

Should Pharmacists Have Prescribing Privileges?

THE “PRO” SIDE

The answer to this question is obvious—it is an emphatic and resounding yes! Over the past few decades, the practice of pharmacy has evolved significantly. Pharmacists are now recognized as drug therapy experts who, in collaboration with patients, physicians, and other health care professionals, strive to optimize medication management to produce positive health outcomes across the spectrum of health care delivery.^{1,2} Notably, this practice change has been led by hospital pharmacy practitioners, and nowhere is the advanced role of pharmacists as direct patient care providers more obvious today. The current trend across Canada to expand the scope of pharmacists' practice to include authorization for prescribing medications is therefore a logical and natural fit for hospital practitioners.

For many practising hospital pharmacists, the question posed here is actually a rhetorical one. Evidence from Canada demonstrates that hospital pharmacists are already involved in and assume a significant amount of responsibility for prescribing drug therapy for their patients.^{3,5} Furthermore, it appears that the extent of prescribing among hospital pharmacists is escalating across the country. In the most recent hospital pharmacy survey,⁵ 63% (66/104) of responding institutions reported approval of prescribing rights for pharmacists, with increases observed in the approval rates for most types of pharmacist prescribing. Notably, dependent prescribing for dosage adjustments (79%) and new therapy (42%) were the most common types of prescribing approved for hospital pharmacists.⁵

Although these trends are impressive, they may actually underestimate the true extent to which pharmacist prescribing now occurs within hospital practice environments. Previous research has demonstrated that pharmacist prescribing within health care facilities often occurs without institutional approval and is based on collaborative practices involving individual pharmacists and their physician colleagues.^{3,4} Consequently, efforts to create legislative change to expand the scope of practice for pharmacists, including the privilege to prescribe medications, should be welcomed by hospital pharmacists. In fact, our national organization, CSHP, “advocates the role of pharmacists as capable prescribers and supports the pharmacist's role in a collaborative prescribing model”.⁶ Given the current nature of hospital pharmacy practice, obtaining prescribing rights should be viewed as an opportunity to continue the transition and constructive evolution of the profession toward a more direct role in providing patient care.

Beyond professional advancement, there are more altruistic goals to be achieved by pharmacists with prescribing privileges. In many jurisdictions, the impetus for legislation enabling pharmacist prescribing has been the desire to make greater use of the unique knowledge and skills of pharmacists, to promote the development of a more flexible health care system for the prescribing, supply, and administration of medications.⁷ This is true of the recent legislative changes in Alberta, which have

enabled pharmacists to apply for and be granted “additional prescribing authorization”—the approval to assess patients and determine their need for initiation of drug therapy or to work in collaboration with physicians and other health care professionals to assume responsibility for the management of drug therapy that patients require. The overall goals that have been identified for pharmacist prescribing include (1) improving access to drug therapy and optimizing patient outcomes from such therapy; (2) reducing both the redundancy and interruptions in therapy that currently occur in the delivery of health care services; and (3) increasing collaboration and synergy among pharmacists, physicians, and other health care professionals for an improved service delivery model.² It is almost incomprehensible to think that hospital pharmacists would not support the contribution of the profession toward the achievement of these goals.

Hospital pharmacists have always been at the forefront of implementing practice change, and taking on the role and responsibility of prescribing medications is no exception. It is frequently argued that pharmacists have developed the expertise in evidence-based pharmacotherapy and patient-centred care that make it appropriate for them to assume responsibility for prescribing.^{4,7} Broadly speaking, hospital pharmacy practice provides the ideal opportunity to support pharmacist prescribing because of the ability of hospital pharmacists to access and interpret patient medical records, their experience in practising as part of a multidisciplinary clinical team, and their familiarity with documenting patient care recommendations and activities. Given these enabling characteristics, it may be logistically easier to implement pharmacist prescribing within this setting, which could lead to more hospital practitioners seeking prescribing privileges when provincial legislation permits it to occur. This expectation was certainly true in Alberta, where 10 (67%) of the first 15 pharmacists in the country to be granted additional prescribing authorization had a patient care practice within a hospital or an institution-based clinic.⁸

