Clinical Pharmacy in Family Practice

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One of the innovative directions in family practice during the last several years has been the introduction of clinical pharmacists into some teaching and community practices. This is not surprising in view of recent changes in pharmacy education and practice, which have expanded the clinical training of clinical pharmacists and increased the range of services which they provide. There are growing numbers of clinical pharmacists in teaching hospitals, outpatient clinics, mental health centers, and other institutional settings.[1] Although the entry of clinical pharmacists into the relatively smaller group settings of family practice is still an early trend, the experience to date in both teaching and community practice settings is extremely positive.

In this issue of *The Journal*, Love and his colleagues describe the role and contributions of a clinical pharmacist in the university based family practice residency program at the University of Kentucky. Over the past two years, the clinical pharmacist's responsibilities there have included providing patient education on drug therapy, teaching, making rounds with the physicians, consultation, preparing a drug information bulletin, and conducting a drug utilization review project. Both patient and physician acceptance of these services has been high.[2] Similar collaborative efforts between family practice and clinical pharmacy have been reported in other medical schools, such as the Medical University of South Carolina[3]; and in community hospital based family practice residencies, such as Family Medicine Spokane in Washington State.[4]

With regard to community practices, several questions are immediately raised concerning this kind of interdisciplinary practice, including ethical and economic issues, if dispensing of drugs is to be carried out; also, logistic and procedural questions; cost-benefit questions; and questions regarding satisfaction of patients, physicians, and pharmacists. Of particular interest in terms of how these questions have been resolved in one practice is the report of Davis and his colleagues of their experience since 1976 in a rural-suburban family practice in Lexington, South Carolina.[5] This practice includes two family physicians and one clinical pharmacist, all of whom trained together at the Medical University of South Carolina. The clinical pharmacist's duties include reviewing the prescription written by the physician for each patient; taking a complete medication history; maintaining a profile card for each patient's drug therapy; counseling patients concerning drug and

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poison information; conducting ongoing patient compliance programs; providing consultation to physicians regarding dosage calculations and product evaluation; and monitoring selected patients on long-term drug therapy. A pharmacy is also included in the family practice office, together with a prescription oriented pharmacist, for four basic reasons: (1) convenience to the patient; (2) cost savings to the patient (medications are dispensed at cost plus a small professional fee); (3) improvement in compliance; and (4) assurance of a quality product. The physicians receive no income from the pharmacy. The average time spent by the clinical pharmacist with a new patient for services *exclusive* of drug prescriptions is eight to nine minutes, with four to five minutes being the average for a return visit. A modest professional fee is charged for these services to all patients since all of the patients benefit from these services.

Two other joint practices involving family physicians and clinical pharmacists have been described during the last few years in other parts of the country: one in York, Pennsylvania,[6] the other in Mechanicsville, Iowa.[7] Both of these practices include a dispensing pharmacy, and appear to be providing cost savings to patients while expanding the range of pharmacy services.

The benefits of these initiatives are promising to all concerned. *To patients,* cost savings, increased convenience, and increased compliance may be realized. *To students and residents,* the value of the clinical pharmacist as a teacher in family practice teaching programs is amply demonstrated by the frequency of questions and consultations requested in those programs which include such individuals. *To clinical pharmacists,* limited early returns appear to indicate that a professionally satisfying, expanded role is increasingly available and viable in various family practice settings. And *to family physicians,* the benefits are obvious: expanded range of clinical services for all patients within the practice, involving cost savings to the patient and improved quality of care through ongoing drug audits; utilization reviews; consultation for problems related to drug therapy and drug interactions; and, a ready source of continuing medical education in clinical therapeutics.

References

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