks the other meaning of care as caring about—the individual, the institution, the profession, for example.

A closer examination of attention, which is an essential component of care, might shed light on this easily-neglected aspect of care. There has been no more stimulating thinker on the topic of attention than Simone Weil, a French Jewish-Christian, philosopher-political activist-mystic who died in 1943 at the age of 34. Weil did not, to my knowledge, use the word care; but she often linked attention to compassion and love. One of her major concerns was the inattention paid to the suffering and plight of the working

classes—a concern that led her to activities that were frowned upon because she was a woman: she worked in factories, took part in the Spanish Civil War, went to sea with fishermen. As Robert Coles says, attention “was for her the great gift” (3). Her rich views on attention ranged from the mystical (prayerful) element to such practical elements as how attention could alter education.

Weil insisted that to pay attention to a moral or philosophical problem is not to concentrate with tightened muscles. Instead, we must engage in negative attention, removing obstacles to understanding, and then simply conceive “the insoluble problems in all their insolubility,” contemplate them, and patiently wait for understanding (19). She seems to be suggesting that when we see a moral problem, and then directly turn our attention to describing it in analytic and abstract terms and applying universal principles to it, we have not done justice to the task of morally understanding the problem itself.

Weil also placed attention at the center of ethics. She notes that “unequal objects unequally solicit our attention” (20, p. 6). But all humans are equal and, in fact, “absolutely identical in so far as they can be thought of as consisting of a centre, which is an unquenchable desire for good, surrounded by an accretion of psychical and bodily matter” (20, pp. 6-7). Those minds whose attention and love are turned towards the center of others are the intermediary through which good can come among humans (20, p. 5). Weil then turns this idea into a demanding ethic: The same person, whose attention and love are directed in that way, “recognizes at the same time that he is bound, both in public and private life, by the single and permanent obligation to remedy, according to his responsibilities and to the extent of his power, all the privations of soul and body which are liable to destroy or damage the earthly life of any human being whatsoever” (20, p. 8).

For Weil, attention is at the heart of moral choices that rely on judgments of human dignity. She points out that modern ethics argues for human dignity on the basis of humans being persons. She calls this “a grave error of thought.” If one person says to another, “You do not interest me,” the speaker commits a cruelty and offends against justice. But, Weil adds, if you said to the person: “Your person does not interest me,” these words can be used in a

friendly conversation without offense (20, p. 13). Weil comments further:

There is something sacred in every man, but it is not his person. Nor . . . is it the human personality. It is this man; no more and no less. I see a passer-by in the street. He has long arms, blue eyes, and a mind whose thoughts I do not know. . . . It is neither his person, nor the human personality in him, which is sacred to me. It is he. The whole of him. . . . Not without infinite scruple would I touch anything of this. (20, p. 13)

Respect for humans is not based on personhood, for if we harm others we do not harm their person. What is sacred in human beings is not their person but rather the impersonal in them, that is, it does not depend on what they personally accomplish in art, science, or whatever. Their sacredness is at the level where the highest things are achieved; and these things are essentially anonymous. Thus, respect for persons requires attention to the anonymous center of the individual that lies beyond any particular human characteristic.

Weil acknowledged how difficult it is for people to view others in this way because a variety of allegiances and social collectivities prevent them from seeing the other precisely as individual and particular. Weil's ethic of attention—we could just as well call it an ethic of care—is unusual and somewhat demanding, but it offers a marked improvement over the current, standard account of respect for persons, which views humans abstractly and in isolation from what it means to experience a relationship of respect.

Weil's ideas about attention could be extremely useful in the task of rethinking the ethics of pharmacy. The profession of pharmacy is at an ethical crossroads; it has the unique opportunity of accomplishing what I would call the reprofessionalization of pharmacy ethics. If the term "pharmaceutical care" is to serve as a central idea for rethinking the identity of the profession, and if the term is to have the ethical implications that the word care suggests, then the profession, its scholars, and its educators must develop a vision of care. They need to decide what it means to care about—while also taking good, technical pharmaceutical care of—the patient.

This task entails considering what sort of attention (caring attention) pharmacists would want to give to the individuals they serve

and to the tasks they undertake. If pharmacists are to take a strong turn toward clinical care, they need to examine the ways in which an appreciation of the dignity of patients requires predispositions for respecting others.

This is what Weil offers when she plumbs the depths of a caring attention—an attitude that is accessible to all but which requires discipline and training. Weil would have us go to the core of every individual without having to know them personally. She would have us contemplate with an uncluttered mind whatever is “part of the problem,” including the unpleasant, the unpopular, and the unspeakable in those we are serving. This is good advice for those who are trying to establish a professional ethic based on the centrality of the individual being treated.

### *TWO IMAGES OF PHARMACY*

In developing a new ethic for pharmacy, it is important to be aware of the ways in which ethics is radically shaped by the concern that serves as our starting point—what we judge to be most salient and to which we turn our moral attention. The following two images of pharmacists—representing two pharmacists I have known—exemplify two notions of care that will be crucial for developing an ethic of pharmaceutical care. In each case, the moral character of the pharmacist’s care-behavior was shaped by the pharmacist’s judgment as to what deserved his or her moral attention.

