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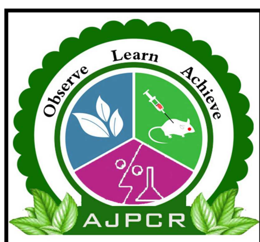

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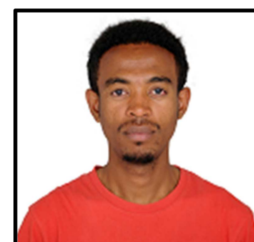

RETHINKING THE ACTUALIZATION OF PHARMACY PRACTICE IN ERITREA; A CRITIQUE

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ABSTRACT

The adoption of pharmaceutical care both as a theoretical and practical possibility should be understood as a response to and best applicable in an environment for which it was developed. In this respect the adoption of pharmaceutical care in the Eritrean health care system raises the question whether we have taken the right lesson from the history of the emergence of pharmaceutical care. There are different models of pharmacy practice, their successful adoption however depends on the degrees of similitude between the settings for which they were developed and the settings they are in question of being adopted by. In short, the successful implementation of Pharmaceutical care (PC) in Eritrea is a function of the path pharmacy practice might have taken so far. The suggestion made for change of pharmacy practice in Eritrea is however a reversal of the sequence of steps that led to its development in the west. After studying the Eritrean pharmaceutical experience there is no reason why we shouldn't draft a genuinely different model rather than advocating the implementation of Pharmaceutical care all along.

KEYWORDS

Pharmaceutical care, Eritrea and Actualization.

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INTRODUCTION

It is hard to disagree with what one would call the '*mainstream conviction*' that the pharmacist is over educated but underutilized[1]. For one thing, it is a historical fact that pharmacy has been struggling to redefine its professional roles in the clinical area and none of its current achievements in this area was an overnight accomplishment. It takes careful planning and time to reform a profession. For this to happen, however, all reform oriented initiatives

should be taken seriously and be refined or even debated before any change is to be expected. Along this line, this article reflects on one of the works published on the Asian journal of phytomedicine and clinical research in 2014, entitled “self-actualization of pharmacy in Eritrea”[2] and attempts to comment on the approach utilized by the authors.

The authors approach was prescriptive in nature in that it tried to recommend the implementation of pharmaceutical care in the Eritrean health care system. It is clearly put that there is a need for upgrading the Eritrean traditional pharmacy practice in to pharmaceutical care. The pharmacist’s contribution is emphasized and research results revealing the benefits accrued from the adoption of the new philosophy of practice in hospital pharmacies around the world are used to back the need for endorsing pharmaceutical care in Eritrea. Pharmaceutical care focuses on the attitudes, behaviors, commitments, concerns, ethics, functions, knowledge, responsibilities and skills of the pharmacist on the provision of drug therapy with the goal of achieving definite therapeutic outcomes toward patient health and quality of life[3]. This clearly indicates that pharmaceutical care is applicable in clinical setting (be it in the hospital or community pharmacy) where the pharmacist is expected to make direct contact with the patient (Figure No.1).

In this article three main concerns which should have been considered while assessing the feasibility of pharmaceutical care in Eritrea become apparent.

1. Is pharmaceutical care really pharmacy actualized? Doesn’t equating pharmaceutical care with pharmacy as a whole overemphasize the former while under estimating the latter?
2. How reflective is the absence of pharmaceutical care in Eritrea when it comes to the underutilization of the pharmacist? How comprehensive an answer is the endorsement of PC for the underutilizations of the pharmacist in Eritrea?
3. What are the lessons we should learn from the evolutionary process which clinical pharmacy had to undergo and be transformed in to PC? After understanding our current situation properly perhaps PC is not as feasible as it was thought to be.

