1 Pharmacy's professional imperative

Distinguishing between pharmacy providers and practitioners

September 15, 1994

Pharmacy is often painted with a brush so broad that important distinctions in the field are lost. In particular, the difference between pharmacy providers and pharmacy practitioners is often obscured. This lack of discrimination impedes the advancement of pharmacy practice.

For purposes of this discussion, *pharmacy providers* are defined as the owners of businesses or facilities that provide prescription medications to the public. *Pharmacy practitioners* are licensed pharmacists who provide medication-related services to individuals. Most pharmacy practitioners today are employees of pharmacy providers.

Pharmacy providers are a diverse group, including *for-profit corporations* (e.g., chain drugstores, prescription mail-order companies, investor-owned hospitals), *private businesses* (e.g., community pharmacies owned by practicing pharmacists), *nonprofit organizations* (e.g., community hospitals, public health clinics), and *government* (e.g., state health care facilities, the Department of Veterans Affairs). The world's largest drug manufacturer (Merck) is now a major pharmacy provider by virtue of its acquisition of a pharmacy benefit management firm that is also the nation's biggest mail-order pharmacy (Medco).

Since most pharmaceuticals are distributed to ambulatory patients, the providers who serve that market are in the public eye more than the others. Further, because prescription dispensing is the core business of chain drugstores and independent community pharmacies, they tend to be more aggressive than other pharmacy providers in protecting their interests.

The pharmacy practitioner is the atom — the irreducible constituent — of the profession of pharmacy. If it were not for the personal health care service that individual pharmacists provide to individual clients, pharmacy would be merely an area of knowledge and an array of technical functions in the sequence

of steps from drug discovery to drug consumption. It is pharmacy practitioners who have made personal commitments to attain and maintain the knowledge required to help people with their medication-related needs. It is pharmacy practitioners who have internalized the ethical standards of pharmacy. The core values of the profession, as well as the yearning for continued improvement of the profession, reside in the hearts of practitioners, not in the policies and procedures of providers.

Two circumstances sometimes confuse the distinction between providers and practitioners: Some pharmacists are both (i.e., those who own and operate community pharmacies), and many top managers of corporate providers are pharmacists. But this should not be allowed to cloud the fact that the interests of providers and practitioners are separable. Sometimes those interests are aligned, other times they are opposed.

Application of the framework discussed here is essential for accurate analysis of controversies in pharmacy. A partial list of issues that would profit from examination through this lens includes the implementation of pharmaceutical care, work-force planning, pharmacy technicians, patient counseling, entry-level education, and priorities in health care reform.

Consider the case of pharmaceutical care. Many practitioners have concluded that their future lies in taking responsibility for helping people make the best use of medications. But the structure of most practice settings presents huge barriers to movement in this direction. Without an alliance between practitioners and providers, it will be difficult or impossible to lower those barriers. Such an alliance can best be built by helping providers discover how their interests will be served by a transformation in the pharmacist's role. So far, the leaders of pharmaceutical care have given insufficient attention to this tactic.

The provider–practitioner framework is also useful in weighing arguments on certain issues. For example, in the debate on entry-level education, whose perspectives should be given greater value — those of the provider or those of the practitioner who has a social contract to meet the needs of patients? If providers' views are considered relevant, then should not the opinions of the full range of providers be sought, not just those of the chain store industry? Sometimes there is great power in simply exposing a provider assertion for what it is and not allowing it to be mischaracterized as a contention of practitioners.

Practitioner organizations must be forceful in differentiating themselves from provider groups in their communications with those outside of pharmacy, including legislators. Opportunities for advancement of the profession have been missed because lawmakers assumed that the provider perspective was all that mattered. This well-entrenched assumption on Capitol Hill and in statehouses will take time to change, but change it we must.

Unfortunately, practitioners often are blind to the facts that they have a unique responsibility to the public, and that they cannot rely on providers to champion their cause. The first step in reversing this pattern is for practitioners and their professional societies to pursue a deeper understanding of the conflicting moti-

vations in pharmacy. That understanding and the actions that flow from it will help propel the profession to a higher plane.

