

Revisiting Concepts, Attitudes and Expectations of Brazilian Pharmacists to the Practice of Pharmaceutical Care: A Qualitative Perspective

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ABSTRACT

Background: Research has shown advancements in pharmaceutical care services to the population, with a change in practitioners' professional behaviors. **Objective:** This study aimed to assess present attitudes, expectations and associated meanings facing these pharmacists' extended role in primary care. **Methods:** The study followed a qualitative design. Data collection was carried out between 2011 and 2012, in two stages: the first used semi-structured individual interviews; the second one followed a focal group strategy. Data were gathered from purposively selected participants, i.e. pharmacists directly involved in primary care provision. A dialectical theoretical frame work in formed the data analysis. **Results:** Seven participants allowed reaching data saturation on their concrete conditions and their social and institutional interfaces with impact in experience and practice. It was possible to extract five meaningful dimensions: Pharmaceutical Care conceptualizations, the Pharmacist and its relationship with the health team, the Pharmacist and the management of services, the Professional daily work and training. Overall, these dimensions were didactically clear, but significantly intertwined: **Discussion:** Data have shown that Brazilian primary care pharmacists' education and training in pharmaceutical care is not considered essential for present pharmacists' practice, since caring for patients does not permeate daily routines. **Conclusion:** The deployment of pharmaceutical care remains as a management challenge within the Brazilian Unified Health System. Pharmaceutical care is not only dependent on a required training process, with refocused practice for each pharmacist, but also mediated by a significant change of profession meaning to society and self-accepted relevance of the pharmacist in the Brazilian primary care.

Key words: Pharmaceutical Services, Pharmaceutical Care, Primary Health Care, Qualitative Research, Brazil.

INTRODUCTION

The worldwide movement concerning the extended pharmacists' role in health systems, mostly known as “pharmaceutical care,”^{1,2,3} is recognized by the Brazilian government since 2004. Since then, the concepts of pharmaceutical care have been incorporated in the formulation of rules and public policies, compatible with the current health policy,^{4,5} particularly within the Brazilian Public Health System

(*SUS*). *SUS* provides universal, whole and equalitarian access to health assistance, in a regionalized structure, centered in primary care.^{6,7} Recommendations for a qualified pharmaceutical professional practice within the *SUS* have been issued, but in reality still is possible to identify pharmacies working without a pharmacist, precarious pharmacy services and inappropriate dispensing of medicines.^{8,9} Even when there is a qualified

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pharmacist working in public or private health services, clinical assistance by pharmacists is often conflicting with traditional tasks, because these professionals are mainly concerned with drug logistics and pharmacy management, i.e. product supply and inventory, as well as bureaucratic processes.^{10,11,12,13} However, it is possible to identify in a very large and diverse country as Brazil that in some Brazilian cities, like Curitiba (Paraná state), the advanced training and qualification in pharmaceutical care is being translated into clinical services to the population, with an increased and effective use of professionals' clinical knowledge and skills in practice.¹⁴ In 2006, one city of the metropolitan region of São Paulo (SP), began a process of structuring the pharmaceutical assistance to the population, recognized as a group of actions within the national health policy for the promotion, protection and recovery of health, individually and collectively, where medicines played an essential part; it was aimed to provide equitable access to medicines and promote their rational use, thus including pharmaceutical care activities.^{4,15} As part of this pharmaceutical restructuring, professionals started to support primary health care units, with the aim of developing actions that could contribute to patients' quality of care. The pharmacist intervention was planned for both logistics and management of medicines, as well as for patient care, with professionals' participation in health-care teams. The healthcare provided by these public services is developed according to a family healthcare strategy, with the healthcare team comprising at least one of the following professionals: a physician, a nurse, a nursing assistant, plus around five community health agents; this team provides assistance to a population of approximately 4,500 people.¹⁶ Pharmacists' role within this team is to provide the common pharmacy service (e.g. procurement and storage), to support health staff in medicines use, and to adopt activities associated to primary care patients and families dealing with medicines. These activities are institutionally confirmed also by the engagement of university staff in the organization of these tasks. Pharmacies are located within the primary care service, thus pharmacists have easy access to prescribers and other professionals, as well as to the patient records and clinical information, available through an on-line system. As part of the service implementation, pharmacists attended in 2011 two courses offered by the associated university, one in pharmaceutical care for hypertensive patients and another for diabetes care. To better understand the context of practice and how reality structures the provision of advanced pharmaceutical services, the study objectives were to assess the professionals' attitudes, including perceived facilitators

and barriers, as well as expectations towards the new role, according to those involved in primary municipal health. It was aimed to discover how the Brazilian guidelines for the implementation of pharmaceutical care, applies to reality. This study also contributed to create a practice research environment, which has not yet received researchers' attention.^{17,18,19}

