PHARMACEUTICAL CARE NETWORK EUROPE
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Position Paper on the definition of Pharmaceutical Care 2013

Over 20 years after Hepler and Strand first defined Pharmaceutical Care (PhC) as "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life"[1], the board of the Pharmaceutical Care Network Europe (PCNE) invited all members (33 individual and 20 institutional members) and 44 additional experts in the field of pharmaceutical care to attend a one day workshop with the purpose of redefining pharmaceutical care. On February 5, 2013, 14 members of PCNE and 10 additional experts met in Berlin. They represented pharmacy practitioners and academics from 11 different European countries, plus the USA and Australia.
The scene for this workshop was set by a recent editorial in the International Journal of Clinical Pharmacy (IJCP)[2], which was sent to all workshop participants. In addition, all participants received a summary of an extensive literature review two weeks in advance. To simplify the comparison between the 19 unique PhC definitions, a generic syntax was used for paraphrasing the definitions into a standardised text format (Provider, Recipient, Subject, Outcome, Activity). At the end of the one-day session, participants reached a consensus on the "PCNE definition of Pharmaceutical Care 2013" that reflects current thinking.*

«Pharmaceutical Care is the pharmacist's contribution to the care of individuals in order to optimize medicines use and improve health outcomes»

This PCNE definition of PhC directly derives from previous definitions and is intended to unite the current understanding of PhC with respect to the evolution of this practice philosophy during the last 35 years.

Pharmaceutical care is the pharmacist's contribution…
Previous definitions, in general, do not explicitly define the pharmacist as the provider of pharmaceutical care, or they also include the pharmacy team or other healthcare professionals. However, from the context of these definitions, it is evident that they usually directly or indirectly expect pharmacists to be the *primary* responsible provider of PhC. They are the healthcare providers particularly specialising in medicines. While pharmacy staff (e.g. pharmacy technicians, nurses) can be part of pharmaceutical care services, the education of these professions differs greatly between countries and thus, they may not always provide the same level of care. It is clear that pharmacists are not the only profession involved in the provision of medicines, and a multidisciplinary approach is to be desired. Each of the collaborators should focus, however, on their specialty, which should not be subsumed in a single definition. Care around medicines provided by a nurse, for example, would be termed "nursing care", defined as "care given to patients by nursing service personnel" (MeSH term since 1966). As a consequence, in the PCNE definition, PhC is defined as the *contribution* of the pharmacist, which implies collaboration between different contributors and does not exclude any other healthcare provider.

… to the care of individuals …
The provision of pharmaceutical treatment should always be tailored to a person's *individual* needs, and the same applies for the provision of care. Targeting individuals, and not a population or society as a whole, is a key concept of PhC. The term "care" describes a process that includes, as a minimum, a follow-up to determine the impact of the service. Both of these aspects distinguish PhC from simple counselling at the time of dispensing only and from other one-off pharmaceutical services that would be provided by pharmacists (e.g. vaccination programs).

... in order to optimise medicines use …

Medicines are increasingly and easily accessible for individuals throughout the world[3]. The responsible use of these medicines remains a challenge, as reported by the WHO and IMS in 2012[4,5]. In addition to the common pharmacy practice of dispensing medicines, optimizing the use of medicines is a critical responsibility of pharmacists. This optimization process should not only include system-based elements (e.g. indication, safety or effectiveness), but also patient-centred elements (e.g. adverse drug events, handling difficulties or management of dosing regimen). Even deciding not to take a medicine can be an optimization of medicines use during the PhC process, if the recipient's health would benefit from this non-use.

… and improve health outcomes

The expected outcome of PhC is that there are health benefits for the individuals receiving the service. The pharmacist should always consider every aspect of the recipient's well-being, including (but not limited to) quality of life. This is an extension to other definitions, including the Hepler and Strand definition from 1990, which exclusively focuses on quality of life[1]. It is important to decide on measurable health outcomes, in order to assess and quantify PhC services using robust research studies. When we have evidence for validated services that improve health outcomes, we can legitimise the pharmacist's role as a competent healthcare provider, in the face of criticism from other healthcare professionals.

Conclusion

Limiting the provider of PhC to the pharmacist, the recipient to the individual patient, and the subject to the use of medicines, the PCNE definition is a framework for describing specific services that should show measurable improvements in health outcomes. These services are not limited to any one setting: pharmacists working in community pharmacies or hospitals, as well as freelance pharmacists, can provide pharmaceutical care.

With this redefined definition of PhC, the board of the Pharmaceutical Care Network Europe hopes to harmonize the use of a single definition amongst European researchers and, ultimately, practitioners.

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** Both, the review of existing definitions in literature and the discussion of the process of achieving a redefined definition have been described in a scientific paper [6].*

References

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