The culture and subcultures of pharmacy

April 1992

Just as a nation has a culture and subcultures, so do occupations such as pharmacy. We cannot fully understand a person from, say, the Ukraine, without unraveling Ukrainian culture. Likewise, we cannot fully understand a fellow pharmacist from another sector of practice without some appreciation for the subculture of that component of pharmacy.

Culture, in the sense used here, is a concept from anthropology that relates to the beliefs and behavior of a group of people. More precisely, culture may be defined as "those customs, beliefs, ways of behaving, and values which evolve from cumulative group experience and which are passed from generation to generation as the best or the most acceptable solutions to problems of living."[1]

How might one characterize the culture of pharmacy? What are the core "customs, beliefs, ways of behaving, and values" of pharmacists that have evolved over the generations? Some elements of an answer to that question might be the following:

1. Respect for the power of drugs,
2. Respect for authority,
3. Respect for the limits of one's knowledge, skills, and abilities,
4. Precision and accuracy,
5. Orientation more toward fact than emotion,
6. Compulsion to complete tasks, and
7. Conservative and cautious attitude toward change.

Although one may quibble with this intuitive list, the point is that pharmacists tend to have certain attributes, and in their totality, these attributes help define who we are as a profession and the role we play in society.

Pharmacy has several prominent subcultures that are somewhat (but not exclusively) related to sector of practice. Individuals who regularly attend the conventions of various national pharmacy organizations often comment on the differences in values and perspectives among the pharmacists who participate in each meeting. These observers are noting, in effect, the subcultures of pharmacy.

The existence of pharmacy subcultures helps explain the wide range of attitudes toward contemporary issues in the profession. Hence, it is vitally important to recognize and understand these subcultures as we search for a unifying theme to advance pharmacy in its service to the public.

Among the subcultures of pharmacy are the following:

1. *The dispenser–communicator* — pharmacists who combine prescription dispensing or medication distribution functions with information-related activities such as patient counseling or prescriber consultation.
2. *The dispenser* — pharmacists who concentrate on dispensing prescriptions or filling medication orders.
3. *The clinician* — pharmacists with a solid knowledge base in therapeutics, sometimes in a highly specialized area, who concentrate on applying that knowledge in patient care, education, or research.
4. *The manager–leader* — pharmacists who use their positions of authority to advance the status of pharmacy in their practice settings.
5. *The manager–administrator* — pharmacists in positions of authority who place far more emphasis on efficiency and productivity than on professional leadership.
6. *The entrepreneur* — pharmacists in the business of providing pharmacy-related services to a paying clientele, including the pharmacist owner-operators of independent community pharmacies, home infusion therapy services, and a growing array of other services.

Each of these groups of pharmacists has a set of characteristic "customs, beliefs, ways of behaving, and values" that distinguishes it from other groups or subcultures of pharmacy. These subcultures are created and reinforced over time through the influence of many factors, including teachers, mentors, peers, and the media of pharmacy. Although pharmacists in one type of practice may be highly perplexed by the behavior or values of other pharmacists, there is no "right" or "wrong" subculture. From the perspective of a particular group, its way of doing things and its way of viewing the world represent the "best or the most acceptable solutions" to the problems it faces.

If one accepts the reality of subcultures in pharmacy practice, and if one eschews moralistic attempts at conversion from one way of pharmaceutical thinking to another, does pharmacy practice have a prayer of uniting behind a unifying mission? Indeed it does, but it will happen largely through the influence of external forces. Societal and economic forces are causing a search in all sectors of practice for a new focus for the work of the pharmacist. That search is centering on the concept of the pharmacist as a health professional who helps people make the best use of medications. The power of this concept will be strengthened as the subcultures of pharmacy follow their individual paths to this conclusion.

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1. Perkins HV. Human development and learning. Belmont, CA: Wadsworth Publishing; 1969:135.

Can pharmacy control its destiny?