MATERIAL AND METHODS

The study design followed a pure qualitative perspective, in which social phenomena are understood in their relation to the context. The method integrates a theoretical framework that allows an interpretative and explanatory look of concrete reality, overcoming the descriptive aspect.²⁰

Theoretical framework

The theoretical model used in the present study was inspired by Russian authors, such as Vygotski,^{21,22} Luria²³ and Leontiev.²⁴ According to these authors, human, world and society are constructed dialectically, in the concrete conditions of human existence. Therefore, humans are social beings, a product of multiple determinants.²⁵ The development of consciousness and autonomy of the individual is therefore dependent on the specific conditions of existence, which is mediated by society, culture, economy and education.^{26,27} Understanding how pharmacist perceive their practice and the constructed meaning simplifies the analysis of their concrete conditions of existence. Particularly important are the social and institutional mediators that will impact professionals' experience. In this sense, the dialectic analysis based on the cited authors will support the interpretation of the pharmacists' speeches as a whole.

Sampled population

Seven pharmacists of a medium-sized city in the metropolitan region of SP, active in primary care and responsible to start the reorganization of pharmaceutical services in the public system, were purposively selected from a group of professionals that have participated in a pharmaceutical care 2011 survey (Table 1).

Data collection

Data collection was carried out in the end of 2011 and 2012, in a 2 steps approach. The one-year gap aimed to identify possible changes as a result of management guidance and/or training courses.

- 1st step: 7 individual semi-structured interviews with the selected pharmacists, aimed to describe the work reality in relation to pharmaceutical care, including expectations as to on going changes. The data collection

instrument allowed for deepening subjective aspects of practice, such as beliefs, attitudes and important values for understanding senses and meanings. Conversational dynamics was followed to drive participants' meanings from personal experience, according to their individual subjectivity.²⁸ All the individual interviews were conducted by a single researcher.

- 2nd step: a focus group interview was conducted with the same pharmacists. The moderator avoided issues (e.g. policy) to promote participants feeling comfortable and confident enough, looking for true expressions of opinions and feelings from their lived experience. A collective space provides the emerging of examples, memories and emotions not always evoked in individual interviews.²⁹ The focus group comprised 5 pharmacists (one did not attend and the other was dismissed from the public service) and the group dealt with topics such as the process changes implemented, the progress made within one year considering the main daily difficulties in work, and expectations for the future work. The moderator recorded and registered verbal and non-verbal information. Choosing a focus group as a second step was a result of the previous interaction between the researcher and participants, favoring the capture the dialectical movement between thinking and expressing. The collective participation favors the expression of views in confrontation or association with others, allowing the (re)construction of meanings attached to each one experience. This should deepen the understanding by which participants were experiencing or have experienced changes in the pharmaceutical services.

All information collected by the individual interviews and the focus group were fully transcribed, ideas organized in significant codes and dimensions, analyzed based on the adopted theoretical and methodological assumptions, and further compared with the existing literature.³⁰

Ethical Aspects

Participants were informed about the research objectives, read and signed a free and informed consent form, according to the rulings of the Ethics Committee of the Federal University of São Paulo (Process number 0374/11). To ensure anonymity, the names have been changed to fictitious initials.

RESULTS AND DISCUSSION

From the analysis of the collected material, five dimensions or core meanings were extracted, although keeping the content of each dimensions in relation with the others, avoiding fragmentation of the speech.

A. Pharmaceutical Care conceptualizations

In Brazil, pharmaceutical care is defined as a pharmacy practice model in which the professional interacts directly with a patient taking medicines, aimed at rational pharmacotherapy and achieving defined and measurable therapeutic results.³ In general, pharmaceutical care definitions provided by participants were diffuse and unclear. Some explained their understanding of pharmaceutical care by the use of negative examples, without tangible definitions of patient care. This is illustrated by the following excerpts:

C1. For me, the Pharmaceutical Care is one concept, a method, a way of working and that, in general, we do not do in this institution. (J.U., focus group)

C2. The Pharmaceutical Care is the attention that we give to the patient. Besides that, in the same pharmacy, I can give pharmaceutical patient care. I do it in patient care. I always, always inform because we're using, always give guidance. (R.I., focus group)

As noted in the studies conducted in other contexts,¹³⁻³¹ professionals have appropriated some pharmaceutical care notions, but still find difficult to conceive them in objective terms and as another way of working with health services users. There is an oscillation between paying attention to the patient and playing the traditional role in public services, without envisioning these two activities linked. The citation below illustrates this idea:

C3. It is through this talk, of giving a person's opportunity, explaining what's going on in front of a prescription, because the only material we have at hand is the prescription [...] and we evaluate against that he (the patient) takes. That would-be attention to the patient. (S.O., focus group)

S.O.'s answer supposes the pharmacist is restricted to the time of drug dispensing, without considering the pharmacy as a part of the health service, in a multi-professional environment and where clinical data is available. The practice carries a bureaucratic work meaning, unlinked from the health care process. Besides a sense of disconnection, this difficulty is also shown in the way that needs were conceived, if pharmacists start working in a different perspective.

C4. I really enjoyed the classes we had in the course, both for diabetes and hypertension, it's like aiming a very good target, very interesting, but far from us now, [far] with the conditions that we now have here (B.R., individual interview).

C5. (...)I would start [pharmaceutical care] tomorrow if I had a fixed workplace. I already have a computer and already have the Internet. I would only miss one cooler database, but I think this is not the most important. I

think a [stable] workplace [is the most important] (...). (J.U., individual interview).

Professionals see not to conceive pharmaceutical care disconnected from a specific place, where they could receive patients within the health service. They do not set their minds on the possibility of sharing spaces that already exist nor to provide home care. Paradoxically, part of the participants considered pharmaceutical care necessary, as if it did not exist. Pharmaceutical care is already conceptualized, although its materialization, in view of some participants, can only occur if there is a concrete setting. This indicates the frame of conceiving a health service through the usual framework associated with the dominant biomedical model, where healthcare professionals, holding knowledge and authority, are behind a desk consulting patients in one-way communication. Actually, pharmaceutical care should be guided by other logic, where the relationship between the professional and the patient builds together the necessary knowledge, similar to a health counseling or education model. This does not require a physical place, although it is a way to feel safe and closer to the dominant model, where the professional is not being challenged to get involved with patients' doubts and uncertainty. Participants have not expressed understanding of the relationship importance, and how this is linked to practice improvement needed to materialize pharmaceutical care. Professionals remained tied to a professional practice focused on drugs, without turning their full attention to the service user. According to Angonesi and Sevalho,³² the idea of taking responsibility regarding therapeutic decisions is complex for pharmacists and is detached from the reality experienced by them. This points to the need for training of professionals who do not feel prepared for this type of intervention; this topic will be further addressed in a following dimension.

The traditional care model prevalence may be based on the absence of a guiding model for professional practice. Freitas *et al.*³³ pointed out that the concept of pharmaceutical care adopted in Brazil, by including activities such as dispensing and health education, hinders a clear understanding of the concept. Without the settlement of a guiding, underlying and accepted philosophy, a practical model that facilitates a different role does not develop and implement. According to Ramalho Oliveira,³⁴ it is essential that professionals internalize the pharmaceutical care philosophy to transform professional practice.

Pharmaceutical care was even figured as an ideal, almost imaginary practice; the aspirations of having pharmacists as part of a really team, with a defined and valued role, still is considered philosophy.

C6. (...) What I see today of pharmaceutical care is not what we try to do here. I still think it's that model, I think that model [of pharmaceutical care] might work (V.I., focus group).

It seems that professionals have ready other practice models, indicating further barriers to collectively build a different practice. Their views point to the prevalence of a conservative biomedical and physician-centered model, confirming the pharmacist's supporting role and a professional not fit for advanced clinical services.

B. The Pharmacist and his relationship with the healthcare team

This dimension captured participants' meanings of their role as pharmacists, comprising also main experiences perceived by pharmacists in relation to other professionals.

Pharmacists mentioned difficulties in integrating the healthcare team, as a result of different factors. For Campos and Domitti,³⁵ interdisciplinary work is limited by obstacles ranging from the structure of health organizations to ethical and subjective aspects in the inter-relations. These authors highlight the importance of clearly defined roles for each professional, exchange and joint work plans. These requirements were identified as absent by study participants.

C7. I think today be recognized as a pharmacist is the principal. Today we see these healthy aging talks, they talk to physicians, nurses, auxiliary staff..., and the pharmacist? (R.I., individual interview)

C8. And one thing that no one understands is the role of the pharmacist. (R.I., focus group)

C9. It's very subjective, because we're in a process to show our service, the physician has this action, the nurse has this performance... the pharmacist, who is acting? Nor we know. (S.O., individual interview)

To be recognized and respected by the counter part has been identified as an important factor for collaborative work between physicians and pharmacists.³⁶ However, the recognition of any professional team results from daily work, where the importance of each professional in the team is permanently under construction. Participants did not feel as part of the whole, and therefore their overall collective relevance in the healthcare unit is poor. Nevertheless, participants seem to expect recognition from the other elements of the healthcare team without concrete actions to make themselves valuable and recognized. The poorly defined and blurring roles within the team are confusing to pharmacists themselves as to other team members, so their expected functions keep centered in the known roles of medicines logistics.

