

THE PHYSICIAN-PHARMACIST INTERFACE IN THE CLINICAL PRACTICE OF PHARMACY

by Rosalyn M. Cain

INVOLVEMENT IN THE THERAPEUTIC DECISION of the physician has put the pharmacist in a new social interface. This paper will deal with that interface: what happens, what each brings to this interaction in terms of roles, goals and authority, what influences the institution in which they practice has on this interaction and how this may influence the overall practice of clinical pharmacy.

When a pharmacist becomes involved clinically on the floors of a hospital he usually checks and often challenges the drug therapy as prescribed. To challenge he must therefore correlate chart data such as laboratory values, past history, progress notes, etc., with his collected knowledge of theoretical pharmacology, recent pharmacological

findings published in journals and clinical experience gained on rounds and patient visits.¹ In ordinary community practice, the pharmacist has only the prescription to provide a clue to therapy. In discussing a therapeutic incompatibility or just the drug therapy of a patient with the physician, the pharmacist will either evoke collaboration or competition from the physician. If an argumentative discussion ensues, the pharmacist may even evoke downright hostility.

In terms of the roles played in this interaction, each person plays a specific role and each of these roles shows a distinctly influencing historical development. Prior to the 1950's, hospitals had drug rooms but few had a pharmacy supervised by a registered pharmacist. When the Minimum Standard for hospital pharmacies was set, the pharmacist started to function in a hospital setting.² However, he worked behind the scenes as a remote drug

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information center, compounding and dispensing according to a physician's order and directing the drug distribution system. He left the pharmacy only to check the medication cabinets on the floors or to attend a meeting. With the growth in quantity of drugs available, their increased potency and complexity and growing awareness on the part of physicians and nurses that drugs cause adverse reactions, the pharmacist had to fill a need in the clinical area.³ However, the pharmacist is still developing the role he must play. Usually, he will serve as a drug consultant.⁴

The physician, regarded as the "omnipotent healer" in the past, was solely responsible for the health care of his patient. With the many advances in medical care, he can no longer carry the ball. He has learned to depend on the services of allied health professionals, especially the pharmacist.⁵

The conflict of roles is evident, for in this dependency the physician relies upon the pharmacist to supply advice if called upon. He is not prepared for the pharmacist to volunteer information, nor is he prepared to coordinate the pharmacist's new function into his therapeutic practices. On the other hand, the pharmacist now views himself as an active part of the health care team, ready for his services to be incorporated into the physician's therapeutic practices.

There is also a conflict in goals because the physician's goal in any setting is to give quality health care to a patient on a one to one basis. Often, the pharmacist becomes involved with a physician's overall drug therapeutic practices as he discusses drug usage in several of the physician's patients.¹

The conflict of values extends to that of authority. In questioning the use of a drug, the pharmacist challenges the sole right and authority of a physician to prescribe. Physicians are accustomed to no one challenging that right and authority given them from time immemorial!⁵

The institution in which the physician and pharmacist interact also influences the interface. Hospitals developed as workshops for doctors. They were to supply room and board for the patients, but the physicians supplied their needs, such as the custom of surgeons bringing their own scrub nurses.⁶ As medical practice advanced, hospital operations grew more complex in the procedures developed to aid the physician in the care of his patient. Hence, a change in roles of allied health professionals within the hospital. The hospital became a "federation of status groups organized in a semi-autonomous hierarchical fashion . . ." The hospital now provides patient care, community health services, does research and teaches.⁷ The physician now must be part of a team to enable the hospital to provide its services.

As seen from the definition of a hospital, the organizational structure of the hospital is such that it is composed of human interdependent subsystems, each group, such as nurses and dietitians, in the organization being a human subsystem further divisible into the subsystem composed of a person. The total organization being a "grid with specialized projects and efforts overlaid upon centralized functions, resources and talents." *e.g.*, a nurse on a ward must rely upon central supply for linen.⁸

When a pharmacist discusses a drug with a physician in a hospital there is a definite interface between the component of the medical staff subsystem and the pharmacy department subsystem. The entire hospital is organized along hierarchical lines with hierarchical authority

and sanctions, except for the medical staff. The medical staff exists as an appendage to the hospital structure with colleague authority and sanctions imposed only by colleagues.⁹

Thus, when a hospital grants the privilege of the practice of clinical pharmacy, it is in fact putting the pharmacist in a colleague position with the physician in the area of drug therapy, but without the ability to impose colleague sanctions. Hence the pharmacist must operate under the usual hierarchical authority should the need for sanctions arise. In essence, the pharmacist can say all he wants to about the way a physician prescribes drugs but he can do nothing about it.

In community practice, the physician never knows where a prescription will be filled unless he telephones it to a pharmacy. Hence, the interaction between the physician and pharmacist is vague and nonspecific. Should an unsurmountable problem arise on a prescription, the pharmacist can and often does refuse to fill it.

Because of the similarity of the neighborhood health center to group practice and the outpatient clinic of a hospital, the pharmacist and physician interaction resembles that occurring in the hospital. There is one exception in that the physician is incorporated into the hierarchical structure and may form the structure of organization.¹⁰

It can be seen then, that this interface or interaction is not to be taken lightly and can definitely influence the clinical practice of pharmacy. If the interaction is one in which competition is evoked, whatever good the pharmacist suggests will fall on deaf ears. The physician will neither accept, reject nor contemplate the suggestion. The physician will not benefit by the pharmacist's knowledge, the pharmacist will have taken a step backward in establishing his role and the patient will not have received benefit of their combined knowledge. If the issue discussed involved negative feelings (usually sensitive ones, too) on the part of the physician, then the pharmacist should skillfully raise the issue to a higher level where it can be discerned properly. This can be done by the presentation of some pertinent data for his inspection, for example, an article on the subject from a journal.⁸

If the interaction is one in which collaboration is evoked, then an expansion of service is possible. The physician will usually readily accept the idea, accept with explanation, reject and give reasons for the rejection or contemplate the idea for future use. The pharmacist has taken a step forward in developing his role, gained an experience and used his knowledge to precipitate the physician's thinking process. Most assuredly, they have both contributed to patient care. Even if the fact suggested were completely "shot down" by the physician, there would be a gain in the pharmacist's clinical knowledge.

Can the pharmacist make certain that these interactions promote collaboration? Not always, but he can take steps to create a positive atmosphere for collaboration. This would include:

1. Listening to the physician's rationale behind prescribing a certain drug before questioning it.

2. Promoting a spirit of inquiry on the part of the physician by encouraging feedback. Let him know he is always open for discussion or comments.
3. Maintaining a positive attitude toward the role.
4. Heading off anticipated areas of trouble. An example would be to approach physicians in the halls, not at the patient's bedside.
5. Being certain of the facts to be presented.
6. Presenting the information as a suggestion rather than a directive.
7. Promoting a psychological bonding via meetings in which problems and knowledge are shared.⁸

Physicians realize the complexity of consideration in drug usage. They are aware of indications, contraindications, side effects, dosage forms, dosages and sometimes cost factors. Yet, it is not uncommon for physicians to prescribe several drugs for a patient, with a bonafide rationale for each but with no thought to the interaction in the body. The pharmacist of yesterday was the one the physician expected to know all about physical incompatibilities in compounding. Now the pharmacist finds a role created around that particular aspect of his knowledge: incompatibilities and drug interaction in the body. The benefit the pharmacist will derive from this role will be directly proportional to how he handles his personality and knowledge at the physician-pharmacist interface.

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INDEX TERMS

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