January 1985

Expanding corporate control is the dominant force in American health care today. Witness the mushrooming multiunit hospital systems, HMOs, and diversified health-care conglomerates — all structured along corporate lines. Hence, it is not surprising that last year's historic strategic-planning conference for pharmacy[1] predicted that most pharmacists will practice in some sort of corporately owned setting by the year 2010. Those settings will include inpatient and outpatient branches of vertically integrated health-care systems (e.g., HMOs) and chain drugstores. If the vast majority of practicing pharmacists are employed by large corporations, will the destiny of pharmacy be controlled by the profession or by the business executives who run the corporations? No other question is as important to the future of pharmacy.

The majority of pharmacists are already salaried, but up to now their employers have not been predominantly large corporations. Even within medicine, which for years had fought to preserve solo practice, a growing number of practitioners are salaried.[2] Although medicine is still in a powerful position to maintain its autonomy, corporate health care is expected to exact profound changes in the nature of medical practice. Sociologist Paul Starr[3] has sketched the depth of those changes:

The rise of corporate medicine will restratify the profession. A key question will be the control over the appointment of managing physicians. . . . Another key issue will be the boundary between medical and business decisions; when both medical and economic considerations are relevant, which will prevail and who will decide? Thus far, conflict has been muted by affluence. A regime of medical austerity will test the limits of professional autonomy in the corporate system.

. . . In the multihospital systems, centralized planning, budgeting, and personnel decisions will deprive physicians of much of the influence they are accustomed to exercise over institutional policy.

Perhaps the most subtle loss of autonomy for the profession will take place because of increasing corporate influence over the rules and standards of medical work. Corporate management is already thinking about the different techniques for modifying the behavior of physicians, getting them to accept management's outlook and integrate it into their everyday work.

Is pharmacy shrewd enough to recognize the challenge posed by corporate health care, and does it have sufficient inner strength to stand up to the challenge? The post World War II development of chain drugstores and of hospital pharmacy may suggest answers — answers that are conflicting and unsettling.

In the case of the chains, pharmacists have been emasculated as health professionals. Their work has been standardized and reduced to the lowest common denominator. Moreover, their services have been melded with the drug product "as a commodity package that can be discounted at will."[4] Communication between pharmacists and patients has been reduced to a bare minimum. These developments occurred in broad daylight with only a whispered protest from a few pharmacists who were cavalierly dismissed as academicians or idealists. No pharmacy organization stepped in to reverse this decline through the development and forceful promotion of practice standards.

In contrast, two hallmarks of hospital pharmacy have been its strong professional society and its formal standards of practice. These standards (ASHP Statements, Guidelines, and Technical Assistance Bulletins) have been used widely to define optimal hospital pharmacy practice. Admittedly, there is still immense room for improvement in level of services and in job satisfaction of hospital pharmacists, but steady, measurable progress has been made over the years. If nothing else, the standards have given practitioners an ideal to strive for. In their pursuit of this ideal, hospital pharmacists have developed a shared sense of mission focused on professional service.

Hospital pharmacy's success has come in an era when hospitals have had strong financial incentives to expand services. Also, practitioners generally have had to justify their programs only to a local administrator, not some higher authority at corporate headquarters. The vigor of hospital pharmacy is untested under fixed-rate reimbursement and the new corporate environment.

Whatever hope pharmacy has of controlling its destiny lies with professionally oriented practitioner organizations. These organizations should consider the following strategy:

1. Create a strong identity as a protector of the professional rights of pharmacists vis-à-vis their employers.
2. Create a strong identity as an advocate for optimal pharmaceutical services to the public.
3. Adopt minimal standards for pharmaceutical services in all settings.
4. Develop a meaningful liaison with the top management of health-care corporations and chain drugstores.
5. Show these managers why it is in their best interests to enrich the work of pharmacists; cooperate with management on specific job enrichment programs that expand the pharmacist's professional role; protest when the work content or environment demeans the pharmacist.

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1. Anon. Pharmacy in the twenty-first century: results of a strategic-planning conference. *Am J Hosp Pharm*. 1985; 42:71–9.
2. Friedman E. Salaried doctors. *Hosp Med Staff*. 1983; 12(Aug):11–8.
3. Starr P. The social transformation of American medicine. New York: Basic Books; 1982:447–8.

