Pharmacists Set to Become More Active Clinicians in Pennsylvania

Robert I. Field, JD, MPH, PhD

Pharmacists often know more about the medications that they dispense than the physicians who prescribe them, yet they have little authority under the laws of most states to make actual decisions about patient care. Pharmacy school provides rigorous training in the physiology and chemistry of pharmaceuticals and related products, and pharmacy practice affords regular personal contact with the patients who use them. However, pharmacists make almost no clinical decisions directly. In both institutional and retail settings, their clinical judgment is relegated to raising occasional questions and making suggestions to prescribers, who may choose to ignore them.

Several states have recently taken steps to expand the clinical authority of pharmacists. The latest to do so is Pennsylvania, which is about to implement a major set of regulatory reforms. Act 102, the Collaborative Drug Therapy Management Law, was enacted in 2002. When its regulations go into effect this year, they will bring about the most substantial steps to expand the clinical authority of pharmacists. The latest to do so is Pennsylvania. The new Pennsylvania law also addresses concerns about the quality of health care. Widespread medication errors in hospitals have been well documented, and research indicates that active pharmacist participation in the process of prescribing and administering drugs can reduce the frequency of errors. Act 102 affords pharmacists an enhanced role in directing institutional patient care by managing drug therapy. Under the law, pharmacists may (1) adjust the regimen, strength, frequency of administration, and route of administration of drugs; (2) order laboratory and other diagnostic tests; and (3) administer medications.

As is the case with administering injectables in retail settings, pharmacists performing these activities are required to have a written agreement with a licensed physician. This agreement must be subject to renewal at least every two years.

Prior to Act 102, Pennsylvania pharmacists could accept delegation of some medication management authority from physicians, but this responsibility was considerably more limited. Forty other states permit such collaboration to at least some extent. Pennsylvania will now be among the most aggressive in this regard.

NEXT STEPS

Pharmacists may find themselves gaining even more extensive clinical autonomy in the years ahead. A logical next step would be to permit retail pharmacists to monitor some diagnostic indicators such as blood glucose and cholesterol levels and to adjust insulin and statin medications accordingly. Rite Aid plans to place primary care clinics in some drugstores, where pharmacist-administered medications can be delivered to patients. The federal Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which implemented the new prescription drug benefit, permits an enhanced pharmacist role in medication management that may further promote this trend.

Although advocates see the expanded clinical responsibilities of pharmacists as a solution to shortcomings in health care access and quality, others fear a potentially dangerous overlap with physician practice. Concerns among physicians led the Pennsylvania Board of Pharmacy to limit the authority to manage medications to pharmacists in institutional settings. As a result, the authority does not extend to retail pharmacists. The law’s requirement that written agreements with physicians govern new pharmacist responsibilities has further alleviated physicians’ unease.

As with most expansions of professional roles, the growth of clinical autonomy among pharmacists may also arouse fears of economic competition by physicians and members of other health care professions. Some predict that

continued on page 105
greater pharmacist involvement in providing primary care might lure patients away from medical practices. However, national experience indicates that the availability of vaccines, when administered by pharmacists, increases immunization rates overall and can actually lead to a greater number of physician-administered vaccinations. Increased access to primary care services at pharmacies might also engender more early diagnoses that ultimately produce more patient visits to physicians.

POLICY CONCERNS

Enhanced clinical autonomy for retail pharmacists also raises a potential conflict of interest. Vesting a single professional with the authority to prescribe, dispense, and administer medications could create an incentive to overprescribe. However, the steps taken to date by Pennsylvania and other states concerning retail pharmacists affect a limited range of products and do not involve actual prescribing.

Pharmacists are trained as experts in the uses and effects of medications. They are often the first professionals to whom patients turn with questions, and they are commonly among the most trusted. In both retail and institutional settings, pharmacists also tend to occupy the best position from which to observe the overall medication therapeutic regimens of patients and to identify gaps and errors. Increasing their direct clinical role seems to be an obvious way to enhance patient care.