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Dinosaurs, dodo birds, and dispensing pharmacists

MOST COMMUNITY PHARMACISTS WHO HAVE BEEN around a while have become comfortably numb with all of the proposals for change in pharmacy. After all, we have come to many crossroads where seemingly nothing terrible or groundbreaking has happened in our profession. And so it is absurd to suggest that the dispensing pharmacist will become extinct, that in time he or she will go the way of dinosaurs and dodo birds. But is it really?

There was a time when we were known as chemists and druggists, when the majority of prescriptions were compounded, concocted, prepared, or procured. We had considerable leeway to substitute what a doctor had ordered if we did not have it in "stock." We could also freely give advice to our customers — even make recommendations for "minor" ailments. The public loved us and we were integral to the health and welfare of the communities we served, especially to the poor and less fortunate who could not afford to go elsewhere. Life was good. We enjoyed a wonderful reputation because we really cared about people.

Unfortunately, we were not a real profession. We were unqualified to provide care. Even those among us who were highly educated, in some cases with 5- and 6-year degrees, were rebuked and repudiated by the medical profession because our practice setting — the drugstore — was deemed a conflict of interest. Why should people trust the advice of the druggist? How could we provide care?

With the 1950s came the advent of modern pharmaceuticals. The powers that be decided our role was to dispense as written by the doctor and just provide directions for use. We could not provide the name of the drug, the indication, side effects, or discuss with the patient the management of their condition. If you could keep your lips still, fill and bill, you were spared reprimands by your college and the ire of your local doctor. It was a time of great dismay, as pharmacists wrestled with their consciences about the relegation of their role.

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However, at this time there were fortunately many pharmacists brazen enough to prove that we were not only well trained and capable of providing patient care, but that we could do so with the utmost professionalism. Eugene V. White, who graduated with a 4-year Bachelor of Science degree in 1950, chose to revolutionize pharmacy practice in Berryville, Virginia. In 1960, he decided to eliminate the soda fountain and all the retail displays and replace them with a patient waiting lounge, a prescription laboratory, and a private counselling area.[1]

"It was at this juncture that I knew I must disobey the Code of Ethics in order to discuss the medications with the patient," said White. "On April 9, 1960, I began to record a profile of each patient, his or her disease states, allergies, and a continuing medication history." White observed prescribing errors, side effects, lack of efficacy, drug interactions, and drug duplication when patients would see more than one doctor. He kept meticulous patient records that enabled him to intervene and make a huge difference.[1]

In the 1960s, the era of clinical pharmacy was born, as pharmacists began to do the same not only in the community, but in hospitals and long-term care facilities as well. Fortunately, White only had to the break the law for 9 years, because in 1969 the code of ethics was changed to allow pharmacists to provide health care services to their "patients" (the term that replaced "customer").

In the 1970s and 1980s we were now expected to dialogue with each patient, not only to check the suitability of the prescribed drug but to ensure the best possible outcome for the patient. We were now required to be more involved with patients and always bear in mind their best interests. We were told that what we were doing was providing "cognitive services" and that

we should document these exchanges. Why? Well, in the event of patient/physician discrepancies and to protect ourselves from legal exploitation. And, oh yes, there was also the promise, as remote as it was, of reimbursement for these cognitive services. But what is it that we really do? And what do we call it so we can bill for it?

In 1990, we decided to call this pharmaceutical care. And for the first time ever, our objective (among a lofty list) was to improve patient quality of life. But where was the research and why should pill counters be paid for care? Pharmacy practice research exploded to meet this challenge and demonstrated that we were capable of extraordinary care that was worthy of payment.

Eighteen years later, here we are, hormonal teenagers in our evolution, needing to accept that reimbursement for dispensing will continue to decline. Dispensing medications has undoubtedly brought us great success, but will it continue to? Our profession is marching, albeit awkwardly, towards reimbursement for care and we need everyone to move forward. However, those among us who are academically endowed and prolific practitioners in pharmacy practice need to inspire those who are not quite there yet. No one needs to be beaten down or scared into submission with arrogant rhetoric.

Every generation of pharmacists before us rose to the challenges of their day and left enough behind for those coming in to succeed. This is our time. This is our turn. What legacy do current community pharmacists wish to leave behind? ■

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Reference

1. Eugene V White. Chronicle of giving. Richmond, VA: Medical College of Virginia Foundation; Spring 2007. Available: www.mcvfoundation.org/Chronicle%20of%20Giving%20Spg%2007.pdf (accessed April 16, 2008).