In keeping with current shifts in the delivery of health care services within institutions, hospital pharmacists are increasingly providing clinical care for ambulatory patients through their practices within hospital-based outpatient clinics.⁵ This practice trend affords hospital pharmacists the extraordinary opportunity to provide continuity of patient care across the spectrum of the health system. In this regard, many hospital pharmacy practitioners contribute to chronic disease management for many patients, such as those with solid organ transplants, congestive heart failure, or HIV infection, to name only a few. The provision of prescribing privileges to pharmacists with this type of practice is appropriate, logical, and likely to be successful, in terms of achieving the goals of pharmacist prescribing stated above.

Within the current Canadian environment of increasing demands for and costs of health care, the focus of the pharmacy profession must be on the provision of services that improve the quality of medication use and promote better health outcomes for patients. Pharmacists face multiple professional challenges that could be viewed as limitations to the further evolution of pharmacy practice, including human



resource shortages, questions about the role of practice and communication technologies, and difficulty with remuneration for professional services. Yet pharmacist prescribing provides an opportunity for pharmacists to contribute to a new model of health care delivery and to improve patients' access to medication. A number of hospital pharmacy practitioners have already taken up this challenge, creating new and expanded roles with prescribing privileges for the purpose of improving medication use, continuity of care, and patients' health outcomes. As a natural extension of pharmacists' current role in direct patient care, we should be granted prescribing privileges once provincial legislation permits such an expanded scope of practice. This new role for pharmacists will provide the opportunity for us to continue to offer benefits to patients, to the health care system, and to the profession as a whole. To quiet the cynics who oppose this practice evolution, however, we need to study the impact of pharmacist prescribing on patient care outcomes, processes of health care delivery, and costs.

Yes, pharmacists should have prescribing privileges! Better utilization of our knowledge, skills, training, and ability to work collaboratively with patients and other health care professionals through the addition of prescribing privileges will permit us to evolve our practice. The conscientious application of an expanded scope of practice will ensure that pharmacists are key participants in a reformed health care delivery system and that they contribute to the optimization of medication use and to improvements in patient health outcomes.

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THE "CON" SIDE

The term "prescriptive authority" has been used in many different contexts to describe actions that are within pharmacists' current scope of practice and also for proposed changes to our scope of practice. In essence, pharmacist prescribing has been going on for some time in the form of recommendations for over-the-counter medications, approved institutional protocols or programs, and provisions of provincial regulatory authorities (such as the bylaws of the Saskatchewan College of Pharmacists¹) that allow pharmacists to provide emergency supplies of medications. Where the debate really lies is in the issue of pharmacists taking on independent prescriptive authority. This proposed change to our scope of practice raises many questions for me: In what setting should we be allowed to prescribe? Should this prescribing be independent of other practitioners? Will having prescriptive authority actually translate into further improvements in patient outcomes? Do all pharmacists want to prescribe medications? Are all pharmacists equally prepared to have prescriptive authority? What credentials and experience should be required for pharmacists to have prescriptive authority? I am not alone in asking these questions; other authors have asked the same questions, even after their region made a legislative change to allow pharmacists to prescribe.²

Within Canada, the provinces of Alberta, Manitoba, and New Brunswick now have legislation allowing pharmacists to prescribe independent of medical practitioners. The CSHP statement on pharmacist prescribing supports a "collaborative prescribing model to improve patient health outcomes and increase the successful and efficient delivery of pharmaceutical care."³ As hospital or community pharmacists, we often do not have access to family physician charts, specialist reports, community laboratory or diagnostic reports, or acute care information that may be required for prescribing decisions. In most areas within Canada there are no seamless health information systems that would allow pharmacists to follow patients along the continuum from the hospital to the community. In institutional practice, prescribers must have privileges to prescribe within a particular health care facility; as such, prescribing authority defined by the provincial college of pharmacists will not necessarily translate into pharmacists being able to prescribe medications in a hospital setting.

