The imperative – to become patient-centred and collaborative

By Debbie Rigby

In recent times there has been much research, discussion and debate over the changing role of pharmacy practice. Throughout the world we have seen a trend for pharmacy practice to move away from its original focus on medicine supply towards a more inclusive focus on patient care. The role of the pharmacist has evolved from that of a compounder and supplier of pharmaceutical products towards that of a provider of services and information and ultimately that of a provider of patient care.

‘Pharmacists should move from behind the counter and start serving the public by providing care instead of pills only. There is no future in the mere act of dispensing. That activity can and will be taken over by the internet, machines, and/or trained technicians. The fact that pharmacists have an academic training and act as health care professionals puts a burden upon them to better serve the community than they currently do.’

Increasingly, the pharmacist’s task is to ensure that a patient’s medication therapy is appropriately indicated, the most effective available, the safest possible, and convenient for the patient. By taking direct responsibility for individual patients’ medicine-related needs, pharmacists can make a unique contribution to the outcome of drug therapy and to their patients’ quality of life. More than 20 years ago, Hepler and Strand defined the concept of pharmaceutical care.

‘Pharmaceutical care is the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient’s quality of life.’

Accepting responsibility for consumers’ medication and health outcomes is a critical and essential part of pharmacists’ changing role. The imperative for pharmacists to become more patient-centred and to better utilise their distinctive competency as a medicine expert is very clear.

In 1975, the US Millis Commission prepared its landmark report Pharmacists for the future, citing pharmacists as the most over-educated and under-utilised of all professionals. In 2008 the Royal Pharmaceutical Society of Great Britain released its white paper Building on strengths – delivering the future showcasing what pharmacy offers now and how it can offer more. The Canadian Pharmacists Association released its Blueprint for pharmacy: Designing the future together in June 2008 which defined a vision and clear action plan for the future of pharmacy in Canada. PSA has taken the lead in developing a vision paper for pharmacy practice in Australia, along with the Pharmacy Guild’s Roadmap.

The changing role of pharmacists and pharmacy practice is now clearer and well defined. The concept of the seven-star pharmacist, introduced by WHO and adopted by FIP in 2000 in its policy statement on Good Pharmacy Education Practice, sees the pharmacist as a caregiver, communicator, decision-maker, teacher, life-long learner, leader and manager.

Australia has led the world in demonstrating through research and implementation the value of pharmacist-conducted medication reviews and disease state management services, so-called professional or cognitive services conducted by appropriately trained and credentialed pharmacists. And yet community pharmacy businesses struggle to embrace these services. The professional culture and psyche of many pharmacists does not align with this opportunity and imperative to pharmacy practice change.

Similar to other countries like Canada, the USA and New Zealand, consultant pharmacy practice has evolved in Australia to make the most of these opportunities and needs, and to establish its place in the primary health care team.

The phrase ‘consultant pharmacist,’ coined by George F Archambault who is referred to as the ‘founding father’ of consultant pharmacy in the USA, originated in the nursing home environment when a group of innovative pharmacists focused on improving the use of medicines in these facilities.

The American Society of Consultant Pharmacists (ASCP) defines consultant pharmacists as:

‘Medication therapy experts, [who] take responsibility for their patients’ medication-related needs; ensure that their patients’ medications are the most appropriate, the most effective, the safest possible, and are used correctly; and identify, resolve, and prevent medication-related problems that may interfere with the goals of therapy.’

William Simonson (ex-president ASCP) says in his book Consultant Pharmacy Practice: “consultant pharmacists are professionals who, through scientific investigation andixeau and practice in written and oral communication, have achieved the highest levels of education and certification in any other profession that can be performed by any other profession.”

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Pharmacist is not an exclusive practice area that is limited to a few elite individuals. He defines a consultant pharmacist as a:

- provider of pharmacy systems
- management expert
- communicator
- educator
- drug information resource
- innovator
- problem solver
- clinical practitioner
- entrepreneur
- patient care advocate
- member of the health care team.

Consultant pharmacists practice in a variety of settings and the scope of practice varies considerably. Consultant pharmacists are no longer defined by where they work, but rather by what they do. They have a common commitment to enhance the quality use of medicines and promotion of healthy living, ideally in a multidisciplinary environment.

Residential Medication Management Reviews (RMMRs) commenced in 1997, followed by Home Medicines Reviews (HMRs) in 2001. The Australian Association of Consultant Pharmacy was set up to provide accreditation for pharmacists to deliver these services. There are now more than 2,000 pharmacists credentialed to conduct these Australian Government-funded medication reviews. Over 300,000 HMRs have now been conducted and the vast majority of residents in residential aged care homes have at least an annual RMMR. Whilst RMMRs can be contracted to consultant pharmacists, until now HMRs have had to be conducted through a community pharmacy. This was seen by many consultant pharmacists and general practitioners (GPs) as a barrier to the uptake of HMRs as trust, communication, and collaboration are essential for team-based care.

Health systems in the UK, Canada and to a lesser extent New Zealand have integrated pharmacists in to general practice settings. GPs support a collaborative model integrating pharmacists into primary health care teams. There is evidence that greater collaboration between GPs and pharmacists can improve patient care.

We have been talking for a long time about these changes and future roles, in particular the shift from product-orientated service to patient-orientated service, and a service more focussed on the patient, but many have resisted the external and internal drivers. Dr Alison Roberts and Professor Charlie Benrimoj have identified the many barriers to change in community pharmacy and implementation of professional services.