Pharmacists' devaluation by the management and other professionals seems contrary to pharmacists' apparent intentions and attempts. However, if looking to pharmacists self-valuing in their daily work and in the relationship with other professionals, there is a sense of disqualification of the pharmacist, what Foucault calls as a list of know-power.³⁷ For this author, power and knowledge are directly connected, because there is no relationship of power without a correlated field of knowledge, even if not assumed and not establishing at the same time power relations (Foucault, 2004, p. 27). Pharmacists disclose their knowledge as less important or influential than physicians, and therefore have less power in the definition of roles within the multidisciplinary team. Nevertheless, and according Foucault,³⁷ it's not the person's activity that produces knowledge, useful or aloof to power, but is the power-knowledge, i.e. the processes and struggles that cross it and its constituent, which determine the possible forms and fields of knowledge.

C10. What I think is this: there is a whole culture of a society of a power of a class, we know that a specific class has a higher power ... there is a gap, there are two classes: physician - nurse and the rest. (S.O., focus group)

C11. I think the difficulty is that you have to come across a physician who does not want to exchange information, you know, to share information (R.I., individual interview)

Survey participants do not seem to construct the knowledge-power relationship, being a professional endowed with a specific and necessary knowledge, but remaining in a subservient knowledge to the physician, which is embodied in the prescription drug prerogative of physicians, falling to the pharmacist "only" the dispensation. In this logic, it seems difficult for pharmacists to build a sense for pharmaceutical care when socially this relationship is marked by the sovereignty of medical knowledge and no further actions are expected from pharmacists. It also reflects that knowledge and power are not necessarily assigned previously, and can be built in the daily work, depending on the empowerment of its actors in the daily processes with other knowledge.

In the Brazilian public service physicians are prescribers, as well as dentists and nurses in some protocols. The pharmacist, has recently been granted the right to prescribe, through protocols approved by the national health service and only when the professional has the title of pharmacy medical specialist,³⁸ a rare condition and presented by only one of the participants in this study (Table 1). The following excerpts illustrate the feeling experienced by professionals regarding this situation:

C12. They [nursing staff] covered the gap of someone being missing in the pharmacy. Physicians already cover this gap; the nurse, to the community worker, everyone covers a little ... they fill the gap, never existed a pharmacist [in the service before], so everyone understands some drugs (V.I., focus group).

The previous quotation illustrates that pharmacists do not react when occurring what they consider the takeover of your role by other professional, being unable to take control of their role in patient care.

C. The pharmacist and management services

The previously described difficulties contribute to professionals discouraged and, in some cases, leads to high work-related stress. Work stress seems to be justified from high labor demands with little available support.

C13. It is very discouraging ... I feel ultra-charged because I have to make a difference, because I'm pharmaceutical, because I have to do justice to the work, I have to take this patient, I have to fix medical error (...) I feel much the charging and I feel well worn down (crying). (J.U., individual interview).

The feeling of not being valued the extra effort to provide services also comes from frustration with working conditions and contributes to the non-implementation of new attitudes or behaviors that they believe to correspond to their optimized role.

C14. When you want a job to run, you have to give minimum conditions to be executed (L.E., individual interview).

In fact, the conditions in which pharmaceutical assistance to the population is provided are precarious in the Brazilian health system, starting in the preliminary steps of the cycle of pharmaceutical assistance, such as adequate supply of therapies, including appropriate areas for storage and dispensing of medicines.^{39,40} And thus the pharmaceutical services seems to be a neglected area of the healthcare production, from the pharmacists' perspective. In this context, the attention to the patient gets lost, worsened by the fact that the professional must accomplish many obligations from several team and organization managers:

C15. This pharmacist of 60,000 inhabitants have to ensure won't miss medicine, to keep products on validity, to control inventory, to lead with feelings of workers and bosses. (V.I., focus group)

C16. But the directions that come from the coordination of the pharmaceutical assistance never match the need for unity, in reality. I think the individual pharmacist care a good idea, but I know that the manager does not like it (V.I., focus group).