DISCUSSION

Rethinking ‘actualization’

“*Self-actualization of pharmacy in Eritrea*”[2] ignores pharmacy practice as a whole and emphasizes the importance of pharmaceutical care to the point where pharmacy, a multifaceted field, is reduced to just a portion of its big and perhaps more important potentials. To start with, pharmaceutical care represents only a dimension along which pharmacy can be better utilized in the hospital and particularly in the wards where the pharmacist is expected to make direct encounters with the patient. Even in the hospital, however, procurement, storage and distribution of medicines are tasks taken care of by the pharmacist. These activities do not demand direct contact with patients; they are nonetheless irreplaceable roles of the pharmacist in the hospital along which ‘actualization’ must also be sought. Proper management and storage of medicines and medical equipment, scientifically informed allocation of pharmaceutical resources, dosage form modification and compounding and formulary management can be added to this list of responsibilities that the pharmacist can be tasked with in the hospital. It becomes clear, then, that even in the clinical area, pharmacy practice is too big to be confined in to pharmaceutical care. This becomes even more significant when one considers the increase in mortality rates due to unavailability of medicines attributable to week pharmaceutical management in hospitals when compared to deaths related to Adverse Drug Reaction (ADR) in the third world.

It is important to see problems in the clinical area, but it is also equally significant to propose efficient means of solving them. One of the notable successes of PC in the clinical area is the reduction of ADR incidents as a result of the involvement of the pharmacist in direct patient care. However, given the law staffing of pharmacists in Eritrea, it is not feasible to direct the pharmacy task force to direct patient care activities. In countries like ours ADR incidents can, for example, be reduced more

efficiently by promoting continuous sensitization programs on ADR monitoring rather than by involving the pharmacist in direct patient care. The enrolment of pharmacists, when there are already too few of them, in direct patient care activities represents poor prioritization of man power allocation. Therefore, given the underutilization of the pharmacist in areas where his roles are irreplaceable, it is not proper to entertain PC as the ultimate goal of pharmacy profession as a whole.

Apart from the clinical area the pharmacist has the potential to contribute in many other settings as well, which even further adds to the point that pharmaceutical care is not and cannot be pharmacy actualized. The World Health Organization (WHO)[3] identifies seven roles of the pharmacist which should be considered essential, minimum and common expectations of national health care systems worldwide. These roles are summarized in the “seven star pharmacist,” where the pharmacist is described as care-giver, decision maker, communicator, leader, manager, lifelong learner and teacher. This description represents the multiply array of the roles of the pharmacist of which PC can only be a part and not the encapsulation of the whole package. The actualization of pharmacy in Eritrea, whenever discussed, should consider all settings where the pharmacist is actually assigned to work. Apart from the hospital setting, pharmacists in Eritrea are enrolled in the academia, pharmaceutical industry, Pharmecor (which is the sole distributor of pharmaceuticals and medical equipment) community pharmacies and regulatory services. Their utilization in those areas in light of the ‘seven star pharmacist’ should be discussed if one is interested in the actualization, if there is any such thing, of pharmacy profession in Eritrea.

Contextualizing ‘Underutilization’

The pharmacist has been described (and for good reasons) as overeducated but underutilized. The degrees of and reasons for underutilization of the pharmacist however vary from one country to another or even from setting to setting within the same country. For example, in some countries the work force demand for pharmacists might be higher in the industry than in the hospital or vice versa, which may in turn create differences in the degrees of utilization of pharmacists from sector to sector. Apart from this, even in sectors which are well staffed with pharmacists it is not uncommon to find pharmacists working below their actual potentials. The reasons for this can be technical in nature or even due to the inexistence of assumable responsibilities demanding of the pharmacist’s actual professional aptitudes.

In the Eritrean health care system the pharmacist professional skills are not well exploited. The absence of pharmaceutical care, however, does not even begin to address why it is so. The reason for this is, as mentioned above, because pharmaceutical care as a philosophy of practice is applicable in the clinical area. More importantly, however, the concern with the underutilization of the pharmacist in Eritrea should extend beyond the clinical area and cover all the sectors in which the pharmacist’s academic background may be relevant for his/her enrolment. In this regard bringing the case of PC does very little, if at all, in depicting the real and most pressing issue of why pharmacists are being underutilized. The reasons for and the extent of the underutilization of the pharmacist in their respective working settings or departments should first be assessed. If done properly, this will dictate the list of things that can or should be done to improve the status and utilization of the pharmacist in Eritrea.