These barriers are real – workforce issues, time constraints, remuneration models, lack of private consulting areas, poor implementation and change management strategies, and variable support from GPs and pharmacy owners. But perhaps the actual barrier is pharmacists’ own psyche and culture. This idea was proposed in an elegant article where Canadian researchers suggested that, ‘if professional culture and the approach to change do not align, practice change will remain elusive’. The authors termed pharmacist personality traits as lack of confidence, fear of new responsibilities, paralysis in the face of ambiguity, need for approval and risk aversion. They suggest that those pharmacists who have already taken steps to advance their practice by adopting a more patient-centred approach (i.e. consultant pharmacists) will continue to be successful. Those who are unable to make the transition from dispenser to patient-centred practitioner will soon realise it will not be enough to simply dispense medicines.

For the practice of consultant pharmacy to grow flexible frameworks, IT platforms and tools, appropriate education, quality and practitioner development along with leadership and advocacy must occur. In 2010, the Pharmacy Guild confirmed that HMRs and RMMRs will continue to be funded under the 5th Community Pharmacy Agreement, with some changes proposed to both models. For HMRs, this includes a direct referral model (which commenced operation on 1 October) and post-discharge HMRs initiated by the hospital for high-risk patients. For RMMRs, it includes funding QUM services separately from the review component and increasing the focus on collaborative reviews. These proposed changes to the HMR model are welcome news to many consultant pharmacists and are well supported by the evidence.

Capacity building for consultant pharmacists requires the appropriate level of education, training and skills development. Credentialing for advanced practice is critical. Mentoring and an ethos of life-long learning must be fostered to build that culture and commitment to patient-centred care.

The sustainability of consultant pharmacy practice requires recognition of champions together with flexible and modifiable services to meet the changing needs of consumers and other health providers. New programs must be integrated into existing services. Only then will community pharmacies be seen as members of the primary healthcare team.

Only then can consultant pharmacists work in general practice as part of a multidisciplinary team. Only then will consultant pharmacy be an attractive and viable career path for pharmacists.

Consultant pharmacy is not a threat to traditional community or hospital pharmacy practice. All elements of the profession need to work together, not against each other. We need a shared vision for pharmacy and shared plan for pharmacy practice change. We must be ready now to take advantage of the opportunities, so that they are not lost.

This article is based on a presentation to attendees at the 2011 PSA Offshore Refresher Conference.

References

Pharmacists’ culture – the ultimate barrier?

By Debbie Rigby

As the pharmacy profession seeks to meet the changing needs of an ageing population, an increasing burden of chronic disease, a shift towards preventive care and health promotion in an increasingly financially constrained environment, it is timely to reflect on the culture of pharmacists.

The imperative for pharmacists to shift towards a patient-centred collaborative model is clear. The aspirations of many pharmacists to have more involvement with patients and medical practitioners have been voiced within the profession. Pharmacists have a societal obligation to use their unique knowledge and skills to help patients better manage their medicines and avoid medicines-related problems.

Despite a wealth of evidence on the benefits of professional services, pharmacists have been slow to embrace this responsibility. It has been suggested that pharmacists are the ultimate barrier to pharmacy practice change. Zubin Austin, a Professor of Pharmacy in Canada and Co-author of, Are pharmacists the ultimate barrier to pharmacy practice change?, has suggested that the actual barrier is pharmacists’ own psyche and culture.

Culture relates to values, beliefs, customs, norms, and expected behaviours. Attitudes and beliefs characterise professionalism and they must be acquired and inculcated throughout the process of true professional socialisation. This process must begin at early stages of professional education and continue throughout a pharmacist’s career with a commitment to lifelong learning. Any disconnect between the skills, knowledge and attitude acquired during training and opportunities to practice at the top of our training in actual practice can lead to disillusionment and realistic disenchantment.

Divergent cultures may form within a health profession. This is apparent in community pharmacy practice in the dichotomy of our role as a health professional. Consumers and other health professionals, and indeed pharmacists themselves, may struggle to understand our role – are we a retailer in a health setting or health provider in a retail setting?

Culture is also a potential barrier to interprofessional collaboration. There is evidence that greater collaboration between general practitioners and pharmacists can improve patient care and reduce medication misadventure, yet the uptake of collaborative professional services such as HMRs and RMMRs has been variable. The integration of professional services into community pharmacy workflow is minimal. Changes need to occur to ensure pharmacists realise the vision for pharmacy practice.

Zubin Austin et al., have suggested personality traits that provide insight into pharmacist culture:

- lack of confidence
- fear of new responsibility
- paralysis in the face of ambiguity
- need for approval
- risk aversion.

The authors suggest that ‘pharmacists who have already taken steps to advance their practice by adopting a more patient-centred orientation … will continue to be successful’. Those pharmacists in the majority resting in the middle, ‘will have to face the reality that it soon will not be enough to simply dispense medications’.

Finally, there was a strong warning that, ‘those pharmacists at the opposite end of the spectrum focused solely on the technical aspects of pharmacy practice will continue to be nonsignificant contributors to outcome-focused patient care and will quickly be replaced by regulated pharmacy technicians’.

Dr Alison Roberts and Professor Charlie Benrimoj have identified facilitators for change in pharmacy practice in the Australian setting which clearly resonate with these personality traits. They have previously suggested that pharmacist competence, motivation, knowledge, communication and leadership skills, attitudes and confidence are barriers to the widespread implementation of professional services.

Too often a focus on remuneration is seen as the most significant driver for practice change. Innovative practitioners who have the courage to ‘rattle the cage’ should be applauded as role models and mentors. Exploration of the culture of pharmacists is critical to the advancement of the profession.

References