According to Campos and Domitti,³⁵ the fragmented way in which the healthcare production is accomplished, with professions or areas organized according to medical specialties, impair the integrative approach

and care as a whole, valuating the pharmacists' presence. All aspects exposed to here influence the pharmacists' action in daily work.

D. Professional routine

The meaning built by professionals in relation to their importance in the team and for the management of services seems to follow the same precepts of not valuing the profession. In general, pharmaceutical seems to experience a professional identity crisis, which will directly affect about your daily tasks. In general, the professional identity crisis, seems dissociated from pharmacist's consciousness, not allowing professionals to realize their daily experiences as a way to reframe their performance., following on Vygotsky's argument: "the experience it is the real dynamic unity of consciousness, it is the basis of consciousness" (Vygotsky, 1999, p. 383).²¹ The experience as a product of experiences by the subjects enables the development of self-consciousness, which in this case seems tied to no or little culturally valued profession, according to participants. Considering the daily life as a sphere of experience of the subject, the materialization of thinking and doing, in Heller's perspective, we can understand participants' accounts as highlighting the fragmentation between thinking and doing, as a relationship disposed between practice and theory, between the experience and the experience meaning, as discussed in the previous dimension. They conceive pharmaceutical care in theory, but not envision the change process in their daily practice. The reasons for failing to carry out changes place the blame in others, such as other professionals, the system (e.g. conditions, management) or even the service users. The following excerpts illustrate how pharmacists seem to stand in their daily lives in public service:

C17. I'm not the person I have to blame for it (i.e. to enable pharmaceutical care), (...) Then if I'm paid to think of it, I think (of it), but as there's no use getting racking my brain, so ... (L.E., interview individual).

C18. We try (to enable pharmaceutical care), but cannot, also because of the refusal of the patient. By one I'm trying, but we're not having return (V.T., focus group).

C19. I have not found a gap where I could fit myself. (...) I now do nothing of pharmaceutical care, (maybe), 1% of my work (V.I., focus group).

In contrast, some of the participants recognize the biggest difficulty is the pharmacist understanding of the extended service proposal and to seek building a differentiated intervention in everyday life, especially in places where other professionals still do not follow or value these actions, as illustrated by the next quotations.

C20. I've had to do open pharmaceutical care and I think I have no conditions (...) I am giving a (pharmaceutical care) touch, even push things to the belly, even doing little (S.O., individual interview).

C21. (...) the greatest difficulty in user's attention is the lack of pharmacist will. But there is a lot of places that does not have this type of service and then if you desire to get your space where you do not ... (L.E., individual interview).

It seems to exist a "not knowing-power,"²³⁷ i.e. an inability to take on other roles. Nonetheless, there is the perception that changes occur slowly in a procedural way, in the relationship with service users, other teammates and with the system. Change is possible, although in a limited way according to the next participant.

C22. In terms of doing something, it was very slowly, very painful, but I think the whole group had an evolution (...) I thought it was really cool being able to be part in the investigation of a drug, an antibiotic to a patient, making an adjustment of a therapy ... (S.O., focus group).

These advances are important for the professional and for users when modifies some actions, because when some actions are modified, the thinking is transformed too and dialectically the daily routine is modified, especially in the perspective of building links between the team members and users of services. However, links are built in relation to the other, every day, and not necessarily by specific contact time or physical space. These opportunities can facilitate but do not guarantee change.

C23. What I see what to do from the care model, would have to be a staff pharmacist. A pharmacist for three UBS never, ever(...). It is a minute you have there, does not create a bond, you do not see results, then you do not know if it is working. (V.I., focus group)

C24... how will we be able to display our work if we cannot take time? It is not just capacity, is not only lack of will, not only (lack of) fitness, but also time. (S.O., individual interview)

Participants seem to harness the potential of making the changes in everyday dynamics as a consequence of problems in establishing ties, while attaching responsibility not only to them as determinants for their non-action. Contradictorily, the following statements reinforce the bond that can occur even in situations considered not ideal, realizing some daily relational construction, even if limited:

C25. Despite being one or two days there, some people we get to hit the eye and talk: (patients' say) I have seen this person here, I'm feeling the difference, you guided me in this way, why I'm doing this treatment, (...) there's this difference, yes (S.O., focus group).

C26. *This makes little difference (...) to people, what we were doing needs a personal bond, but it is more a matter of personal bond because the patient already knows what could ask you, as you help. (V.I., focus group).*

Even with some power to act every day, possibly triggered by the perception of users' needs, the limited assumption of professionals' ownership in overcoming their difficulties may be related to pharmacists' education and training.