Doc Ward was the local pharmacist in the Alabama town, population 1,700, where I spent childhood years between the late 1930s and the mid-1940s. Our town had one drug store, one grocery store, one ice house, one physician, and so on—all serving a widespread area. Doc Ward did more than run the pharmacy and manage the rest of the drug store; he presided over it and all the townsfolk who entered his place of business. Doc was an unforgettable Norman Rockwell-type of character: short and trim, with closely cropped, gray-white hair, spectacles, a ready smile, and a neighborly greeting. And he always wore a white shirt and bow tie. Doc Ward was a stellar figure in the town—cheerful and always helpful. We sometimes played with his grandson, when he was home from the special school he attended.

Doc Ward showed enormous pride in his calling by the way he connected with his fellow townsfolk who sought his aid. He didn't stay behind a counter; he ranged about his store, checking on the people who dropped by. He'd eyeball a youngster and say, "Hello, Tom, is your daddy doing better today?"

We knew we could take our ailments to Doc Ward, too. We children never confused his role with that of the town's physician. I always reckoned that Doc Ward had no doctoral degree; I felt the title "Doc" was honorary, conferred by the community. But I also figured it was merited by his professional role, for there was never any doubt about his being a healer. After all, he was the town's pharmacist; he knew about ailments and infections and medicines and had wonderful counterside manners. We could tell him what was bothering us; he would recommend a treatment; and it worked. It always worked, because Doc Ward knew his stuff; but more important, we *knew* it would work, because Doc made us feel confident in his recommendations through his genuine concern for us. We started feeling better as soon as we talked to him. That was Doc Ward.

Now, about 55 years later, I have an image of a very different sort of pharmacist whom I encountered in the summer of 1994. Her name is Ms. Tuong-Ri;<sup>a</sup> she's one of the pharmacists employed by a large, chain-owned drug store in my large, suburban town. She would have been nameless to us customers had her name tag not been inserted in the appropriate slot behind the pharmacy counter along with those of two other colleagues. Having stopped by the store to pick up a prescription, I stood in line behind four or five silent, anonymous suburbanites who showed the annoying impatience of citizens of a city of bureaucrats resenting this final queuing of the day.

A little old lady at the head of the line had asked in vain for her prescription. She repeated several times that the prescription had been called in by her doctor; but her speech lacked the vigor and assertiveness so often required to gain attention and respect in the public world of commerce. The clerk referred the request to Ms. Tuong-Ri, the pharmacist, and gestured the old lady out of the way while she waited on other customers. Each customer, in turn, fulfilled

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a. The name is fictitious; the event is real.

the cardinal rule demanded of purchasers at this pharmacy: they pronounced and spelled their names clearly so the clerk would not be inconvenienced or delayed in searching for the customer's envelope.

I began thinking that the little old lady, who was tucked up against the towering counter of the pharmacy, had been forgotten. Not so: beyond the counter I could see Ms. Tuong-Ri giving her concentrated attention to a computer screen. Finally, speaking from behind the pharmaceutical rampart where she was totally invisible to the sick little lady, Ms. Tuong-Ri mumbled in a heavy accent, while still studying the computer screen, "It's not here, we don't have any record of it." I could tell that the tiny, elderly customer didn't hear a word the pharmacist had spoken. Apparently convinced she had expedited the problem, Ms. Tuong-Ri turned her attention to filling a different patient's prescription. The sick little lady, still standing to the side—where the service counter meets the pharmacists' white wall—kept waiting and waiting to be taken care of, ignored by the clerk who was dealing with other customers who pressed ahead in the line.

Angered at the neglect, I overcame my reluctance to publicly correct the situation, aiming my firm voice over the heads of customers and beyond the white pharmacy wall. "I don't think she heard you, ma'am, could you give her the answer to her question?" Ms. Tuong-Ri mumbled again, "There is no record here, it never came in." It was clear that the pharmacist felt she had fulfilled her responsibility by verifying the record, rather than by attentively communicating with the sick woman who still had not heard the information about her medication. I then spoke more pointedly, in hopes of turning Ms. Tuong-Ri's attention from the record to the person. "Would you please come over here from behind that high counter and stand in front of this lady and talk to her face-to-face and give her a clear answer and help her solve her problem? She is not hearing you."

Ms. Tuong-Ri moved from her post. She spoke face-to-face with her elderly customer, restricting her comments to clarifications about her pharmacy's records. The obviously confused elderly customer kept repeating in a variety of ways that she had done everything she could to get the prescription renewed.

I wondered, shouldn't a pharmacist care more about the special

needs of a sick person who shows up in his or her pharmacy? What if the elderly woman urgently needs the medication tonight? Rather than be little more than a computer's partner in filling and recording prescriptions, shouldn't a pharmacist be concerned about solving patients' problems? I asked myself, couldn't the pharmacist attempt to solve this lady's apparent need for medication by calling her doctor's office, or by offering to call the lady herself later at home, or by contacting a relative or friend of the sick person?

