EDITORIAL

Professional Boundaries

L. Lee Dupuis

In January 2002 the American College of Physicians and the American Society of Internal Medicine jointly published a position paper describing the pharmacist's scope of practice.[1] No pharmacist is listed either as an author or as a member of the Health and Policy Committee that developed the paper. Neither is a pharmacist acknowledged for contributing to the position paper. Therefore, this paper represents the position of a group of physicians on what they perceive the job of a pharmacist to be.

The conditions that would prompt 2 physician associations to delineate the pharmacist's scope of practice are not entirely relevant to the current Canadian climate. Yet they do have some resonance here. As the position paper explains, US state legislatures have been inundated with proposals to extend the scope of practice of many health care providers (e.g., pharmacists, clinical nurse specialists, and physician assistants). For example, in some states, pharmacists have recently been authorized to modify drug therapy, administer medications and injections, perform physical assessments, and order laboratory tests. The adoption of these activities by pharmacists has blurred the traditional boundaries between professions. As well, issues related to compensation have been raised. Thus, US physicians have felt the need to define what pharmacists should do. Five positions are outlined in the paper; my discussion will be limited to the first 3 of these:

- Support of research into the effects on pharmacy practice of automation and the move to the PharmD degree.
- Support of collaborative practice agreements limiting pharmacist involvement to patient education and hospital rounds.
- Opposition to independent pharmacist prescribing privileges and initiation of drug therapy by pharmacists.
- Support of the pharmacist as an immunization information source, host of immunization sites, and immunizer.
- Support of therapeutic substitution policies that ensure the highest level of patient care and safety.

Increasing reliance on technicians and automation, as well as the higher expectations of new graduates from clinically focused curricula, have changed and will continue to change the practice of pharmacy. The paper admits that, generally speaking, active involvement in drug therapy by pharmacists has been successful. It would be difficult not to concede this point, given the weight of evidence of the benefits to patients.[2] However, the paper implies that successful collaborative practices with pharmacists may, in fact, be no more effective than computer-generated reminders of potential adverse effects or drug interactions.

To be fair, the position paper supports pharmacist–physician collaborative practice. Yet it stipulates the physician's primary position as the gatekeeper in any patient–pharmacist relationship and, for all intents and purposes, restricts pharmacists to providing education rather than care.

The paper deems pharmacist prescribing to be unsafe because of pharmacists' inability to access complete medical histories and their lack of appropriate training. Pharmacists' involvement in symptom assessment and self-medication in the retail setting is not acknowledged. Neither is anything said regarding practice settings where a pharmacist can obtain the appropriate training and experience and where the pharmacist has access to appropriate patient information. It is painfully true that the depth and breadth of clinical training in undergraduate and postgraduate pharmacy programs may not consistently provide the supervised "hands-on" experience required to appreciate the subtleties of therapeutics. Nevertheless,

there are many formal training programs that do give students the opportunity to develop care plans and evaluate therapeutic outcomes. These programs are not mentioned. In my opinion, this is a very narrow-minded view of the world.

In a quietly Canadian way, many pharmacists in this country have been using various legislative tools to obtain authorization to practise collaboratively within an interdisciplinary model. As outlined in the recently published CSHP information paper,[3] such practices have usually developed between individual pharmacists and physicians within health care institutions when there has been an opportunity to improve the delivery of patient care. We Canadian pharmacists are using our knowledge, skills and judgement to efficiently provide pharmaceutical care and to improve our patients' lives.

References

1. American College of Physicians and American Society of Internal Medicine. Pharmacist scope of practice. *Ann Intern Med* 2002;136:79-85.
2. Dupuis LL. Hospital pharmacy: an evidence-based profession. *Can J Hosp Pharm* 2000;53:74-5.
3. Task Force on Pharmacist Prescribing. An information paper on pharmacist prescribing within a health care facility. *Can J Hosp Pharm* 2002;55:56-62.

L. Lee Dupuis, MScPhm, FCSHP, is Manager of Clinical Services, Research and Education, Department of Pharmacy, The Hospital for Sick Children, and Assistant Professor, Faculty of Pharmacy, University of Toronto, Toronto, Ontario. She is also an Associate Editor for *CJHP*.

Address correspondence to:
L. Lee Dupuis
Department of Pharmacy
The Hospital for Sick Children
555 University Avenue
Toronto ON M5G 1X8
e-mail: lee.dupuis@sickkids.on.ca