E. Training

When it comes to education and training, participants did not stress the relevance of mastering pharmaceutical care as a system of practice. Their complains were more focused on pharmacotherapy training i.e. better knowledge of medicines and drugs, their uses and prescriptions. This appears to highlight the difficulty that these professionals have to conceptualize pharmaceutical care as a different way of performing healthcare, that has not yet taken place in their daily tasks, if assuming the dialectical movement between thinking and doing.²² There is a weak manifestation of the need to receive further training, which confirms pharmaceutical care to be limited to verbalization. The need to be fitted to practice is perceived in a diffuse manner:

C27. *I think it is lack experience, practice, contacting with the patient. The nurse and the physician have eye to eye with the patient. (V.I., focus group)*

C28. *I think it's a very different reality from what you have in college. You are in the outside world, you do not use a third party here, and (you should) prepare your mind to understand that working with health is working with people. Are you prepared to do that? (V.I., individual interview).*

From the previous quotations it is evident a not yet established relationship between theory and practice, between the everyday work and thinking about the work itself, as a form of procedural and dialectical change. It still is predominant the "alienated doing."⁴¹

C29. *I have clearly said that I want to do it (pharmaceutical care), but I have no idea how I have to do, what could we do? I do not know ... (V.T., individual interview)*

C30. *If I should assist the team in discussion about diabetic or hypertensive patients' cases, If I had any information I could add it (R.I., individual interview).*

Even nowadays, and although the Brazilian pharmacist curriculum guidelines establish the need to train professionals to work directly with patients in public services, there are difficulties in the implementation of such practices from pharmacy courses in different places in Brazil.⁴² The key message are presented in Table 2.

FINAL CONSIDERATIONS

The opposition and balance of the data obtained by interviews and focus groups led to a better understanding of the process experienced by participants in the construction of meanings, expectations and difficulties related to possible changes in their professional practice, in a didactic and articulated way. This was evident by the presence of content overlapping in most core dimensions.

Overall, the five dimensions or core meanings were didactically independent, but significantly intertwined, and showed that pharmacists have not matched their daily work lives with the work proposal of pharmaceutical care and, consequently, not yet have they integrated this extended role in their practice.

It was evident that inter-professional relationships in daily services hinder the assimilation of new pharmaceutical knowledge and its translation into practice, which is exacerbated by poor training, contributing to limit the experience of professional care in normal work. This way, traditional routines in healthcare services at the primary care level dominates at full extension, with little possibility of a paradigm shift, i.e. to have professionals' attention directed to patients and medicine users, therapeutic and individual needs.

Not being able to attach meaning to pharmaceutical care, no conversion of actions into a particular direction behaviors that mediate pharmacists' everyday actions will occur. Consequently, a professional identity crisis seems clear, that should be tackled by professionals and their leaders, especially when it comes to indi-

Table1: Participants' general features (fictitious initials)

ID	Gender	Age	Number of years of study	Specialization	Number of years working at the same place
V.I.	Female	31-40	5 – 10	No	4 years
S.O.	Female	41-50	5 – 10	No	3 years
V.T.	Female	51-60	25- 30	No	3 years
J.U.	Female	41-50	15-20	Yes	5 years
B.R.	Male	41-50	15-20	No	3 years
L.E.	Male	41-50	20-25	No	5 years
R.I.	Female	31-40	15-20	No	3 years

Table 2: Key messages extracted from Brazilian pharmacists accounts

<i>Pharmaceutical Care conceptualizations</i>
Pharmaceutical care definitions seem diffuse and unclear The concepts about professional practice carry a bureaucratic work meaning, unlinked from the healthcare process Pharmaceutical care is not possible to be disconnected from the physical place A guiding model for professional practice seems absent Pharmaceutical care is a theory distant from practice, a utopia
<i>The Pharmacist and its relationship with health team</i>
Professional role undefined within the primary care team Recognition by team is expected without concrete actions to make themselves valuable and recognized Pharmacists' knowledge is perceived to have less powerful than physicians' knowledge Other health professionals take on the extended role of the pharmacist, covering already possible gaps
<i>The pharmacist and management services</i>
A high a workload is described and negatively perceived Pharmaceutical services are perceived as a neglected area of healthcare provision to patient There are many managers acting in a non-articulated way that hinder pharmacists' work and its value
<i>Professional routine</i>
Fragmentation between thinking and doing No practitioners' responsibility for the transformation of reality Inability to take new roles Severe limitations on identifying ways to create pharmacist-patient ties
<i>Training</i>
Lack of clarity about what is necessary to learn and master Present training not enough to the envisioned pharmaceutical care practice There are need of education for the practice

vidually assume an extended role, as well as in relation to other healthcare professionals and managers.

