Chair Report for the Professional Affairs Committee

Metta Lou Henderson
College of Pharmacy, Ohio Northern University, Ada OH 45810

AACP Bylaws state that the Professional Affairs Committee is to study issues associated with professional practice as they relate to pharmaceutical education, and to establish and improve working relationships with all other organizations in the field of health affairs. The Committee is also encouraged to address related agenda items relevant to its Bylaws charge and to identify issues for consideration by subsequent committees, task forces, commissions, or other groups.

Pharmaceutical education and pharmacy practice have just undergone a paradigm shift to one that recognizes pharmaceutical care as the basis for the practice of pharmacy. This major shift must be rapidly and creatively followed by a period of change if the full value of the vision of the profession is to be realized. As a result, it was necessary and desirable for the Association to consider strategically its role and plan for achieving the new mission. President Leslie Z. Benet charged the 1993-94 Professional Affairs Committee with helping the Association develop its future agenda as it relates to issues of professional practice and the practice/education interface. The Committee was asked to consider the direction and impacts suggested by several documents (including Dr. Benet’s 1993 presidential address(1), the works of the AACP Commission to Implement Change in Pharmaceutical Education(2), the 1993 report of The Pew Health Professions Commission(3), and the Association’s strategic plan) on the future of academic pharmacy and the Association. The Committee was encouraged to consider strategies and tactics to assist the Association in achieving its mission.

The Committee held its initial meeting in conjunction with the 1993 AACP Annual Meeting in San Diego, California. President Benet met with the members of the Committee to review the Committee’s charge and to discuss several of the ideas that were outlined in his inaugural speech.

In subsequent weeks following the Annual Meeting, the Committee members were requested by the Committee chair to identify key issues which should be examined by the Committee at its October meeting. The issues were collected and grouped by the chair and given priority scores by Committee members in two rounds of rankings. Rankings were then shared with Committee members prior to the formal meeting of the Committee.

These activities were taking place concurrently with an intensifying national discussion on the issue of health care system reform as a result of the initiatives of the Clinton Administration. Within that discussion, there has been, and continues to be, substantial rhetoric about the role of primary care, or the lack thereof, in the U.S. health care system.

By the time of the Committee’s meeting in October, a consensus to devote focused attention to the issue of the relationship between primary care and pharmacy practice and education had begun to emerge as a result of the issues that had been identified and prioritized as a group. The Committee focused its October deliberations on several key aspects of the primary care, pharmaceutical education, and pharmacy practice interfaces. Among these were:

1 Committee members: Heidi Anderson-Harper (Auburn), Metta Lou Henderson, (Ohio Northern), Ronald W. Maddox (Campbell), M. Peter Pevonka (Florida) and Mary M. Piascik (Kentucky). Liaison Member: William A. Lockwood, Jr. (American Society for Automation in Pharmacy).
• The nature of the contribution of pharmaceutical care to primary care.
• The roles of pharmacy practice, education, and research within primary care pharmaceutical care systems.
• The need for enhanced research and data on pharmaceutical care and its contribution to primary care and the health care system.

BACKGROUND

Reform of the American health care system has been clearly articulated as one of the fundamental goals of the Clinton Administration. As 1994 begins, no less than six major proposals for reform of the health care system have been or will be introduced in the 103rd Congress for consideration.

Among the several concerns which have been expressed by the President and other policymakers are the specialty orientation of American health care and a relative deficiency of primary and generalist care, preventive care, and public health within the medical profession specifically(4) and other professions generally. Many of the reform initiatives under consideration seek to address this issue by reorienting financial aid programs in health professions education, redirecting support for graduate medical education toward primary care disciplines, and enhancing support for communities to attract and retain primary care providers in rural and urban areas underserved by the existing health care system.

As might be expected, this renewed emphasis on primary care has prompted examination by many health professions (and specialties within professions) of the relationship between themselves and an emerging health care system very likely to be focused on primary and preventive health care services and activities. As a result of these impending changes, it often seems that practically every discipline is touting its “primary care” focus.