There is a paucity of literature supporting expansion of pharmacists' scope of practice to include prescribing, and no trials have been conducted to evaluate whether such a change will improve outcomes for patients.⁴ In contrast, many trials have supported the concept that pharmaceutical care leads to improved patient outcomes. In an often-cited trial, Bond and Raehl⁵ found lower mortality rates in association with pharmacist-provided in-service education, drug-use evaluation, management of adverse drug reactions, management of drug protocols, and preparation of admission drug histories; mortality rates were also lower when pharmacists participated on cardiopulmonary resuscitation teams and on medical rounds. In a recent systematic review, Kaboli and others⁶ found lower mortality rates in association with pharmacist participation in medical rounds, pharmaceutical care, drug-class services, discharge counselling, and postdischarge follow-up. There are no other health care professionals who provide pharmaceutical care, but there are other health care professionals who can prescribe. With high-quality evidence supporting our current role in patient care, why should we divert our valuable time to



a task for which there are no outcome data—especially when we may not be taking full advantage of our current scope of practice, which has been shown to improve outcomes? Canada is not the only country where legislation has been passed without an evaluation of efficacy before implementation. Two pharmacists from the United Kingdom, commenting on UK legislation allowing pharmacists to prescribe, wrote that “It is worrying that the Department of Health has not waited for further evidence to accumulate before launching their new policy allowing pharmacists to prescribe.”⁷

In Canada, an undergraduate pharmacy degree currently consists of 5 years of university training, with many fewer patient-contact hours than are available to our medical and nursing student counterparts. With limited structured practical experience, it is unlikely that a graduating pharmacist would have the commitment, competence, and confidence to prescribe independently. In Alberta, where all pharmacists may now apply for independent prescriptive authority, only a handful have done so.⁸ Other countries have required additional credentials or competencies before pharmacists are allowed to take on the prescribing role.⁹ In Canada, no postgraduate training is required or mandatory for pharmacists working in hospital or community practice, nor are pharmacists licensed on the basis of credentials or level of competence. Basing the ability to prescribe on advanced credentials may also not be feasible within Canada because of the low numbers of pharmacists who are trained at the residency, masters and PharmD levels. In British Columbia, 8 PharmD students graduate each year, and 24 hospital pharmacy residents complete their residencies annually, yet these numbers are still inadequate, given the vacancy rate for positions within the province. It would also be difficult to expand training opportunities, given the limited availability of training sites and mentors at both the undergraduate and postgraduate levels.

There is also an issue of perceived conflict of interest in both prescribing and dispensing a patient’s prescription; this may be of most concern for community pharmacists. Physicians do not sell prescribed medications directly to their patients, partly because of this same perceived conflict of interest. Our provincial regulatory bodies may enact legislation to prevent both prescribing and dispensing of an individual prescription, but the perception of a conflict may remain in the minds of patients and other health care professionals. Just like the medical community, pharmacists would be subject to an increase in marketing efforts from drug companies. There is some direct marketing to the pharmacy profession now, but most of these efforts focus on those with a prescription pad. It may become increasingly difficult to remain at arm’s length from industry influence; we therefore risk being viewed as a biased source of medication information.

Now may not be the time to consider expanding our scope of practice to include prescriptive authority, considering that there are not enough pharmacists to meet the current demand and given that we are not yet practising to our full scope to favourably affect patient outcomes. We should not spread ourselves thinner by performing a function that has not been shown to improve patient outcomes if done by a pharmacist. We risk diverting our efforts from responsibilities that have been shown to improve patient outcomes. First and foremost, should

we not ensure that all patients receive high-quality pharmaceutical care? There will always be a minority of pharmacists who practise beyond the profession’s current scope of practice because of their unique practice settings, but in the eyes of the public and other health care professionals, our scope is defined by how the majority of the profession practises.

In summary, I am not completely opposed to the idea of pharmacists having prescribing privileges. I just believe that we have too many unanswered questions to address before we should consider taking this on as a priority role for our profession.

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