Lessons to be learned from the experience of Pharmaceutical Care

Pharmaceutical care (PC) has achieved a degree of success in many countries especially in the west. However, one should always be cautious of advocating change in the Eritrean pharmacy practice simply because a degree of success has been achieved elsewhere. Careful and complete analysis of the situations that unite and distinguish both the subjects under comparison should first be established. Then, perhaps, can one pass on to theories and recommendations. It is however sad to realize that much of our motivation for incorporating change is based upon the naïve confidence that if it worked there it should also somehow work here.

Pharmacy's leadership is clear about the future direction of the profession: Pharmacy is to adopt the practice *philosophy* of pharmaceutical care. However, nations, regions within nations, and individual practice sites have widely varying levels of pharmacy practice, and adoption of new concepts like pharmaceutical care has often been slow. Furthermore, technology, while a vital tool for pharmaceutical care may never completely free the pharmacist from responsibilities for drug preparation and distribution. Practicing pharmacists are being urged to change their practice, but many do not have a clear picture of how the new practice model is to fit into current reality[4].

The emergence of pharmaceutical care should primarily be understood as an adaptive response[4]. PC was developed as a desirable change for the American healthcare system where a wealthy documentation of pharmacy's professional history is available. The evolution of pharmacy practice in the United States over the past 140 years has been described to have culminated in the development of pharmaceutical care. The story tells of frequent, dramatic changes in practice spurred by advances in technology, by economic alterations, and by legislation[4].

The adoption of pharmaceutical care both as a theoretical and practical possibility should, there for, be understood as a response to and best applicable in an environment for which it was developed. In this respect the adoption of pharmaceutical care in the Eritrean health care system raises the question whether we have taken the right lesson from the history of the emergence of pharmaceutical care. There are different models of pharmacy practice, their successful adoption however depends on the degrees of similitude between the settings for which they were developed and the settings they are in question of being adopted by. In short, the successful implementation of PC in Eritrea is a function of the path pharmacy practice might have taken so far. The suggestion made for change of pharmacy practice in Eritrea is however a reversal of the sequence of steps that led to its development in the west. After studying the Eritrean pharmaceutical experience there is no reason why we shouldn't draft a genuinely different model rather than advocating the implementation of PC all along.

In this article no attempt has been made to propose a model of practice that could solve the problems of underutilization of the pharmacist in Eritrea. However, it is the conviction of the authors that given the existence of a number of models out there for adoption, what Pharmacy needs is 'a descriptive model of practice that allows pharmacists to see not only the individual elements but also the big picture. And for this to happen the best lesson to draw from the reformative experiences of others is how the problem was approached and not what the final outcomes were. In this respect a suggestion towards the implementation of pharmaceutical care in Eritrea can only be a precipitate of a lesson taken wrongly.

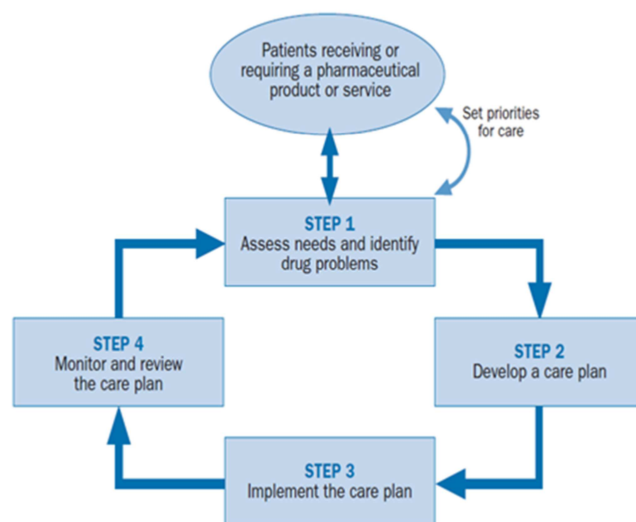

Figure No.1: Systematic approach to the delivery of pharmaceutical care[5]

CONCLUSION

Pharmacy practice in Eritrea requires change. This change how ever needs to be directed in the right direction. Adopting changes that showed fine results elsewhere may not always be the right move to take here in Eritrea. We should first understand the problems for the underutilization of the profession then try to propose a reflective model of practice more suitable to our situation. This is the lesson we should draw from the experience of the emergence and development of PC in the west.

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CONFLICT OF INTEREST

We declare that we have no conflict of interest.

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