The World Health Organization defines primary health care in the following way(5):

Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part of both the country’s health care system of which it is the central function and the main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.

Emerging from this and other descriptions of primary care(6) are several key elements which have traditionally been used by policymakers to characterize both primary care and its providers. Thus it is said that primary care is:

• first-contact,
• coordinated,
• continuous,
• comprehensive, and
• accessible.

Utilizing these characteristics, relatively few disciplines are commonly deemed “primary care” disciplines in health policy planning and administration(6). These include general and/or family medicine physicians, nurse practitioners (advanced practice nurses), physician assistants, general pediatricians, and in some cases obstetrician-gynecologists. Each of these disciplines is able to satisfy one or more of the above criteria for primary care services. However, even these professionals rarely are able, individually, to achieve all of these goals without collegial assistance of some type.

This has occurred, in large part, because of the leadership position of the U.S. in the technological revolution in health care and the hospital-based training of most health professionals, especially physicians. The human resources infrastructure of the U.S. health care system has evolved over the last 30 years to be highly specialized and subspecialized, particularly in the field of medicine(7). Approximately two-thirds of all U.S. physicians now practice a specialty discipline. This structure is essentially unique in the industrialized world(6).

Further, this technological approach to health care in the U.S. has often focused rather narrowly on disease-oriented delivery models seeking to cure, rather than on broader, preventive strategies focused on care. The economic systems and incentives for compensating health professionals and educating health professions students have provided additional reinforcement for this “curing rather than caring” approach(6).

Renewed emphasis on primary care and preventive services is found in most of the major proposals for health care reform which are under consideration by the U.S. Congress in 1994. From enhanced support for immunization programs to proposals to allocate numbers and locations of specialty residency training programs, from enhanced support for nurse practitioner and physician assistant training programs to radical proposals to “retrain” specialists, significant change in the U.S. health care system is being clearly signaled to all.

The Pew Health Professions Commission has similarly focused its deliberations on primary care and has outlined significant changes in the education of health professionals which must occur in order to address these policy concerns(3). The Commission envisions a health care system significantly different from that which exists today, calling upon health professionals and their programs of professional educational to develop different “skills, values, and attitudes to be successful in this emerging world.” The Commission outlined seven broad areas of competence which will be needed by all future health care workers to meet the changing needs of patients and the public:

• care for the community’s health;
• provide contemporary clinical care;
• participate in the emerging system and accommodate expanded accountability;
• ensure cost-effective care and use technology appropriately;
• practice prevention and promote healthy lifestyles;
• involve patients and families in the decision-making process; and
• manage information and continue to learn.

These and other initiatives emphasize the fact that the very foundations of health care delivery and health professions education are changing dramatically. It is within this context that pharmaceutical care is emerging as the professional role of current and future pharmacists in the U.S. health care system.

THE PHARMACIST’S ROLE IN PRIMARY CARE

In reviewing the background documents provided to it, the Professional Affairs Committee noted the double challenge facing pharmacy at this time. The profession is cautiously but surely embracing a significant shift in its professional activities and duties as described by the Commission to Implement Change in Pharmaceutical Education(2) and others(3,8). This is occurring concurrently with the substantial changes in the U.S. health care system described previously.

A recent background paper prepared by the American Pharmaceutical Association for its Policy Committee on Educational Affairs reviewed aspects of the primary care role of pharmacists(5). The paper noted that a key element of primary care accessibility has been a hallmark of the pharmacy profession for decades, and that pharmacists often serve as the key entry point for patients into the health care system. However, as is true for the
majority of health professionals, pharmacists are not, and arguably should not be, expected or prepared to provide all elements of primary care that patients need.

