

## VIEWPOINTS

### A Case Study in Terminology: the FIP Pharmacy Education Taskforce

Sarah Whitmarsh, MA,<sup>a</sup> Billy Futter, MBA,<sup>b</sup> Michael Rouse, BPharm (hons),<sup>c</sup> Ian Bates, PhD,<sup>d</sup> and Claire Anderson, PhD, BPharm<sup>e</sup>

<sup>a</sup>International Pharmaceutical Federation

<sup>b</sup>Rhodes University, South Africa

<sup>c</sup>Accreditation Council for Pharmacy Education

<sup>d</sup>School of Pharmacy, University of London, UK

<sup>e</sup>School of Pharmacy, University of Nottingham, UK

Recently, members of the International Pharmaceutical Federation (FIP) Pharmacy Education Taskforce, whose objective is to develop pharmacy education globally, found ourselves ensnared in the tangled web of pharmaceutical care terminology. To give a little background, the Taskforce aims to support a sustainable global approach to strengthening the pharmacy workforce through a strategy that involves determining local needs, identifying the range of services required to meet those needs, articulating the competencies to be achieved by all practitioners, and then using these criteria to facilitate comprehensive education development that ultimately ensures that local and national needs are met. This strategy, called *needs-based education*, is illustrated in Figure 1 below, which has been published previously.<sup>1-4</sup>

In fact, it is Figure 1 that prompted the Taskforce's recent discussion, specifically the box labelled "Services: pharmaceutical care services to meet these needs." FIP is the global professional organization for pharmacists and pharmaceutical scientists. As a working arm of FIP, the taskforce strives to use terminology that is easily understood in different country contexts and also, if translated, can maintain its core meaning. So in preparing Figure 1 for a recent publication, we reconsidered our use of the term "pharmaceutical care services" – did this in fact accurately describe what we meant it to?

One view was that "pharmaceutical care services" were a set of services distinct from some of those delivered by pharmacists and needed by countries (eg, pharmaceutical manufacturing) – which fall outside of the scope of "pharmaceutical care." Accordingly, it was suggested that we drop "care" and change it to "pharmaceutical services." However, another view was that the definition of "pharmaceutical care" in fact included the care taken by pharmacists relating to the supply and use of pharmaceuticals, and therefore we should keep "care" in the description.

Our small, amiable discussion mirrors a much larger, often intense debate among the wider profession over terminology, particularly the confusion arising around the term "pharmaceutical care." Even within the United States, where the term was first widely used to describe

a specific and somewhat new area of pharmacists' services, there are differences of opinion in how it should be defined.

Hepler and Strand originally defined the term as "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life."<sup>5(p539)</sup> They identified the criteria for judging a profession and explained how pharmaceutical care as a philosophy of practice would help the profession contribute to its professional status through meeting these criteria. Only 5 years later, following the Minnesota Pharmaceutical Care Project, Tomechko et al wrote that *pharmaceutical care* was too loosely applied a term, and that *comprehensive pharmaceutical care* better described value-added services.<sup>6</sup>

Even as the term has spread among different countries, pharmaceutical care is now less used in the United States and is more commonly supplanted with *medicines management*, the term most frequently used in the United Kingdom, or *medication therapy management services*. For example, the Accreditation Council for Pharmacy Education's Accreditation Standards and Guidelines for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree adopted in July 1997 (*Standards 2000*) used the term pharmaceutical care, but the current standards adopted in January 2006 (*Standards 2007*) do not.<sup>7,8</sup>

The confusion is not limited to practice or regulation either. In a 2001 commentary, Simpson addresses the use of "medicines management" in health policy documents in England. "Pharmaceutical care is a type of medicines management. . .but the terms are not synonymous. Pharmaceutical care is medicines management, but medicines management is not necessarily pharmaceutical care."<sup>9(p150)</sup>

McGivney et al describe "medication therapy management" as driven by the philosophy of pharmaceutical care, but which additionally involves techniques and behaviors such as patient counselling, motivational interviewing, patient education, documentation, follow-up, and interprofessional collaboration.<sup>10</sup>

Barber argues that the ideas behind both terms are too limited in view to be sustainable professional philosophies.<sup>11</sup>



Figure 1. Pharmacy Education Taskforce Needs-Based Education Cycle (original version)

Has the debate continued for so long that it has actually impeded the uptake of the practice model and philosophy of patient-centered care that has broad and global support in principle?

