

EDITORIALS

Expanding Clinical Pharmacy Services in the Community

IT IS ALWAYS HEARTENING AND INSPIRING when a professional person develops his practice in such a manner as to not only make his own work more stimulating, exciting and enjoyable, but also, at the same time, to provide expanded services to the public. An excellent example of this was presented by Emil W. Baker at the tripartite meeting of the Academic Section, the Section for the General Practice of Pharmacy and the Press and Documentation Section during the meeting of the Fédération Internationale Pharmaceutique (FIP) in France last September.

Emil W. Baker, pharmacist practitioner of Mt Sterling, Kentucky and Assistant Clinical Professor at the College of Pharmacy, University of Kentucky, provided an excellent example of growth and development of clinical pharmacy practice in the community. Pharmacist Baker, inspired by the example of Eugene V. White of Berryville, Virginia, expanded his pharmacy practice by the provision of significant clinical services and personalized patient care concepts, from which his clients have greatly benefited. While achieving this expansion he gained the wholehearted support and cooperation from the medical practitioners in his area. In fact, his success has been so great that he now monitors the therapy of several hundred patients and has developed physician-accepted criteria for referral of patients to the physicians.

Among the clinical services offered by Pharmacist Baker are a blood pressure screening program for patients not taking antihypertensive medication and a monitoring service for those who are taking such medication. The latter service is appreciated by both the physician and the patient, because it keeps both parties better informed of the patient's progress and enhances confidence in the therapeutic regimen.

For some time I have believed that the pharmacist's role as a counselor and monitor of patient therapy would be greatly enhanced if certain simple tests were utilized during the monitoring process. For example, I once wrote:¹

When patients on long-term therapy return for a prescription refill it affords the pharmacists a good opportunity to monitor their response to drugs, to detect adverse drug reactions or harmful drug interactions, to note their response to therapy, to discern their compliance or noncompliance, and to answer any questions they have relative to their medication. Often pharmacists could do a more effective job of monitoring patients if they made or ordered one or more simple tests. For example, the taking of blood pressure would help in judging the hypertensive patient's compliance. It would also be valuable to the patient and would tend to reinforce his compliance. The "health team" concept would be materially strengthened if physicians and pharmacists worked out plans and protocols for a

large number of conditions in order for the pharmacist to more effectively monitor patients taking medication.

Another innovative clinical practice instituted by Baker is a parenteral service, whereby injections of hormones, vitamins, allergenic extracts, etc. are administered to patients by Mrs. Baker, who is a nurse. Originally started as a service to patients who had to travel several miles to a physician in a distant city, the demand for a parenteral service has developed to the point where numerous local physicians now order the administration of injected medication such as influenza vaccine, gamma globulin and penicillin. No injections are administered in the Baker pharmacy unless ordered by a physician.

There is no question that the presence of a nurse in the Baker pharmacy organization has given its clinical services a new dimension. Mrs. Baker gives the injections, helps with the screening and monitoring of blood pressure and can competently perform the additional tests that are part of the Baker pharmacy services. Clinical pharmacy services in community practice could be much more rapidly implemented if nurses were part of the pharmacy organization.

In addition to the previously described services, Baker provides a diabetes screening and monitoring program, which he conducts with the aid of a reflectance colorimeter for the determination of blood sugar, and a series of urinalysis tests. He also provides special dietary information for patients on diabetic diets, low sodium diets, prenatal diets, hypochromic anemia diets and several others.

One of the principal arguments against the provision of clinical pharmacy services in the community setting is the question of who will pay for them. Pharmacist Baker did not let this argument get in his way. He ignored it, blinded perhaps by professional zeal. Initially he offered his clinical services free of charge; later, when their value had been proved and accepted by both patients and physicians, a fee was charged and willingly paid.

Few colleges of pharmacy are as fortunate as Kentucky in having a professional preceptor for their students whose everyday practice is an embodiment of the type of pharmacy practice almost everyone would like to see. Years ago a great teacher spoke words to the effect that "whosoever will save his life shall lose it . . ." Pharmacist Baker saved his professional life by giving up all of the nonprofessional merchandise which clutters American drugstores and binds the pharmacist to a mediocre professional life. Let us hope that his example will be followed by many more.

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Reference

1. Francke, D. E.: Counseling The Patient (Ed.), *Drug Intell. Clin. Pharm.* 10:416 (July) 1976.