Journal of Positive Psychology & Wellbeing
2022, Vol. 6, No. 3, 467-472
http://journalppw.com
ISSN 2587-0130

The Benefit of Health Education Among Population, and the Role of Pharmacist, Nurses and Physicians in Health Education

Raoom Alsarhan[1], Ahmad Taleb Alhajaili[2], Naif Abdulrahman Alzaidi[3], Fatimah Hani Almashor[4], Ziyad Zayed Ghaeb Alotaibi[5], Bandar Nazzal Al Azmi[6], Hosam Ahmad Iessa Dhaea[7], Amel Mohammed Alharbi[8], Sarah Mohammed Ali Alzayer[9], Nada Ghazi Faraj[10], Fahad Abdulaziz Alabduljabbar[11], Yosef Mohammed Monajed[12], Mohammed Shahhat Alsharif[13], Ahmed Ateaqallha Alsubhi[13], Hessa Ahmad Assiri[14]

[1]Health Educator, Ministry of Health
[2]Pharmacy Technician, Hera General Hospital
[3]Pharmacy Technician, King Abdulaziz Hospital Makkah
[4]Pharmacy Technician, Dammam Medical Complex
[5]Pharmacy Technician, King Saud Medical City
[6]Pharmacy Technician, King Khalid Hospital in Al Majmaah
[7]General Physician, Vector Control Center in Al-Ardah
[8]General Practice Doctor, King Fahad Specialist Hospital -Buraydah
[9]Alnakheel Primary Health Care Center- Buraydah, General Practice
[10]Alnoor Specialist Hospital – Makkah, General Practice Doctor
[11]Resident Physician of Family Medicine, Alnuzha Phc
[12]General Practitioner, King Salman Hospital in Riyadh
[13]Patient Care Technician, National Guard Hospital
[14]Nurse, Alfalah Phc

Abstract

Education on health and health promotion are two processes that are intertwined and may overlap with one another. The process of defining messages that are intended to enable individuals to take greater control over and improve their own health is referred to as health education. The first thing that has to be done in order to begin the process is to get an understanding of the fundamental cause of the disease process that is considered. There is a significant contribution that the collaboration of physicians, pharmacists, and nurses makes to the provision of patient care and education.

Keywords: *health education, physicians, pharmacists, and nurses.*

Introduction

When it comes to providing high-quality treatment and better meeting the requirements of patients, effective collaboration among nurses, physicians, and pharmacists is essential. Two of the key criteria for this type of collaboration are clear definitions of responsibilities and good communication within the team. There are multiple levels of collaboration that are hindered by unclear job boundaries. These levels include the quality of interprofessional communication and collaboration in everyday clinical practice, transnational collaboration in research, education, and innovation, and the mobility of nurses in the workforce [3]. On the other hand, there is not always a clear explanation of the

roles that are involved in pharmaceutical care (PC) and medicines optimization [4]. The term "professional contribution" (PC) is defined as "the contribution of healthcare professionals to the care of persons in order to optimize the use of medicines and improve health outcomes according to this study." Both the original definition of Hepler and Strand from 1990 and the definition of the Pharmaceutical Care Network Europe (PCNE), which was restricted to the contributions of pharmacists, served as the foundation for this definition. However, the PCNE's definition was confined to the contributions of pharmacists. When all is said and done, the necessity of interprofessional collaboration in the field of PC is widely acknowledged [5]. A cross-country comparative study that was conducted in 39 different nations revealed that there are significant differences in the functions that nurses play. Nurses have taken up advanced duties previously held by physicians in two thirds of the countries, although the amount of this change varied. There was a growing movement toward broadening the area of practice that nurses might exercise in primary care [6]. According to the findings of the EUPRON study that investigated nurses' current clinical practices in interprofessional pharmaceutical care (PC), there is a significant amount of variance in the roles that nurses play. The results of this study demonstrated that monitoring the effects of medications, monitoring the adherence to medications, prescribing medications, and providing patients with education and information about medications are already components of nurses' clinical practice. Furthermore, the participation of nurses to patient care varies from country to country, both in terms of the law and in terms of practice [7]. A nurse's scope of practice is defined as the complete set of duties, responsibilities, and tasks that they are authorized to perform, as well as those for which they have received the necessary education and training [8]. In the context of this scope of practice, a framework for nurses' ideal responsibilities in interprofessional PC would make it possible to get insights into current and potential roles in PC, as well as facilitate conversations in clinical practice, teaching, research, international comparisons, policy-making, and legislation. Furthermore, this framework has the potential to be utilized for the development of an evaluation to assess nursing competencies in personal care, as a guide for evaluating nurse education, as a tool for nurse educators, for benchmarking, and for the purpose of facilitating nurse labor mobility. Despite our best efforts, we have not been able to locate a framework of this kind in the published literature. For the purpose of developing a robust framework that is tailored to the requirements of clinical practice, it is crucial to get insights into the preferences of the most significant stakeholders, which include nurses, physicians, and pharmacists. It is necessary to do in-depth qualitative study in order to investigate those preferences [9].