4. Mrtek RG. Absent the incentive: an example of contemporary history. *Pharm Hist.* 1981; 23:145–51.

Achieving pharmacy's full potential

June 1985

The recent consensus-development conference on Directions for Clinical Practice in Pharmacy turned out to be an important assessment of pharmacy itself, not just of clinical practice. The 150 conferees at the Hilton Head Island meeting concluded, in essence, that the value system fostered by the clinical movement should be assimilated by all practitioners so that pharmacy may become more fully professionalized.

The conferees agreed strongly on the following points:

- Pharmacy is *the* health-care profession most concerned with drugs and their clinical application.
- A fundamental purpose of the profession of pharmacy is to serve as a force in society for safe and appropriate use of drugs.
- A fundamental goal of the profession is to promote health, and pharmacists can best pursue that goal by working to promote optimal use of drugs (including prevention of improper or uncontrolled use of drugs).
- In pursuing the above goal, pharmacy should be expected to provide leadership to other health-care professions; this implies that pharmacists should be involved in a very positive way in advocating rational drug therapy, rather than just reacting to treatment decisions made by others.

The conferees were not ivory-tower types who found it convenient to overlook hard realities. As evidence of this, the group also strongly agreed that

- Pharmacists should continue to have ultimate responsibility for drug-distribution and drug-control activities, but these functions should be carried out by technicians under pharmacists' general supervision, thus freeing the major portion of pharmacists' time for clinical services. Further, drug distribution should be mechanized and automated to as great an extent as possible.

In several respects, the conference reflected an important notion that has begun to gel within pharmacy; namely, that clinical pharmacy should be thought of less in terms of discrete functions by discrete pharmacists and more in terms of responsibilities of a pharmaceutical services department. The management of the department is responsible for orchestrating comprehensive services that integrate

drug dispensing and distribution with informative services. As the leader of a group of professionals, the department director seeks consensus among pharmacists on what level of service the department will provide, how pharmacists will spend their time, and what functions will be delegated to well-trained, well-supervised technical personnel. (Of little import within this construct is whether the pharmacy department is in a hospital, a medical clinic, or a drugstore. With respect to a drugstore, it is helpful not to think of the whole establishment as a pharmacy, but rather that there is a pharmacy department within the store.)

One of the gems of the Hilton Head conference was Hepler's[1] discussion of the sociological and philosophical basis for the concept of a profession, coupled with an analysis of how pharmacy stacks up. Of particular interest to hospital pharmacists is his review of research on professionals employed by large organizations. One of the findings of this research, according to Hepler, is that

. . . professionalization can occur in a bureaucratic organization if the professionals are organized in a separate professional department headed by a person who is able and willing to insulate the professionals from the bureaucracy. This suggests a seldom-recognized dimension of hospital pharmacy management that could have great strategic importance in the future.

This idea makes a lot of sense given the continuing pressure that pharmacy faces from corporate management to standardize and mass-produce its services.[2]

Translating the philosophy of the Hilton Head conference into changes in the way pharmacy is practiced will be a big challenge. As a first step, every pharmacy department should devote some time to reviewing and discussing the proceedings. Consider setting aside some time for a departmental meeting for this purpose within the next month or two. State and local pharmacy organizations may want to conduct programs patterned after the Hilton Head conference or review the conference findings in small group discussions.

ASHP will be building on the conference through its Practice Spotlight Program for 1985–86 under the theme "Patient-Oriented Pharmacy Services." In September, the ASHP councils and SIG Cabinet will consider whether any policy recommendations should be issued as a result of the meeting. Further, the Society will be bringing the proceedings to the attention of Congress, federal health officials, colleges of pharmacy, and professional societies and trade associations in the health-care field.

The greatest force for change in pharmacy lies within pharmacists themselves. If they truly see themselves as practitioners of a clinical profession, they will behave accordingly, others will perceive them as such, and the pace of professionalization will accelerate. Widespread reading and thinking about the ideas of the Hilton Head conference could be an important catalyst in this process of enhancing the self-concept of pharmacists.