Consequently, the Committee discussed at length the interface of primary care with pharmaceutical care. A full range of possible roles and scenarios was debated. It was recognized that models calling for a role for pharmacists based in diagnosis/triage would necessitate even more radical changes in curriculum and experiential education than those currently being explored and implemented for pharmaceutical care. Further, the Committee questioned the appropriateness and cost effectiveness of attempting to educate pharmacists for roles and responsibilities in such areas, especially in the face of health reform initiatives emphasizing these roles for nurse practitioners and physician assistants.

Instead, the Committee’s discussion focused on the potential contribution of pharmacists, and pharmaceutical care, to the evolution and refinement of primary care. A recent article by Trinca(10) has suggested that pharmaceutical care can be the profession’s most effective contribution to primary care.

In the ensuing discussion of the Committee, several important themes emerged:

- There continues to be a lack of focused attention on the issue of improved medication use in a reformed health care system. Certainly no other discipline has embraced this issue as part of its reform agenda. This represents a substantial and unique opportunity for pharmacy.
- Several years of increasing emphasis on multidisciplinary training opportunities have both educated and positioned pharmacists to collaborate effectively with other health professionals.
- Given the national momentum for curricular reform, schools and colleges of pharmacy are presented a unique opportunity to make rapid transition to emphasize primary care, preventive services, and team-based care.

These themes recurred throughout the remainder of the Committee’s deliberations and resulted in the development by the Committee of several policy proposals and recommendations concerning the interrelationships of pharmaceutical care, primary care, and pharmaceutical education.

POLICY STATEMENT 1: AACP supports the position that pharmaceutical care is pharmacy’s most essential and integral contribution to the provision of primary care.

(The Bylaws and Policy Development Committee recommended acceptance of this Policy Statement; the House of Delegates voted to accept this Policy Statement.)

POLICY STATEMENT 2: AACP encourages its member colleges and schools to develop or enhance relationships with other primary care professions and educational institutions in the areas of practice, professional education, research, and information sharing.

(The Bylaws and Policy Development Committee recommended acceptance of this Policy Statement; the House of Delegates voted to accept this Policy Statement.)

POLICY STATEMENT 3: AACP believes that pharmacy faculty have a responsibility to use their experience with health services research and pharmacoconomics to examine and document the effectiveness of pharmacist-provided pharmaceutical care as an essential element of primary care.

(The Bylaws and Policy Development Committee modified the Committee’s statement and recommended acceptance of this Policy Statement; the House of Delegates voted to accept this Policy Statement.)

POLICY STATEMENT 4: AACP supports the development and implementation of curricular components and associated instructional strategies which assure a common set of core competencies and knowledge concerning population-based epidemiology, the determinants of health, effective programs in health promotion and disease prevention, and primary health care services delivery for all health professionals.

(The Bylaws and Policy Development Committee recommended acceptance of this Policy Statement; the House of Delegates voted to accept this Policy Statement.)

POLICY STATEMENT 5: AACP supports the structuring of systems of federal support for health professions education to assure the teaching and clinical application of core competencies in primary care health services delivery which are community-based and fully interdisciplinary.

(The Bylaws and Policy Development Committee recommended acceptance of this Policy Statement; the House of Delegates voted to accept this Policy Statement.)

POLICY STATEMENT 6: AACP supports the elimination of legal, structural, social, and economic barriers to the delivery of primary care health services that prevent competent health professionals from providing necessary health care services.

(The Bylaws and Policy Development Committee modified the Committee’s statement and recommended acceptance of this Policy Statement; the House of Delegates voted to accept this Policy Statement.)

The Committee also makes the following recommendations:

RECOMMENDATION 1: Colleges and schools of pharmacy should examine and further define specific curricular outcomes consistent with the competencies described by the Pew Health Professions Commission.

RECOMMENDATION 2: Colleges and schools of pharmacy should experiment with the pharmacist’s primary care role in various contemporary and evolving practice settings. Such experimentation must be conducted using fully interdisciplinary health care teams.

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References