EDITORIAL

ROSS T. TSUYUKI, BSC(PHARM), PHARMD, MSC, FCSHP, FACC, FCAHS

FAQs (frequent asinine questions) on pharmacists' scope of practice

As the scope of pharmacy practice continues to evolve, we sometimes hear of objections from physician groups and even some pharmacists. I have been around long enough to be able to say that these are the same, tired, misinformed and frankly ridiculous arguments over and over again. Often the response to these objections from pharmacists and pharmacy organizations is pretty weak. So, let's look at some of these issues and statements:

"Fragmentation of Care": The premise of this worry is that having patients receiving care from their pharmacist might lead to some discontinuity of their care (i.e., all care providers not working in a coordinated fashion). For example, a pharmacist's actions might be contrary to what the physician would do, patients might receive conflicting messages or the physician might not know what was being done by the pharmacist. Indeed, these would all be unfortunate occurrences if they were true. But they are generally not. All jurisdictions require a pharmacist to communicate with physicians and other providers when they intervene. So there is no reason to suggest that this fragments care. In fact, speaking of fragmentation, wouldn't it be nice if that patient care communication went in both directions?

Furthermore, one cannot have fragmented care if patients don't receive care at all. Don't forget, between 30% and 40% of patients with chronic diseases cannot, do not or will not see a family physician.[1] This is where primary care pharmacists really shine, by assessing patients, providing care and actually bringing the physician into the loop.

So, if anything, having pharmacists as accessible primary care providers in the community enhances continuity of care.

"Do pharmacists have the training for this?" This statement probably suggests that pharmacists do not have the training to assess patients, determine their needs and, gasp, make decisions. To start with, pharmacy schools are providing good training in patient assessment, including interviewing techniques, history taking, physical assessment and communication. Even physicians would admit that pharmacists have superior knowledge about drugs and therapeutics, so doesn't that qualify us to prescribe?

Pharmacists are, by nature, systematic and like to base their decisions on evidence. That means that we actually read and follow clinical practice guidelines. As an example, we recently reviewed the teaching of the Hypertension Canada guidelines in undergraduate programs in all pharmacy schools in Canada and found that almost all teach to the guidelines.[2]

Pharmacists are also cautious. That can be a good thing—if we feel uncomfortable with a situation, we refer the patient. Our regulations and professional good sense prevent us from working outside of our competencies. Isn't that what all health professionals should do?

So, yes, we are well trained to assess and manage pharmacotherapy, thank you.

"Conflict of Interest": This premise refers to the potential conflict of interest of both prescribing and dispensing.* Yes, the construction and auto repair industry are very troubled by this issue. But one of the hallmarks of being a health care professional is that we put the patient's needs first. We all sign an oath that binds us to those principles. So to suggest that pharmacists would do otherwise is, frankly, insulting. Would you say the same about a physician who gets paid to do procedures like surgery, endoscopy, bronchoscopy, echocardiography or heart catheterization? Or a dentist who gets paid for the procedures he or she recommends?

Finally, this allegation also assumes that we are foisting care upon the unsuspecting public, but they often ask for help from their pharmacist (particularly because we are more accessible). Is it wrong to provide what the patient wants (and needs)?

"Evidence": Interestingly, none of the objections refer to evidence for pharmacist care. As highlighted by *CPJ*, we have solid evidence for pharmacist care and advanced scope of practice (this is becoming our mantra). Examples include hypertension,[3-5] heart failure,[6] cardiovascular risk factors,[7] urinary tract infections,[8] diabetes,[9] and so on. By the way, how much evidence is there for physician care?

*Actually, in Alberta, this is strongly discouraged by the College of Pharmacists but acknowledged that it is sometimes unavoidable.

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Perhaps we should ask the most important people in this discussion—our patients. Patients love receiving care from their pharmacist. In a recent *CPJ* article, Al Hamarneh et al.[10] interviewed patients who received cardiovascular risk reduction care, including prescribing, lab monitoring and follow-up, by their pharmacist in the R_xEACH study.[7] This randomized trial showed a 21% reduction in the risk for major cardiovascular events.[7] Importantly, when patients were interviewed by a separate third party, they highlighted that they valued the accessibility of pharmacists, their trust in and rapport with their pharmacist and the fact that pharmacists explained things well, supported them, were knowledgeable and provided excellent care.[10] Patients said things like, "[The pharmacist] . . . asks us how we feel and actually talks to us. . . . He cares, the pharmacist. He's very special," "He's definitely . . . been a life saver." "It's been a Godsend," "Gave me a reason to actually care about my health."[10]

Some comments that are circulated are so repugnant and unprofessional that they are not worthy of a response. They include things like, "If pharmacists want to prescribe, they should have become doctors," "It jeopardizes the doctor-patient relationship," "Collaborative teams are fine, but must be led by a physician," and so on (if makes you feel better, please add to the list). This and the issues discussed above make one wonder what the real motivations are for opposing pharmacists' scope of practice. . . . Enough said.

The way forward

This is a profession-defining moment. It is time for all of us to stand up. We need to assist our provincial and national pharmacy organizations. Each one of us has a role to play to set the record straight. Talk to physicians and patients about these issues. We should "take the high road"—be firm, professional, respectful and evidence based.

And it's not as if we don't have support from outside the profession. For example, Hypertension Canada strongly supports expanded scope of practice for pharmacists.[11]

Conclusion

Change is difficult. We all know that. But health care issues and society are different now and we as a profession must adapt to these realities. It still puzzles me why physicians think that they should define the practice of another regulated, autonomous profession. Former CPhA Executive Director Dr. Jeff Poston wondered in 2007 "whether doctors might feel slighted if pharmacists had the temerity . . . to define the suitable duties of doctors."[12] Indeed, it is only our regulatory authorities and our patients and public who are the ones who should define our scope of practice.

Our response to these issues could be what defines us as a profession. Let's not forget the importance of advancing pharmacy practice and the bumps (and bruises) along the way because this is important for our patients and public health. That's why we are pharmacists. ■

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