The existing Brazilian political initiatives in promoting pharmaceutical care in primary healthcare services are a challenge to education and to implementation. For achieving performance in line with the present national aims, an in-site training process is necessary to rebuild the meaning of practice in each professional involved, mediated by changes of what being a primary care pharmacist means as a healthcare practitioner integrated in a working team.

CONCLUSION

Final consideration is the terminology more appropriated to qualitative studies. If is mandatory you can substitute by conclusion.

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

ABBREVIATION USED

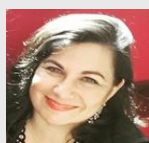
SUS: Sistema Único de Saúde (the name of Brazilian Public Health System).

REFERENCES

1. Hepler CD, Strand, L M. Opportunities and Responsibilities in pharmaceutical care. *Am J Hosp Pharm* 1990;47(3):533-43.
2. World Health Organization. The role of the pharmacist in the health care system paper en la atención del farmacéutico a la salud: declaración of Tokyo. Geneva, 1993.
3. Pan American Health Brazilian Consensus on Pharmaceutical Care: Proposal. Brasília: PAHO / MS; 2002.
4. Brazil. MS / CNS. Resolution 338 of 06 May 2004. Official Gazette of the Federative Republic of Brazil, the Executive Branch, Brasília, DF, May 6, 2004. Available at: <http://www.saude.gov.br>. Accessed on November 28, 2009.
5. Brazil, MS / ANVISA. Resolution of the Board of Directors No. 44 of 17 August 2009. Provides for Good Pharmaceutical Practices for the sanitary control of the operation of the dispensation and marketing of products and the provision of pharmaceutical services in pharmacies and other measures. Brasília (DF); 2009a. [cited 2010 Mar 30]. Available in:
6. Brazil. Law 8080 of 19 September 1990. Regulates the conditions for promotion, protection and recovery of health, the organization and functioning of the corresponding services and other measures. Official Gazette 1990; set 20.
7. Brazil. Law 8142 of December 28, 1990. Provides for community participation in the management of the Unified Health System (SUS) and on intergovernmental transfers of financial resources in health care and other measures Official Gazette 1990; December 31.
8. Arrais PSD, Barreto ML, Coelho HLL. Aspects of prescription and dispensing of medicines processes in the perception of the patient population-based study in Fortaleza, Ceará, Brazil. *Cad Public Health.*; 2007;23(4):927-37.
9. Castro MS, Running CJ. Pharmaceutical care in community pharmacies: practice and research in Brazil. *The Annals of Pharmacotherapy.* 2007;41(9):1486-93.
10. Araujo ALA, Freitas O. Conceptions of the pharmacist on the pharmaceutical assistance in basic health unit: difficulties and elements for change *Rev. Bras. Cienc. Farm.* 2006;42(1):137-46.
11. Araujo ALA, Pereira LRL, Ueta JM, Freitas O. Profile of pharmaceutical care in primary care from the National Health System. *Ciênc. Public health.* 2008;13:611-17.
12. Farina SS, Roman Lieber NS. Pharmaceutical care in pharmacies: there is a process of change? *Health soc.* 2009;18(1):7-18.