1. Hepler CD. Pharmacy as a clinical profession. *Am J Hosp Pharm*. 1985; 42:1298–306.
2. Zellmer WA. Can pharmacy control its destiny? *Am J Hosp Pharm*. 1985; 42:69. Editorial.

A MODEL FOR AMBULATORY-CARE PHARMACEUTICAL SERVICES

February 1991

Although most ASHP members concentrate their practices on inpatient services, a growing number of them focus on the needs of ambulatory patients. Services to nonhospitalized patients have always been a component of hospital pharmacy. With a high degree of variation among institutions, these services include dispensing prescriptions to hospital employees, providing discharge medications, serving hospital clinic patients, and operating an outpatient pharmacy that is open to the general public. Some ASHP members in managed care arrange for the provision of pharmaceutical services by community pharmacies. Pharmacists who negotiate such contracts are responsible for ensuring the quality of the pharmaceutical services provided to the enrollees of managed-care plans.

Hence, it was natural for ASHP to develop comprehensive practice guidelines on pharmaceutical services for ambulatory patients.[1] The advice in this new document is substantially more detailed than that of previous ASHP practice standards that have commented on ambulatory care.

The expansion of mail-service pharmacies and of prescription dispensing by physicians, and the desire of ASHP members to have their professional society comment on these developments, added to the impetus for the creation of the new guidelines. Rather than condemning these nontraditional prescription dispensers, ASHP has taken the position that pharmaceutical services for ambulatory patients, regardless of setting, should meet the same standards. (With respect to physician dispensing, the guidelines do not shy away from the obvious conflict of interest that exists when the prescriber profits from the medication that is dispensed.)

Most ambulatory-care pharmacists, including those who are institutionally based, will find themselves in substantial noncompliance with the spirit and the letter of the new guidelines. Several aspects will be found particularly challenging. Among them are the expectations that pharmacists will actively influence prescribing through direct interaction with physicians, that pharmacists

will review the clinical appropriateness of the medication regimen prescribed, and that pharmacists will be an integral part of any home-care program that involves the administration of medications.

It is not ASHP's intent to proselytize the profession at large on the provisions of the new guidelines; that effort will be confined to pharmacy practice in organized health-care settings. Nevertheless, the profession will be well served if the guidelines stimulate intense debate in the sanctums of prescription departments and the ivory towers of academe. More than any other factor, the interaction between pharmacists and ambulatory patients shapes the opinion that people have of pharmacy. It will be difficult to upgrade the marginal position of the profession until pharmacists are seen as the providers of essential health care, not merely the purveyors of essential health products.

In the past, when hospitals and other institutions established outpatient pharmacies, they usually copied characteristics of typical prescription departments in community pharmacies. From the patient's perspective, all of the problems associated with that model — impersonal service; remoteness of the pharmacist; lack of substantive professional communication; lack of medication regimen review in the overall context of the patient's health status — have applied (sometimes doubly so) to these pharmacies. As pharmacists in organized health-care settings rethink their approach to ambulatory care, they must come up with something better than the practice model that was pioneered in the 1950s.

Wholesale changes are needed in the infrastructure that supports ambulatory-care pharmaceutical services. Critical components that need reform are the physical layouts of most pharmacies, the use of technical personnel, and the use of prepackaged, dispensing-size medication containers. With respect to the last point, in many countries of the developed world, the majority of prescriptions are dispensed in unopened packages prepared by the pharmaceutical manufacturer. If the professions of pharmacy and medicine, in cooperation with the drug industry, put their collective minds to it, consumers in this country could benefit from a similar leap in efficiency in pharmaceutical packaging.

The naysayers and protectors of the status quo will be quick to point out that the guidelines are silent on what compliance with them will cost. Indeed, an economic analysis has not been performed; that is not the function of an ASHP practice standard, which outlines what should be done (for the sake of the patient) and what is feasible to do (given the current state of knowledge and technology). Before the critics unleash their attacks on this point, they should reflect on the vast economies that could accrue if the structure of practice were changed to allow pharmacists to use their time more appropriately.

