

# In Need of a North Star for Canadian Pharmacy Practice

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You know the old saying, “If you’ve seen one pharmacy practice model, you’ve seen ... one pharmacy practice model”. As pandemic restrictions loosen and we begin to gather again, I worry that we aren’t coming together to address the important issue of variation in pharmacy practice models across the country.

Through various channels, I’ve had the opportunity to attend two recent international conferences: the ASHP Summer Meetings and the Global Conference of the American College of Clinical Pharmacists (ACCP). In my role with the CSHP, I’m also part of discussions involving the Society’s board, affiliated boards, task forces, and committees. Being part of such a variety of meetings is a privilege, and I’m forever indebted. As well as sharing learnings from these events with my Canadian colleagues, I have the added responsibility of taking action. My aim in writing this commentary is to point out that your (yes, your!) vision for a health-system pharmacy practice model is different from the next person’s, whose vision is different from that of the person next to them, and so on.

The issue of variant models of pharmacy practice isn’t unique to Canada. At the ASHP and ACCP conferences, it became obvious that we’re all working on similar, but slightly different, plans. Though we share the same *ultimate* goal—to improve patient outcomes—we don’t necessarily agree on how to accomplish it. Some feel that pharmacists should be responsible for every aspect of a patient’s medication therapy and should address every drug-related problem (DRP), while others feel that certain aspects of medication therapy should be prioritized, with others de-prioritized and followed-up after discharge. It’s no wonder the corresponding practice models are different! Some models deliberately target the main DRP and admitting diagnosis, while others rely on the attending physician for those aspects and focus instead on all other DRPs. One model is heavily reliant on regulated pharmacy technicians, while the other struggles with recruitment ... which leads to my next point.

Perhaps the models are justified in being different. All hospitals are different. They evolved from different pasts. They’re funded differently. The corresponding health care

providers’ practices are different. Maybe even patients’ goals of therapy are different. But I worry that these explanations are just rationalizations for keeping the status quo. It can be difficult to look outward, reflect inward, and recognize that we need to change. But with such an approach, we can do more to control the situation, rather than having it entirely dictated by external factors.

You might be thinking, “Hey Zack, back off. Where I come from, we live and breathe vision and change.” If you do, that’s great. Yet I would still ask, “Where are these changes taking you? How do you know it’s where others think we should be going?” Perhaps your North Star is the International Pharmaceutical Federation Basel Statements on the Future of Hospital Pharmacy (<https://www.fip.org/files/content/pharmacy-practice/hospital-pharmacy/hospital-activities/basel-statements/fip-basel-statements-on-the-future-of-hospital-pharmacy-2015.pdf>) or the ASHP long-range vision for the pharmacy workforce in hospitals and health systems (<https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/pharmacy-workforce-long-range-vision.pdf>). Or maybe the visioning work of Jorgenson and others (<https://pubmed.ncbi.nlm.nih.gov/29123593/>) resonates with you: “Pharmacy professionals providing proactive, interprofessional or team-based, patient-centred care that optimizes drug therapy outcomes”. These are all important documents. Yet we aren’t talking about them. What do they mean? How can we use them? In my most recent commentary (DOI: 10.4212/cjhp.v75i1.3256), I borrowed the quote “If you want to go fast, go alone; if you want to go far, go together”, and I’m reiterating it now.

Together, we can really get somewhere. We need to layer on the detail. We need to consolidate our plans for comprehensive medication management, determine pharmacist ratios, specify technician roles, and more.

If I may speak frankly, we’re spoiled in Canada. We have, essentially, a noncompetitive health care system without the burden of ensuring profitability. We have the CSHP Hospital Pharmacy in Canada Survey. We’re the birthplace of clinical pharmacy key performance indicators. We have

a “town square” in CSHP, our community of not-for-profit pharmacy professionals who work to improve patient outcomes, and we should be doing this work in ways that are more similar than different. COVID-19 has kept us apart these past few years, and now we must come together again, hardened by battle, and reignite our conversations on the future of pharmacy practice. Finding a pharmacy practice North Star cannot wait.



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