The pharmacist terminated the conversation by saying she had done what she could by checking the computer; she left it to the confused customer to rectify the situation. I looked around to check the reactions of the other customers. None seemed to be paying attention to what was happening with the little old lady. I heard someone grumble, apparently annoyed by the activities that were slowing down the line.

In the two preceding vignettes, Doc Ward was probably at the end of an era that had enabled him to craft an admirable combination of the virtues of competency and caring devotion to the welfare of the individual patient. The culture of his profession and of his society enabled him to do that. I suspect that he and his culture have died out, leaving only the shards of an old profession.

Ms. Tuong-Ri's professional behaviors, on the other hand, should at least be credited for exercising the contemporary, corporate virtue of competency: she was undoubtedly manifesting her training in what Buerki and Vottero call the product-oriented ethos of pharmacy (2). In this perspective, her training turned her attention, on the evening in question, to the right authorization and the right record-keeping of the right medication, rightly dispensed and paid for. She may have been very conscientious in "taking care of" the dispensing process in a technical way. On the other hand, she could be criticized for her neglect of the needs of the patient. Did her training fail to attune her attention to "caring about" the personal outcome for the individual patient? Did her cultural background orient her to a notion of care that is, perhaps, different from the models of compassionate care considered in this article?

Simone Weil's insights on the nature of attention shed light on the plight of the contemporary, corporate pharmacist represented by Ms. Tuong-Ri. Weil would have the pharmacist turn her interested and empathic attention not just to the computer screen, but to the

individual standing before her and the whole world, including the inner world, of that patient. The Weil-instructed pharmacist would turn her attention to the little-noticed by perhaps crucial discomfort and needs of the sick person—not because the patient displays a strong autonomy and a sense of personal rights, but simply because she is an individual regardless of such personal assets. Weil would have a pharmacist ask, “Of all the things going on around me, which deserve my caring moral attention?” And if pharmacy had as one of its goals the creation of caring institutions (stores, hospitals, corporations), its members would ask themselves, in the spirit of Weil, what this goal would require of them.

***PHARMACEUTICAL CARE: TAKING CARE  
OF versus CARING ABOUT***

The foregoing vignettes represent two pharmacists I have known, fifty-five years and worlds apart. The dramatic clash between their attitudes, their commercial cultures, and their ethics arises principally because they represent two different moral notions of care in two very different eras of American cultural history.

Two moral notions of care are often experienced as being separated from each other and even in conflict in today’s world of health care: taking care of the sick person, which emphasizes the delivery of competent, technical care; and caring about or caring for the sick person, which suggests attentive devotion to the well-being of the other (15, p. 331). Although in today’s world we tend to view the former as mere technique and the latter as virtue, the physician of classical Greece regarded the love of technical skill as a great virtue. Prompted by the influence of Hippocrates, competence in the science and art of taking care of the sick person became the hallmark of medical care through most of history (8, p. 22). By the turn of the twentieth century competence and technical skill had become *the* essential and comprehensive characteristics of medicine. This led to divorcing the disease from the patient and the resulting marginalization of personal “caring about” the patient (15). A swing back in the opposite direction was noted as early as 1926, when Francis Peabody, a Harvard professor of medicine, argued that physicians must engage in “caring for” the patient in order to achieve the goals that are inherent in the practice of medicine (15).

As the profession of pharmacy identifies itself more and more as a profession concerned with the clinical pharmaceutical care of patients, this conflict between taking care of and caring about will become more central to its ethics. The task of formulating and educating for appropriate caring behaviors and attitudes will be enormous.

The question is whether, in our current culture, the pharmacist will begin to see as his or her professional task the recombination of taking care of and caring for the person needing medication. If the Ms. Tuong-Ris of the world of pharmacy are to begin "caring about" the sick who come to them (as customers? clients? patients?), they first must be given permission to do so, for such behaviors do not seem to be part of the highly technologized and depersonalized corporate culture of medical sales that requires perfection in technical skills and the distribution of products.

The further and more demanding challenge for pharmacy is to create a new culture—with its new intellectual, moral, spiritual, scientific, professional, social, educational, and other elements—to prepare for a truly professional pharmaceutical care. Other professions, notably nursing, have given a great deal of attention to the central problem: how to take care conscientiously while also not demeaning the essential role of caring for the one who needs it (1).

Within the profession of pharmacy, important efforts have already been made in the direction of creating a new vision of the identity and responsibilities of pharmacy and a new culture of the profession, based partly on considerations of care and covenant (18,2). Perhaps this undertaking could profitably be expanded through a careful and imaginative dialogue on the implications of images of care—such images as the person who sees a shoeless lady in church; the one who is a child of Care from birth to death; the congenial, bygone pharmacist Doc Ward; and the contemporary, semi-anonymous corporate pharmacist Ms. Tuong-Ri, who is struggling to discover a professional/moral identity.

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