EDITORIAL

by WALTER M. FRAZIER

CAN PROFESSIONAL TIME BE BETTER USED?

IN ATTEMPTING TO IMPROVE the health care services, various theories and ideas have been presented by people who are concerned. For several years we have heard that either there is a growing shortage of professionals[1,2] and technicians, or in many areas there is a maldistribution of practitioners in the health field. Conversely, it has been said that we do not suffer from a shortage of physicians, pharmacists, nurses and others but that the fault lies with the system of delivery of care, *i.e.*, we need appropriate utilization of talent, better management, and better administration of the resources now available. McNerney has also noted that 10 to 30 years plus great additional financial input will be required to significantly increase professional manpower.[3] Dean Louis Zopf has observed that pharmacy's principal problem seems not to be a shortage of men of judgment and vision but men of action.[4]

In a paper published in the *American Journal of Pharmaceutical Education*, Wallace Guess pointed out:

> The pharmacist largely practices a technological function of counting and pouring dosage forms from one container to another. These are mechanical functions which do not require five years of education at our great universities where the emphasis is on highly scientific material, but functions which could be carried out by technicians. We must today recognize that pharmacy is a dynamic profession, a profession that is rapidly changing; we must recognize that many of our own practitioners are saying that they are overtrained for the job that they are doing. If indeed we are only counting and pouring, then we must agree that we are overtrained. But I say that we are undertrained for the job that we should be doing today. That is why we are all so concerned with the question of where is pharmacy going.[5]

Hospital pharmacy has exhibited the ability to develop ideas and to press for action on many occasions. Progress is recognized in the establishment of actual programs in new services including unit-dose drug distribution systems; clinical pharmacy and satellite pharmacies in the patient area; I.V. additive services; drug information centers; drug interaction monitoring through patient profiles; pharmacist-to-patient assistance with drug histories and thorough instruction to the homegoing or ambulatory patient about his physician's directions[6] for use of prescribed medications; and realistic drug systems for security and safety.

Clinical pharmacy[7] has introduced a new value into professional pharmaceutical services to the patient, to the nurse, and to the physician. However, most of the programs are still in the pilot stage. Pharmacists will have to prove that by proper use of their education and professional skills they can make important contributions[8] to the delivery system of health care. It is now time that we stop performing the counting, pouring, packaging and labeling routines[9] and delegate these functions to appropriately educated, trained and qualified technicians,[10] who are suitably controlled and supervised. In so doing, pharmacists can provide the justification for new roles in health care. Also, by providing these new services in overall programs beyond the pilot stage we will show that the nurse can better use her time[11] in behalf of the patient, rather than for the drug-related time-consuming routines that she has performed because of our default. By our offer of pharmaceutical assistance to the physician, he too can devote his time to patient care delivery which only he is qualified to provide.

We must prove it now!

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