Review:

It is necessary for physicians to spend more time with patients in order to improve the outcomes of health care. It is essential that the contact between the teaching physician and the patient be filled with enthusiasm, motivation, and a responsiveness to the specific requirements of the patient. In order for individuals in our culture to be able to reap the benefits of physician health education, there is a requirement for a robust and hearty engagement between patients and physicians [9].

The self-efficacy of individuals has been shown to improve as a result of interventions designed to improve self-care. The term "self-efficacy" refers to an individual's conviction that they are capable of achieving success in particular circumstances or completing particular activities. The manner in which an individual addresses their health-related objectives, responsibilities, and obstacles is significantly influenced by their feeling of self-efficacy. Clinical trials of lifestyle intervention have shown that it is beneficial for patients suffering from a wide variety of illnesses, including diabetes, coronary heart disease, heart failure, and rheumatoid arthritis [2].

The potential for improved health outcomes through patient education and self-management

programs is enormous, particularly in light of the fact that the costs of health care are on the rise and that future cost forecasts are startling. In the early 1990s, it was believed that premature deaths accounted for fifty percent of the yearly mortality toll in the United States. The use of tobacco, a poor diet, a lack of physical activity, the intake of alcohol, exposure to microbiological agents, the use of guns, unsafe sexual conduct, accidents involving motor vehicles, and the use of illegal drugs were the factors that led to early mortality. Approximately eighty percent of deaths that occurred prematurely were attributed to the use of tobacco, patterns of food, and a low level of physical activity [3]. Clearly, all of these are behaviors that we have the ability to change in order to revers the trends. The risk ratio for diabetes, myocardial infarction, stroke, or cancer was 0.22 for those who did not smoke, ate healthy foods, and participated in regular exercise programs [10]. This was the case for people who did not smoke.

Individuals in the medical community are of the opinion that engaging in physical activity and maintaining a healthy diet will lessen the likelihood of getting coronary artery disease, hypertension, diabetes, and metabolic syndrome-related conditions. In a comprehensive systematic review, it was found that there is undeniable and strong evidence for the benefit of exercise in improving clinical outcomes in metabolic diseases, coronary heart disease, and heart failure [10]. This hypothesis was strengthened by the findings of the review.

Improvements in patients' health literacy are necessary for physicians to make in order to encourage patient education and involvement from patients. The ability to seek out, comprehend, and take action based on health information is what is meant by the term "health literacy." It has been assumed that a low level of health literacy indicates that the communication between physicians is not well understood, which in turn results in insufficient self-health management and accountability as well as insufficient utilization of health support services [11]. In order to ensure that patients are able to have more accessible interactions and situations that are beneficial to their health and well-being, it is the obligation of physicians to take proactive measures. Due to the fact that physicians are the ones who determine the parameters of the health interaction, including the physical setting, the amount of time that is available, the communication style, the content, the modes of information that are provided, and the concepts of sound health care decision crafting and acquiescence, health literacy is the primary responsibility of physicians. There are communication strategies and behaviors that physicians can implement to mitigate the potential risks associated with limited patient health literacy. These include avoiding the use of medical jargon, engaging in patient questions, explaining unfamiliar forms, and employing the "teach back" method as a means of ensuring that patients comprehend the information [11].

Timing is an essential component of any instructional process. One of the most important aspects of our tried-and-true health preventative strategies, which include nutrition and exercise, is the development of patient health literacy. It is essential for patients to have a comprehensive comprehension of the influence that healthy interventions can have on their current and future health at all times. It will be necessary for medical professionals to devote time and effort to educate patients in order to bring about behavioral changes that lead to improved health outcomes and a reduction in morbidity and mortality rates caused by preventable chronic diseases such as diabetes, obesity, coronary and cerebrovascular disease. As medical professionals, we will be able to determine when we have reached the point where we are capable of being an effective educator by seeing patients who are responsible [12].

