

# Overcoming Barriers to Adoption of Guidelines and Use of Proven Interventions: It Is My Table!

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In the current issue of the *CJHP*, Barry and others<sup>1</sup> describe the reasons for non-use of proven interventions from the perspectives of clinical pharmacists within their health care organization. Of particular interest to me were the 2 most common reasons identified by the authors: a team preference to defer management of these issues to the outpatient care provider and issues related to workload and priorities.<sup>1</sup>

Recently, baseline data for the CSHP 2015 objectives were published in the *Hospital Pharmacy in Canada 2007/2008 Report*.<sup>2</sup> The chapter on CSHP 2015 provided a comparison of current levels of pharmacists' performance against the CSHP 2015 targets.<sup>2</sup> As noted by author and former CSHP President Emily Musing, "While the data indicate that pharmacists actively apply evidence-based methods to the improvement of medication therapy, they do not seem to be as actively involved in the implementation and management of evidence-based drug therapy protocols."<sup>2</sup> According to Musing, "It is possible that . . . individual pharmacists are less frequently involved in the implementation and management of the protocols, possibly due to inadequate pharmacist resources to do so."<sup>2</sup>

Taken together, the findings, speculations, and recommendations of both groups of authors<sup>1,2</sup> led me to ask the question, "What should be guiding the clinical pharmacist's priorities?"

Let me address the 2 main reasons that Barry and others<sup>1</sup> cite for pharmacists not focusing on interventions that have been proven to improve patient outcomes.

The concern regarding workload and priorities is easiest to dispel. Beneficence, nonmaleficence, respect for autonomy, and justice are the 4 commonly accepted ethical principles applied to health care.<sup>3</sup> All other principles being equal, beneficence (i.e., seeking to do good so that the patient's health can benefit) should be guiding our priorities.

If pharmacists are not providing certain aspects of pharmaceutical care because of inadequate human resources or lack of time, then why are these neglected activities considered to have lower priority than others? Let us take a look at the common activity of managing acute pain, typically perceived by hospital

pharmacists to have greater priority than managing chronic disease. Not to underestimate the important and prominent roles of pharmacists in acute pain management,<sup>4</sup> but is our traditional focus on acute care always in the best interest of the patients we serve? Or are we sacrificing the critical issues in favour of the urgent ones?

For example, what is the relative value of pursuing acute pain management? The individual patient certainly benefits from experiencing less pain (at least for a couple of hours). But is that of significance in the patient's overall quality of life, especially if compared with focusing on a proven intervention that has been documented to decrease patient morbidity and mortality? How can we make a case that the most valuable end point can be achieved by focusing on the patient's chronic conditions? Do we need to calculate an NNT (number needed to treat) or NNI (number needed to intervene) to ascertain the number of patients for whom acute pain medications would have to be optimized to save one patient's life and compare that with the number of patients who would have to be started on osteoporosis medications to prevent a broken hip (a condition with known high mortality rates)?<sup>5</sup>

Regarding the team preference to defer management of these issues to the outpatient care provider, the fact that patients are not receiving these proven interventions when they arrive from the community leaves one wondering on what basis the team (including the pharmacist) expects that postdischarge management of these pre-existing conditions is going to be any better. Isn't this analogous to the "it's not my table" syndrome, whereby a restaurant customer needs his or her server, is unable to get the server's attention, and encounters further frustration



when another server responds with the stock phrase “It’s not my table”? This isn’t good service in a restaurant, and it isn’t good pharmaceutical care.

Traditionally, hospital pharmacists have focused on acute or urgent issues; this is justified especially when these issues, left unattended, would prolong the hospital stay or increase morbidity. In contrast, when it comes to chronic disease management, some of the same pharmacists respond by asking, “Shouldn’t the community pharmacist be doing that?” I don’t think so, especially when the evidence suggests that most community pharmacists are not “doing that”<sup>16</sup>. I certainly do not wish to downplay the significant findings of numerous published studies (the Study of Cardiovascular Risk Intervention by Pharmacists [SCRIP]<sup>7</sup> and SCRIP-Hypertension,<sup>8</sup> to name just a couple) that have demonstrated the effectiveness of community pharmacy-based interventions in improving patients’ health outcomes. But that potential is far from being realized today. In the meantime, can we accept the “it’s not my table” mentality as justification for not addressing concerns related to chronic disease in the hospital setting?

Barry and others<sup>1</sup> recommend that efforts to increase utilization of proven clinical interventions should “focus on changing pharmacists’ perceptions of priorities.” I applaud their efforts to challenge the status quo and look forward to seeing the outcome of their continuing efforts to address these critical “care gaps”. Other institutions may wish to follow their lead by adopting the “It *is* my table!” attitude.

#### References

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