The promise of pharmacists today and in the future must be to help people make the best use of medications. The new ASHP guidelines offer clear advice on how ambulatory-care pharmacists should conduct their practices to fulfill this promise.

1. ASHP guidelines on pharmaceutical services for ambulatory patients. *Am J Hosp Pharm.* 1991; 48:311–5.

POSTGRADUATE TRAINING FOR PHARMACY PRACTICE

January 1990

At or near the top of any studied list of factors that have stimulated the professional development of hospital pharmacy will be residency training. It is no accident that the abilities of pharmacists have been harmonized with the needs of patients to a greater extent in hospital pharmacy than in any other area of practice. This happened because leaders were chosen and taught how to do it through residency training.

One veteran preceptor put pharmacy residencies in perspective this way[1]:

It is in their structured programs that we best communicate the values, philosophy, and vision of the profession. . . . A culture develops around these residency programs that breeds commitment and exploration, and from the programs flow energized and motivated people with high individual and professional standards. Those who have been a part of this culture go on to build similar programs and cultures in other hospitals and to foster innovation in and advancement of hospital pharmacy.

This issue of *AJHP* features the proceedings of the most recent residency preceptors conference, a program that looked to the future of postgraduate training for pharmacy practice. The proceedings give one a good sense of the issues facing residency training as well as the pivotal role that training standards can play in advancing the profession.

Since its founding in 1942, ASHP has promulgated standards for postgraduate training in pharmacy practice. These standards have been based on the recognition that entry-level pharmacy education is inadequate preparation for progressive pharmacy practice. Over the years, it has come to be widely accepted in pharmacy that professional education prepares one *to become* a pharmacist; fresh graduates are not imbued with the judgment and confidence necessary for practice. Pharmacists-to-be gain that level of maturity in many ways, but no method has been as successful as accredited residency programs.

The philosophical statement[2] that has guided ASHP for the past decade in matters related to pharmacy personnel expresses the view that "as time goes on, the distinction between a 'generalist' and a 'clinical practitioner' will diminish."

This belief, consistent with the practice philosophy that took root at the 1985 Hilton Head conference, has committed ASHP to a course of action that is designed to shape pharmacy practice around the central objective of safe, effective, and cost-conscious use of medications.

In fulfilling this mission, pharmacy departments will need several types of personnel. Frontline pharmacists — pharmacy's primary-care practitioners — will be equipped to work side by side with physicians in designing and monitoring the therapeutic regimens of patients. Pharmacy specialists will be available to assist the frontline pharmacist in resolving complex medication problems. Drug product distribution will be largely automated, and technical tasks in that process will be carried out by well-trained technicians under the supervision of pharmacists. Management of the entire enterprise will be a highly complicated task.

Pharmacists will be trained for the various roles in this environment through residencies. Although there is no mystery about the types of residency training programs that are needed to nurture pharmacy practice that focuses on drug therapy outcomes, the pace of change that should be fostered in residency training is less certain. It is one thing to have aggressive standards and quite another to have practice sites that are able and willing to meet them.

The issues discussed at the preceptors conference — for example, merging the hospital pharmacy and the clinical pharmacy residency standards, attracting more pharmacy graduates to residency training, and stimulating growth in the number of residency programs — make evident yet again how the lack of consensus about the profession's role leads to so many quandaries. If practitioners and educators universally subscribed to the idea that the mission of the pharmacist is to help people make the best use of their medications, agreement could be reached quickly on the best way to structure postgraduate training.

Many challenges and opportunities face postgraduate pharmacy training in the 1990s. In addition to those fleshed out at the preceptors conference, the following are offered for consideration:

- Consistent with the continuing shift of health-care resources from inpatient to outpatient settings, more attention should be devoted to the development of pharmacy residencies in ambulatory care. Given its sizable membership among practitioners in staff and group model HMOs, ASHP should be able to foster more ambulatory-care residencies in those settings, which might stimulate the creation of programs in other types of managed-care arrangements that involve community pharmacies.
- Alternate sources of financial support for residency training should be tapped, including the pharmaceutical industry and for-profit health-care providers, which reap the benefits of postgraduate training through their employment of residency graduates.
- Experimentation should be encouraged in making residents responsible for the outcome of drug therapy in individual patients. As the clinical movement matures, it is being recognized that pharmacy practice should be structured in a way that requires practitioners to assume personal responsibility for the results of medication therapy. The living laboratory of

residency programs would be an ideal environment in which to explore how this can be achieved.