Dual responsibilities are required for the collaboration that exists between a patient and their physician. It is the obligation of patients to act on the knowledge that is presented to them in a manner that is in their best interest in terms of their health, and it is the role of physicians to inform patients about how to achieve health and wellbeing. The ability of the physician to diagnose and treat patients, as well as the patient's right to accept or reject clinical examination, treatment, or both, are significantly impacted by the patient's ability to

provide informed consent for medical treatment [12].

It is important that the process of medical informed consent be a conversation that strengthens the relationship between the patient and the clinician. The procedure of obtaining consent ought to serve as the cornerstone of the trusting connection that has been established between a patient and a physician. It is imperative that medical professionals, including nurses and pharmacists, acknowledge that informed medical choice is a process that involves education and has the ability to influence the patient-physician alliance in a way that is beneficial to both parties. The covenant requires that physicians provide patients with equal treatment by educating them to make decisions based on accurate information. Patients are required to utilize the educational process in order to make rational decisions regarding their health. When medical professionals, including physicians, nurses, and pharmacists, as well as patients, take the concept of medical informed consent seriously, the connection between the patient and the physician transforms into a genuine partnership, with shared decision-making authority and responsibility for the outcomes. From a generic common-law perspective that requires medical practice to be compatible with the standard of care, as well as from an ethical foundation, physicians, nurses, and pharmacists need to have an understanding of informed medical consent. This understanding begins with an ethical foundation, which is codified by statutory law in many states. When it comes to the connection between a patient and a physician, it is essential that both parties comprehend and acknowledge the level of autonomy that the patient desires in the decision-making process [13].

The following is a list of the responsibilities that are established for a clinical pharmacist: direct involvement throughout the entire process of pharmaceutical use in order to minimize risks and reduce mortalities while simultaneously improving patient outcomes [13]. As an additional point of interest, their scope of practice encompasses activities such as stock procurement and control, pharmacy and administrative work, and activities related to the dispensing of medications from hospital pharmacies. Research conducted in primary care settings in multiple countries, including the United States of America, Canada, Sweden, and the United Kingdom, has brought to light the necessity of understanding the attitudes and expectations of clinical pharmacy services held by healthcare professionals [13]. Having this knowledge is essential for the development of collaborative connections. According to the findings of a study that investigated the working connection between ward-based pharmacists and other healthcare providers, collaborative working relationships are diverse and require a consideration of the professionals' perception of the ward pharmacist's job and capabilities [14]. In a similar vein, research conducted in Kuwait and India has demonstrated that a lack of comprehension regarding pharmacological treatment may be a barrier to collaborative practice. In turn, this could lead to the exclusion of clinical pharmacists, despite the fact that they play an essential role as members of the healthcare team. In addition, the importance for effective working relationships between pharmacists and other healthcare professionals is highlighted by the fact that medication-related outcomes can be optimized and healthcare expenditures can be reduced significantly [15]. Nurses have an active role in monitoring patients for the impact of their medicines, monitoring adherence, making decisions on medicines, and providing patient education and information. Different tasks within these responsibilities have been described, although contextual, knowledge and training factors have to be considered before nurses can perform this ideal role. Lack of time, shortage of nurses, an absent legal framework and limited education and knowledge were the main threats for nurses’ roles in PC. Nevertheless, a positive impact on care quality and patient outcomes was associated with nurses taking up responsibilities in PC. Nurses’ observations and assessments could lead to key information about patients being shared and addressed by the interprofessional team [15].

Conclusion:

Nurses could decide on the route, formulation, and brand of the medication; they could add or deprescribe treatments; they could adjust and titrate doses; they could prepare prescriptions; and they could prescribe repeat prescriptions. These are some of the possible tasks that fall under this responsibility, according to the respondents who considered decision making on medicines to be an essential component of their ideal roles. Respondents predominantly reflected on the selection of products, the level of autonomy and the level of emergency: local and low-risk medicines from a limited list were preferred to systemic and high-risk medicines; supervision by physicians or pharmacists and shared responsibility were favoured above full autonomy for nurses; and life-threatening emergencies warranted increased autonomy. Others were of the opinion that these circumstances call for more nuanced thinking, and they argued against the idea of nurses taking on more responsibilities. There were proposals for guidelines for practice that were more flexible. With regard to the process of decision-making in PC, knowledge was mentioned as an essential necessity. It is necessary to include a greater amount of pharmacology in both pre- and post-registration nursing education as a first step. There was a suggestion that the minimum degree of education required to prescribe should be met by registered nurses, nurse specialists, and nurse practitioners.

