Pharmacists save lives — but who will spread the word?

By K. Farrar, MRPharmS, MCPP

The past year was an interesting one for pharmacy in general and hospital pharmacy in particular. While we are yet to experience the impact of the fallow year as it affects the number of qualified staff, the shortage of all grades of pharmacists continues to be a problem. However, there was good news in the latter part of 2000 with the launch of "Pharmacy in the future — implementing the NHS plan", which identified the profession's contribution to the National Health Service plan.

The pharmacy plan has presented a number of challenges which pharmacists need to think carefully about. In the light of other documents outlining the Government's strategy for the NHS, these challenges represent a tremendous opportunity to establish pharmacy as a caring profession. But, before too many hackles are raised, may I say that while I know that the pharmacy profession has always been a caring one, it has not been fully appreciated by the wider NHS workforce, much less the population at large.

Hospital pharmacy has been seen as the main driver of innovation within the profession. But even in this branch of pharmacy, pharmacists are often regarded as being good at containing drug expenditure or in providing the vital safety net for prescribers, rather than as being direct providers of care. Although some may see this as a purely semantic argument, I see it as essential to the proper recognition (and all that goes with that in terms of adequate resources) of the pharmacist's role. Winter pressures on the NHS are accompanied by moves to increase bed capacity with additional nursing and support staff to provide essential services to these extra patients. In how many cases are additional pharmacy staff seen as essential? If pharmacists were considered to be making a vital and unique contribution to patient care, the situation would be much different.

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Perhaps surprisingly, evidence shows that pharmacists do, in fact, make such a contribution. Data from the United States demonstrate a relationship between investment in pharmacy services and reductions in patient mortality,[1,2,3] with a strong correlation being observed between patient mortality and variables such as ratio of pharmacists to occupied bed-days and pharmacist medication histories.

The impact on reducing medication errors also goes beyond the safety net issue, with a significant proportion of pharmacist interventions made being to correct omissions from therapy. There have been a number of reports highlighting the risks associated with the current process which leaves junior doctors responsible for the majority of prescribing.[4,5] Clinical pharmacy services have been shown to be effective in reducing such risks[5,6] and there is a wealth of data in most hospitals to support this. The database of pharmacy interventions at Wirral hospital contains 24,000 records collated over the past eight years.

In a review of the incidence and implications of medical errors, and more specifically, medication errors, Weingart and colleagues provided an insight into the extent of the problem.[7] They suggested that there was a trend towards preventable errors leading to significant patient morbidity and mortality, with cognitive errors, such as making the wrong diagnosis or choosing the wrong drug more likely to result in permanent disability. Also, errors of omission outnumbered errors of commission by two to one. In another major study, Bates and colleagues[8] found that 1 per cent of adverse drug events (ADEs) were fatal in outcome, 12 per cent were life threatening, 30 per cent were serious and 57 per cent were significant. They also found that 42 per cent of the life threatening or serious errors were preventable. These preventable ADEs occurred most frequently during drug ordering (prescribing), 56 per cent, or administration, 24 per cent. In an earlier review of pharmacy interventions, intervention (error) rates were identified as 2.9 per cent of all prescriptions,[4] 7.8 per cent of which were judged to have major potential for medical harm and 22.8 per cent having appreciable potential for medical harm.

This evidence shows that pharmacists significantly contribute to the reduction in patient morbidity and mortality and have done so for over a decade. Why then is there no mass outcry to tackle the shortfall in hospital pharmacist recruitment, as there is for nurses? Largely because we are victims of our own success. Hospital managers see us as managers of the medicines budget, rather than managers of medicines, and we are largely invisible to the public.

The sad fact is that more effective clinical care is probably more cost effective than budgetary cost containment. International studies have shown that medication errors increase the length of stay in hospital. If we accept that a serious ADE results in a single extra day's stay in hospital, we would only need to prevent 20,000 of these per year to save a sum equivalent to the total drug bill of an average UK hospital.

It is time then that pharmacists assumed their role as care providers, recognised for the unique contribution they make and the benefit of such contributions to patients. Failure to provide a service that will deliver such benefits would present unacceptable risks for chief executives in a clinical governance environment. More importantly, we would be failing patients.

References

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