- The residency accreditation process should be integrated more closely with ASHP's development and revision of practice standards, as well as with broader efforts designed to build consensus within the profession about the mission of pharmacy practice.
- The relationship between residency training and specialty certification should be explored. Now that pharmacy has three recognized specialties with at least two more in the wings, it is time to assess if there should be a link between the completion of specialized residency training and board certification as a specialist.
- Specific goals should be established for residency training. For example, by the year 2000, can we double or triple the proportion of new pharmacy graduates who enter accredited residency programs?

Accreditation of postgraduate training for pharmacy practice has been a powerful lever in elevating the profession. With proper planning, the effectiveness of this tool can be enhanced even further.

1. Smith JE. The future of postgraduate pharmacy training programs. *Am J Hosp Pharm.* 1990; 47:98–105.
2. ASHP position on long-range pharmacy manpower needs and residency training. *Am J Hosp Pharm.* 1980; 37:1220.

Technical personnel in pharmacy

July 1987

The public welfare would be advanced if pharmacy developed a well-defined category of technical personnel. This is the underlying premise guiding the work of the ASHP Task Force on Technical Personnel in Pharmacy, the creation of which is discussed by ASHP President Roger W. Anderson elsewhere in this issue of the *Journal*.[1]

Two factors make an examination of the "technician issue" particularly timely. The first is the growing desire of pharmacists to hasten the transformation of pharmacy into a clinical profession. The second is the acute shortage of pharmacists, at least in certain geographic areas, which is forcing pharmacy managers to evaluate critically who does what in the delivery of pharmaceutical services.

It is anticipated that the work of the ASHP technician task force will extend over two years. The group will review previous analyses of issues related to phar-

macy supportive personnel, assess the current status of technician training and use, identify critical issues facing pharmacy with respect to technicians, and make recommendations for resolving those issues. The task force will examine if lessons can be learned from how other health disciplines (such as dentistry and nursing) have delineated professional and technical roles. In the months ahead, the task force will announce opportunities for public comment on the issues it is examining. In addition to addressing final recommendations to ASHP, the task force may make suggestions to other pharmacy groups, governmental bodies, and individual practitioners.

Although the task force has yet to define its complete agenda, it appears as though the major issues will relate roughly to the following questions:

- In what ways will the public interest be served by the creation of a well-defined category of technical personnel in pharmacy?
- What is meant, in terms of training and responsibilities, by a "well-defined category of technical personnel"?
- What barriers are preventing pharmacy from achieving a progressive stance with respect to technicians?
- How can pharmacy overcome those barriers?

The status of technicians in pharmacy is influenced greatly by pharmacist attitudes and technician self-perceptions. These mindsets are difficult to change. Pharmacists need to be secure enough in their own work to encourage technicians to develop their skills and enhance their contribution to pharmaceutical services. More technicians need to view their jobs as career pursuits and make the necessary investment in developing their abilities in ways that yield satisfying and stimulating work. Figuring out how to catalyze changes of this nature is a particularly challenging aspect of the ASHP task force's mission.

Within pharmacy as a whole, the subject of technicians is clouded by differing opinions on the fundamental role of pharmacists in society. Unless agreement is reached on questions such as those that follow, the place for technicians in pharmacy will remain contentious:

- To what extent should pharmacists wrest themselves from the dispensing counter?
- How rapidly should the profession move toward information functions as the primary work of pharmacists?
- Can pharmacy hope to survive without a plan for attaining a larger role in making decisions about drug therapy?