Reference

[1] Wilson A, Palmer L, Levett-Jones T, Gilligan C, Outram S. Interprofessional collaborative practice for medication safety: Nursing, pharmacy, and medical graduates' experiences and perspectives. J Interprof Care. 2016;30(5):649–54. 10.1080/13561820.2016.1191450

[2] Azhar S, Hassali M, Mohamed Ibrahim M, Saleem F, Siow Yen L. A survey evaluating nurses' perception and expectations towards the role of pharmacist in Pakistan's healthcare system. J Adv Nurs. 2012;68(1):199–205. 10.1111/j.1365-2648.2011.05728.x

[3] Ensing H, Stuijt C, van den Bemt B, van Dooren A, Karapinar-Çarkit F, Koster E, et al. Identifying the Optimal Role for Pharmacists in Care Transitions: A Systematic Review. J Manag Care Spec Pharm. 2015;21(8):614–36. 10.18553/jmcp.2015.21.8.614

[4] Maier C, Aiken L. Task shifting from physicians to nurses in primary care in 39 countries: a cross-country comparative study. Eur J Public Health. 2016;26(6):927–34. 10.1093/eurpub/ckw098

[5] Borrott N, Kinney S, Newall F, Williams A, Cranswick N, Wong I, et al. Medication communication between nurses and doctors for paediatric acute care: An ethnographic study. J Clin Nurs. 2017;26(13–14):1978–92. 10.1111/jocn.13606

[6] Manias E. Effects of interdisciplinary collaboration in hospitals on medication errors: an integrative review. Expert Opin Drug Saf. 2018;17(3):259–75. 10.1080/14740338.2018.1424830

[7] Thoma J, Waite M. Experiences of nurse case managers within a central discharge planning role of collaboration between physicians, patients and other healthcare professionals: A sociocultural qualitative study. J Clin Nurs. 2018;27(5–6):1198–208. 10.1111/jocn.14166

[8] Allemann S, van Mil J, Botermann L, Berger K, Griese N, Hersberger K. Pharmaceutical care: the PCNE definition 2013. Int J Clin Pharm. 2014;36(3):544–55. 10.1007/s11096-014-9933-x

[9] Hepler C, Strand L. Opportunities and responsibilities in pharmaceutical care. Am J Hosp Pharm. 1990;47(3):533–43.

[10] Kijlstra N, Ridge K, Walser S. Pharmaceutical care: where do we stand—where should we go? Key concepts in pharmaceutical care, quality assessment of pharmaceutical care in Europe, sources of information: survey report. Strasbourg: European Directorate for the Quality of Medicines & HealthCare (EDQM), 2009.

[11] Keitel S. Pharmaceutical care–policies and practices for a safer, more responsible and

cost-effective health system. Strasbourg: European Directorate for the Quality of Medicines & HealthCare (EDQM), 2012.

[12] Choo J, Hutchinson A, Bucknall T. Nurses' role in medication safety. J Nurs Manag. 2010;18(7):853–61. 10.1111/j.1365-2834.2010.01164.x

[13] De Baetselier E, Van Rompaey B, Batalha LM, Bergqvist M, Czarkowska-Paczek B, De Santis A, et al. EUPRON: nurses' practice in interprofessional pharmaceutical care in Europe. A cross-sectional survey in 17 countries. BMJ Open. 2020;10(6):e036269. 10.1136/bmjopen-2019-036269

[14] Jack S, Ford-Gilboe M, Wathen C, Davidov D, McNaughton D, Coben J, et al. Development of a nurse home visitation intervention for intimate partner violence. BMC Health Serv Res. 2012;12:50. 10.1186/1472-6963-12-50

[15] Stringer B, van Meijel B, Karman P, Koekkoek B, Hoogendoorn AW, Kerkhof AJ, et al. Collaborative Care for Patients With Severe Personality Disorders: Preliminary Results and Active Ingredients From a Pilot Study (Part I). Perspect Psychiatr Care. 2015;51(3):180–9. 10.1111/ppc.12079