Infectious Diseases Society of America Position Statement on Infectious Diseases Physicians and Hospital Pharmacists: Comment and Editorial

Sir—The position statement from the Infectious Diseases Society of America (IDSA) on the interaction between hospital pharmacists and infectious diseases specialists discourages clinical pharmacists from independently making recommendations regarding therapeutic drug regimens, routes of administration, and location of therapy; the statement specifies that any requests for such information be referred to trained physicians [1].

The authors of this statement seem unaware that decisions of this type are frequently made as the result of recommendations by pharmacy and therapeutics committees or by subcommittees of a pharmacy and therapeutics committee. These committees are medical staff committees whose members include infectious diseases physicians, clinical pharmacists, and others knowledgeable in the proper use of antiinfective agents as well as other drugs. Once these decisions are made, the best way to ensure their implementation is, however, by empowering clinical pharmacists to instruct prescribing physicians on the recommendations, since pharmacists are involved in a wide variety of clinical care areas and have the best opportunity to prevent inappropriate prescribing. Pharmacists who are infectious diseases specialists, often trained by infectious diseases physicians, are particularly effective. Infectious diseases pharmacists are especially useful at institutions that are unable to support an infectious diseases physician.

The staff at our hospital has been actively involved for many years in creating antibiotic management programs that are both clinically and economically sound [2–5]. Our success in any of these programs has required clinical pharmacists to make specific recommendations on antibiotic selection and dosing based on protocols and guidelines established through the complementary activities of clinical pharmacists and infectious diseases physicians (i.e., through pharmacy and therapeutics committees).

No one would argue that pharmacists should not be diagnostician, as pharmacists are not trained in this area of medicine. However, once a diagnosis has been made, there is no reason that a pharmacist should not be involved integrally with patient care. At this point, interactions between physicians and pharmacists represent collaboration between two specialties with different areas of expertise, which may result in improvement in the quality of patient care.

Unfortunately, although pharmacists make up a major contingent of the IDSA’s membership and participate actively in the national meetings, none were authors of the position statement. Clearly, the position of the IDSA, as currently published, does not reflect the whole membership. This was demonstrated at the September 1997 meeting of the IDSA in San Francisco. During the session entitled “The ID-MD and the ID-Pharm.D.: Cooperation or Conflict?”, it appeared that many more infectious diseases physicians supported the role of infectious diseases-trained pharmacists than did not.

Although some infectious diseases physicians may wish to exclude clinical pharmacists from more direct patient care for purposes of economic gain (and this may be the driving force behind the IDSA position statement), in the end this desire will be of little consequence. The scope of pharmacy practice and training is changing in response to market demand, and so must that of infectious diseases physicians.

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References

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Pharmacists and Infectious Diseases Specialists

Sir—We are writing in response to the recent Infectious Diseases Society of America (IDSA) position statement, “Hospital Pharmacists and Infectious Diseases Specialists” [1]. We agree with many of the assertions in this paper, including the statement that pharmacists and physicians who are infectious diseases specialists have complementary patient care responsibilities and, in most cases, a mutually productive relationship. However, we take strong exception to the opinions that “the training and daily activities of clinical pharmacists do not provide them with the expertise and knowledge needed to interpret the adequacy and significance of historical, physical, laboratory, and radiographic findings for individual pa-
We understand that not all pharmacists, nor all physicians, possess the knowledge and skills required to make highly complex, patient-specific infectious disease–related therapeutic decisions and recommendations. We are not suggesting that pharmacists act independently as infectious disease diagnosticians. However, through professional initiatives like postgraduate residency and fellowship training and specialty board certification, many pharmacists have developed and demonstrated competence as pharmacotherapy specialists in a variety of practice areas, including infectious diseases. In addition to expertise and knowledge in the interpretation of historical, physical, laboratory, and radiographic findings, the therapeutic decision-making process requires focused training in pharmacology and comparative therapeutics and a complete understanding of pharmacokinetics, pharmacodynamics, and pharmacoeconomics—areas in which pharmacists are especially well trained. The ability of appropriately trained pharmacists to make recommendations for specific therapeutic regimens has been extensively and rigorously evaluated [2]. In fact, many states and federal health systems now authorize appropriately educated and credentialed pharmacists to enter into collaborative drug-therapy relationships with physicians [3]. At a time when antibiotic prescribing is judged to be inappropriate ≤50% of the time [4] and when levels of bacterial resistance are at an all-time high, it is paramount that all health care professionals work collectively by using their specific education and expertise to optimize patient care and solve the current therapeutic dilemmas in infectious diseases. It is indeed unfortunate that current pressures within the field of health care sometimes place the professions in conflict with each other; we should be working to explore more effective means of collaboration on behalf of our patients.

Pharmacists have for many years been strong supporters of infectious diseases specialists. Many members in our respective organizations enjoy productive and collaborative relationships in clinical practice and research with infectious diseases physicians who are active members of IDSA. This circumstance makes us wonder if the recent position statement truly represents the opinions of the general IDSA membership.

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References


Reply

Sir—We are not surprised that our position statement has provoked controversy, as the session at the annual Infectious Diseases Society of America (IDSA) meeting cited by Quintiliani et al. was held in a large room filled with interested members. Furthermore, we are aware that infectious diseases specialists in numerous medical centers have disagreed with selected pharmacists over the role of these pharmacists in independently advising about the choice of antimicrobial therapy for patients with complex medical problems. However, we are surprised that Quintiliani and colleagues believe that our position statement was intended to exclude clinical pharmacists from patient care or that our motive in writing this position statement was economic gain. We believe the reason that many infectious diseases clinicians oppose the practice of clinical pharmacists independently selecting antimicrobial therapy for patients in intensive care units or in other hospital settings is because these physicians believe that this practice is fundamentally wrong for the reasons cited in our position statement.

Our position statement clearly emphasized that clinical pharmacists play an important role in modern medical practice. The help of pharmacists in optimizing prescribing, reducing drug–drug interactions, and conducting antimicrobial audits has been invaluable to many institutions. We recognize that some pharmacists have pursued specialized training in infectious diseases and have worked closely, appropriately, and effectively with infectious diseases specialists in developing antimicrobial management programs such as those cited by Quintiliani et al. Our position statement does not prevent or discourage the use of protocols for therapy designed by medical staff committees that have been approved by physicians and pharmacists knowledgeable in the proper use of antimicrobial agents.

We agree with Bauman et al. that it is unfortunate that pressures within the field of health care sometimes place professions in conflict, and we endorse the concept of exploring ways to better collaborate. However, we continue to believe that it is inappropriate for clinical pharmacists to independently make specific recommendations on antibiotic selection; even pharmacists with specialized training cannot interpret historical, physical, laboratory, and radiographic data well enough to justify an independent role in making therapeutic decisions.

Our position statement was reviewed and modified by the members of the Clinical Affairs and Antimicrobial Use and Clinical Trials committees and the IDSA Council before publication. We believe this statement represents a consensus opinion of the elected and appointed leadership of our society, but individual members of the society are free to voice their disagreement. Indeed, this dialogue is helpful in further examining an important issue that has previously received too little critical discussion.

Finally, we agree with Quintiliani and colleagues that the scope of pharmacy practice and training is changing, as is that of infec-