VIEWPOINTS

Advancing Our Pharmaceutical Care Agenda: Reaching Out

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As I examine the issues facing AACP and its member schools and colleges, nothing seems of overriding importance as much as the full implementation of pharmaceutical care as the accepted practice of the profession. We, as an organization and as the whole of pharmacy education in the United States, made a commitment to educate all of our graduates to practice in this way, yet several years out from that decision, only a fraction of our graduates enter pharmaceutical care-providing practices. Surely, elements of patient focus have been incorporated into many practices and my perceptions are that pharmacists are using more technology and technicians to get the product delivered so that they can spend more time with patients. Certainly there are experiments — and successful ones at that — where pharmaceutical care has become the standard of practice in a limited area. Yet, when we talk to the public or to payors or other health professionals, we still have to explain what pharmaceutical care is and what it can do. And then when they ask, “How do I find a pharmacist who will provide pharmaceutical care?” or “Can your provide access to pharmaceutical care for my thousands of employees?” the response is a very hesitant, “Well, it is not the standard of practice yet.”

One must ask whether there is something wrong with the model, with the basic concept behind pharmaceutical care. It is fair and, indeed, important to keep asking ourselves that question. Yet, I believe that is not the case. The concept was so compelling it drove an enormous change in direction of the profession, and the rationale for it is even more compelling than ever as we look at the Institute of Medicine (IOM) reports on quality of health care and our growing drug-using population. The data from experiments where it has been implemented are also compelling and seem to uphold the promise of better outcomes from drug therapy and reduced health care costs.

There are many elements to the full implementation of pharmaceutical care from the re-education of existing pharmacists, to compensation for care, to modifying public understanding and expectations, to simple federal recognition of pharmacists as health care providers. We also need to make sure our students are prepared as much as possible to become change agents (an interesting demand to place on the junior members of a profession!). Modified state practice acts that allow for collaborative practice are important as well. I believe that each college or school of pharmacy has the obligation to examine what it is doing in all these areas — does your curriculum explicitly teach students about change and how to lead it? Are you using your experiential program to advance practices in your community? Are your faculty working with community practitioners to develop and document pharmaceutical care providing sites? Are you exploring new economic models of delivering care to patients? Are you working with practitioner organizations and legislators and health departments and other decision-makers to advocate for pharmaceutical care? If not, what do you need to do to be an active participant in this effort?

I think all of the above efforts are of critical importance to making pharmaceutical care practice a general reality. However, I think there is one more important element we are not paying sufficient attention to, and that is what is happening in general to health care delivery in this country. Thoughtful people, including the IOM, are saying that the system is broken, that it is too expensive and not sufficiently safe and effective, and that it is not prepared to deal with the chronic diseases of large numbers of the baby-boom generation. These same thoughtful people do not have all the answers; they

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are looking for answers. We must be part of the solution. In order to be part of the solution, we must be talking and working with our colleagues in medicine and nursing and health policy. We must be engaging in models of interprofessional practice since that seems to be an important component of the solution that people are discussing. Interprofessional education and practice can no longer be “that thing everyone talks about but no one does” (as someone once described it to me).

Interprofessional practice in institutional settings may be easier since all the professionals are in one place, yet it is still considered the anomaly rather than the standard of practice. I was at a health quality forum where an interprofessional team (that did include a pharmacist!) was showcased and applauded, but it was clear they were outside the norms of practice. It is even harder in community settings, although there are some wonderful examples of interprofessional teams in clinic settings. Academic medicine is just beginning to consider community-based practices as they see more and more patients needing better therapies for chronic diseases. This is an area where we can bring lots of expertise and experiences to the table. We can reach out and help lead the effort. We can be part of the solution. And, in the process, I think we will realize the implementation of pharmaceutical care practice.

What can you do? If you are in an Academic Health Center, you can help lead an interprofessional education, practice, and research agenda. We can seek to understand and to work on the nation’s health care agenda, not just pharmacy’s agenda. If you are not in an academic health center, you can find out where the thought leaders in health care are in your community, and see how you can get involved. I think it is up to us to reach out, to see this as a health care issue, not just as a pharmacy profession issue. My bet is that by reaching beyond ourselves, we will indirectly be more effective in advancing our own agenda. It’s worth a try.