All this, of course, adds to the confusion in the minds of pharmacists, patients, and other healthcare professionals with whom pharmacists are meant to be collaborating. Many pharmacists understand the practice philosophy behind the term “pharmaceutical care” but how well is the term understood and translated (within and outside pharmacy) by those for whom the practice model is new or unfamiliar? Does the term encompass the full scope of services provided by pharmacists or is it a distinct subset of services that more directly apply to the care of patients?

As the Taskforce tries to advance a global pharmacy education agenda, this confusion is something to which we must be sensitive and work to overcome. The Taskforce is considering adopting a glossary so that at least when we use a term, people understand what we mean by it, even if they disagree with the interpretation or use another term to describe the same thing in their country.

And what did we determine for our own definition? We aimed for simplicity: that services provided by the pharmacy workforce (however they are termed) should meet needs, whether local, regional, national, and/or international. Figure 2 reflects the Taskforce’s updated graphic depicting the needs-based education cycle.

There may never be an internationally accepted professional lexicon, but as both figures correctly emphasize, it all centers on the correct *vision*. The Taskforce believes that the profession is close to reaching consensus and articulating what the ultimate global vision is for pharmacy practice and education. However, we have to recognize that on the way to achieving that vision, some will be on the same path but at different points along the path, while others will be on different paths altogether depending on the history of pharmacy practice and education in their



Figure 2. Pharmacy Education Taskforce Needs-Based Education Cycle (updated version)

country. This means that the shorter-term vision, goals, and strategies for each country will most likely be different and determined or at least influenced by current national needs, systems, priorities, culture, and circumstances, while still working in a systematic way to achievement of the ultimate vision. The Taskforce looks forward to the day when the term *pharmacy practice* will suffice, without the need for additional terms or explanations.

## References

1. Anderson C, Bates I, Beck D, Brock T, Futter B, Mercer H, Rouse M, Wuliji T, Yonemura A. The WHO UNESCO FIP Pharmacy Education Taskforce: Enabling Concerted and Collective Global Action. *Am J Pharm Educ.* 2008;72(6):Article 127.
2. Anderson C, Bates I, Beck D, Brock TP, Futter B, Mercer H, Rouse M, Whitmarsh S, Wuliji T, Yonemura A. The WHO UNESCO FIP Pharmacy Education Taskforce. *Hum Resources Health.* 2009;7:45.
3. Anderson C, Bates I, Bruno A, Futter B, Rouse M, Whitmarsh S. Part 4. Pharmacy Education. 2009 FIP Global Pharmacy Workforce Report. Wuliji T, ed. International Pharmaceutical Federation. [http://www.fip.org/healthcare\\_workforce](http://www.fip.org/healthcare_workforce) Accessed August 24, 2010.
4. Anderson C, Bates I, Futter B, Gal D, Rouse M, Whitmarsh S. Global perspectives of pharmacy education and practice. *World Med Health Policy.* 2010;2:1.
5. Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. *Am J Hospital Pharm.* 1990;47(3):533-543.
6. Tomechko MA, Strand LM, Morley PC, Cipolle RJ. Q and A from the pharmaceutical care project in Minnesota. *Am Pharm.* 1995;NS35(4):30-39.
7. Accreditation Standards and Guidelines for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree. Accreditation Council for Pharmacy Education; 2000.
8. Accreditation Standards and Guidelines for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree. Accreditation Council for Pharmacy Education; 2007.
9. Simpson D. What is medicines management and what is pharmaceutical care? *Pharm J.* 2001;266(7133):150.
10. McGivney MS, Meyer SM, Duncan-Hewitt W, Hall DL, Goode JV, Smith RB. Medication therapy management: its relationship to patient counselling, disease management and pharmaceutical care. *J Am Pharm Assoc* 2007;47:620-628.
11. Barber N. Pharmaceutical care and medicines management – is there a difference? *Pharm World Sci.* 2001;23(6):210-211.