13. Fegadolli C, Santos DR, Fonseca DC, Marques TCA. Pharmaceutical perception of the possibility of deployment of pharmaceutical care practice in professional. *Revista Space for Health* 2010;12:48-57.
14. Brazil. Ministry of Health. Departamento de Assistência Farmacêutica e Insumos Estratégicos. Pharmaceutical care in primary care. Brasília: Ministry of Health, 2015. Book 4. 100p.
15. Brazil. Ministry of Health. National drug policy. Official Gazette, Brasília, 2001a. Series C (25):23-6.
16. Brazil. Ministry of Health. Department of Health Care. Health Coordination of the Community. Health: a strategy for reorienting the care model. Brasília: Ministry of Health, 1997. 36p.
17. Alano GM, Correa TS, Galato D. Pharmaceutical Care Service Indicators (SAF) at the University of Southern Santa Catarina. *Ciênc. Public health*. 2012;17(3):757-64.
18. Martins BPR, Aquino AT, Provin MP, Lima MD, Dewulf NLS, Amaral RG. Pharmaceutical Care for Patients hypertensive provided Within the Family Health Strategy in Goiânia, Goiás, Brazil. *Braz. J. Pharm.Sci.* 2013;49(3):609-18.
19. Borges APS, Guidoni CM, Freitas, Pereira LRL Economic evaluation of outpatients with type 2 diabetes mellitus assisted by the pharmaceutical care service. *Arq Bras Endocrinol Metab.* 2011;55(9):686-91.
20. Minayo MCS. The challenge of knowledge - qualitative health research. 7th. Ed. São Paulo / Rio de Janeiro: Hucitec / ABRASCO;8:00 pm.
21. Vygotsky LS. Theory and Method in Psychology. Trad. Paulo Bezerra. 2a.ed. Sao Paulo: Martins Fontes, 1999.
22. Vygotsky LS. Chosen Works II. Moscú: Pedagogical Editorial; 1999.
23. Luria A. Thought and Language and the latest Luria conference. Porto Alegre: Medical Arts; 1986.
24. Leontiev AN. Actividad, conscience y Personalities. Buenos Aires: Science Del Hombrr ;, 1978.
25. Marx K. Contribution to the Critique of Political Economy 2nd. Ed. São Paulo: Martins Fontes, 1993.
26. Freire P. Pedagogy of the Oppressed. 17th ed. Rio de Janeiro: Paz e Terra; 1987.
27. Lane TM. Advances in Social Psychology in Latin America. In: ____; Sawaia, BB (eds) New Paths of Social Psychology. São Paulo: Brasiliense: EDUC. p.67-81; 1995.
28. Gonzales REY F. Qualitative Research and Subjectivity: the information construction process. Sao Paulo: A pioneer Thomson Learning; 2005.
29. Carlini-Cotrim B. Potential of qualitative technical focal group on substance abuse research: discussing the potential application of the focus group in Brazil. *Rev. Public Health.* 1996;(30)17:285-93.
30. Aguiar WMJ, Ozella S. Seizure of ways: improving the proposal of the meaning core. *R. bras. Est. Pedagogy.*, Brasilia. 2013;94(236):299-322.
31. Bastos CRG, Caetano R. Perceptions of pharmacists about their work in community pharmacies in a region of the state of Rio de Janeiro. *Ciênc. Public health.* 2010: 15 (suppl.3): 3541-3550.
32. Angonesi D, Sevalho G. Pharmaceutical Care: conceptual basis and critical to a Brazilian model. *Ciênc. Public health.* 2010;15(3):3603-14.
33. Freitas EL, Ramalho de Oliveira D, E. Perini Pharmaceutical Care - Theory and Practice: A Possible Dialogue? *Acta Farm. Buenos Aires province.* 2006;25(3):447-53.
34. Oliveira Ramalho, D. Pharmaceutical Care: from philosophy to the management of drug therapy. 1. ed. Sao Paulo: RCN Editora Ltda, 2011. 328p.
35. Campos GWS, Domitti AC. Matrix support and reference team: a methodology for management of interdisciplinary health work. *Cad. Saúde.* 2007;23(2):399-407.
36. Bradley F, Econ MA, Ashcro DM, Noyce PR. Integration and differentiation: a conceptual model of general practitioner and community pharmacist collaboration. *Research in social and administrative pharmacy.* 2012;36-46.
37. Foucault M. Discipline and Punish: The Birth prison. 29th. Ed Petropolis. Voices; 2004.
38. Brazil. Federal Pharmacy Council. Res. 58 of August 29, 2013. Regulates prescription pharmaceuticals and other measures. Official Gazette of the Federative Republic of Brazil, the Executive Branch, Brasília, DF, September 26, 2013. Available at: <http://www.jusbrasil.com.br/diarios/59577213/dou-secao-1-26-09-2013-pg-136>. Accessed on May 20, 2015.
39. Vieira FS. Providing quality pharmaceutical services in Brazil: Items pending on the Unified Health System's agenda. *Rev PanamSaludPublica.* 2008;24(2):91-100.
40. Barreto JL, Guimaraes MCL. Evaluation of decentralized management of basic pharmaceutical care in Bahia State, Brazil. *Cad. SaúdePública.* 2010;26(6):1207-20.
41. Marx K. Economic and Philosophical Manuscripts. Sao Paulo: Martin Claret; 2002. 198p.
42. Monteguti BR, Diehl EE. Pharmacy education in Southern Brazil: preparing pharmacists for the unified health system? *Trab. educ. saúde.* 2016;14(1):77-95.

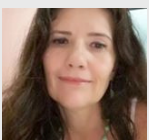
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SUMMARY

- Although presently there is a strong movement from Brazilian community pharmacists towards advanced pharmaceutical services, in-depth opinions on this professional development are yet to be explored. This present study presents evidence regarding limitations on both theoretical and practical plans to appropriately implement pharmaceutical care, mainly rooted on professionals' and society conceptualization of the pharmacist role in primary care.

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