An ASHP "think tank" alone will not have much impact on resolution of these pithy questions. For that reason, an attempt will be made to seek support among national pharmacy organizations for a broad-based invitational conference on technicians. Such an independent conference could explore the issues from the perspectives of pharmacy education and all sectors of practice, searching for common ground upon which to build future plans. The report from this

meeting could be used by the participating groups to help inform their constituencies and develop a consensus among them about needed changes. The report also would be useful to the ASHP task force in formulating its final recommendations.

Pharmacy will find it difficult to contribute its full potential to the public unless it uses technicians to a far greater extent than it does today.

1. Anderson RW. Technicians and the future of pharmacy. *Am J Hosp Pharm.* 1987; 44:1593–7.

Pharmacy technicians: Unresolved issues

February 1996

The recognition and status of pharmacy technicians have advanced markedly in recent times, in part because of the creation of a national voluntary certification program. However, there are still unresolved issues relating to technicians that prevent pharmacy from realizing the full potential of this component of its work force. Because of the immense pressures on all sectors of health care to contain costs without compromising quality, pharmacy should develop a more coherent plan for its technical personnel.

It is generally agreed that a technician must work under the supervision of a licensed pharmacist. But there is a wide range of views about how to apply this basic concept in practice, as manifested by the assorted state laws and regulations on pharmacy technicians. This interstate disharmony reflects poorly on pharmacy in the eyes of public policymakers and employers.

The solution to this problem lies in careful examination of beliefs and assumptions about key facets of pharmacy. Progress might be possible on this issue if widespread agreement could be reached on the following premises:

1. One of pharmacists' most valuable assets is their franchise to dispense prescription medications to the public; the economic basis for the profession is still linked primarily to this function.
2. In the interest of preventing medication-related morbidity and mortality, there is an urgent need for pharmacists to expand the scope of their profession.
3. Although advancements are being made in payment and employment of pharmacists for pharmaceutical care, this basis for compensation is not yet near the point where it will sustain the profession.

4. Licensed pharmacists have completed rigorous study to prepare them for the full array of their responsibilities, including drug product handling; no other health discipline is as well qualified to be entrusted with the nation's supply of medications.
5. Society needs a health professional of the caliber of pharmacists to exercise judicious control over the distribution of prescription medicines.
6. Pharmacy has an obligation to the public to manage practice sites with staffing complements that have the proper balance of qualifications to ensure safety as well as economy.
7. Pharmacists can exert an appropriate level of control over drug product dispensing and distribution through carefully designed systems under which certain tasks are delegated to technicians.

When assessing these postulates, it should be kept in mind that the vast majority of technicians have been trained on the job without the benefit of formal, systematic instruction. The standards for accredited technician training programs specify "a minimum of 600 hours of training (contact) time, extending over a period of 15 weeks or longer." This is in contrast with the minimum of five years of college education required of pharmacists.

The above premises and observations lead logically to some important conclusions, chief among them that the licensed pharmacist must retain full responsibility for the quality of the service performed under his or her supervision. Through state licensure of pharmacists, the public has assurance that prescription medications are being handled properly. It is sometimes advocated that states should license technicians to shield pharmacists from the consequences of any substandard performance by technicians. Licensure, which entails government permission to practice an occupation based on demonstrated competency, could set the stage for eventual independent practice by pharmacy technicians. That would be in blatant conflict with the public's best interest. On the other hand, registration, which is the process of becoming enrolled on a list, is a good mechanism through which states may monitor the individuals employed as technicians.

Licensed pharmacists should have full authority to decide when and how to use technicians at practice sites that have a process for ensuring the quality of services. That process (and ongoing documentation of compliance) should be subject to review (and, when indicated, remedial correction) by the state board of pharmacy. The arbitrary constraints that most states now place on the employment and functions of technicians inhibit the optimum practice of pharmacy.

The profession has begun to standardize the training requirements for pharmacy technicians through the development of a model curriculum based on an analysis of tasks in all types of practice sites. After agreement is reached on training, pharmacy should begin applying the term "technician" only to those individuals who have completed the minimum training requirements and who are certified. At that point, different terminology should be used for other pharmacy supportive personnel who are less qualified.

The critical importance of technicians in contemporary pharmacy practice demands that the profession invest the time and effort required to settle these unresolved issues.