The Pharmacist Activist

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Editorial

2015 { When the Shortage of Pharmacists Becomes a Surplus!

(Unless Major Changes Occur in the Practice of Pharmacy Very Soon)

There has been extensive discussion in recent years regarding the shortage of pharmacists that exists in many parts of the country. Some have suggested that the shortage of pharmacists may continue well into the twenty-first century, and this observation is supported, in part, by the increase in the percentage of the population that are in the elderly age range, as well as the use of a larger number of medications by these individuals and the accompanying greater need for services provided by pharmacists. However, an assumption of some of the projections of a long-term shortage of pharmacists is that pharmacists will be devoting a large amount of their time to the provision of medication therapy management (MTM) and other comprehensive pharmaceutical services that we advocate.

There has not been a previous time when the need for the expertise and services that pharmacists are able to provide has been as great as it is now, and this need will continue to grow for the foreseeable future. We are encouraged by a number of progressive practice initiatives (e.g., MTM) of individual pharmacists and groups of pharmacists that are valued and respected, and for which compensation is provided. However, the pace at which these initiatives are being developed and implemented is far too slow, and the number of pharmacists whose employment situation positions them to pursue expanded practice responsibilities is far too low. With all due respect and appreciation to those pharmacists whose accomplishments have provided excellent practice models, we have been largely ineffective as a profession in providing and documenting the value and need for comprehensive pharmaceutical services to the point that others are willing to pay for them.

During this same period of time we have observed changes such as 1) the increased utilization of technology that has made prescription dispensing systems more efficient, 2) an increase in the number, education, and credentials of pharmacy technicians, and 3) the development of many new schools of pharmacy and an accompanying large increase in the number of pharmacy graduates. These factors will have an important influence on the need for and supply of pharmacists.

Although acute shortages of pharmacists continue to exist in some areas, several indicators suggest that the overall shortage is easing. The number and type of factors that most influence the supply of and demand for pharmacists make it very difficult to make predictions with any degree of certainty, and most are wise enough not to make such predictions. However, a surplus of pharmacists may occur sooner than many would have anticipated. In the absence of studies, data, or statistical projections, my expectation is that there will be a significant surplus of pharmacists in 2015, UNLESS major changes

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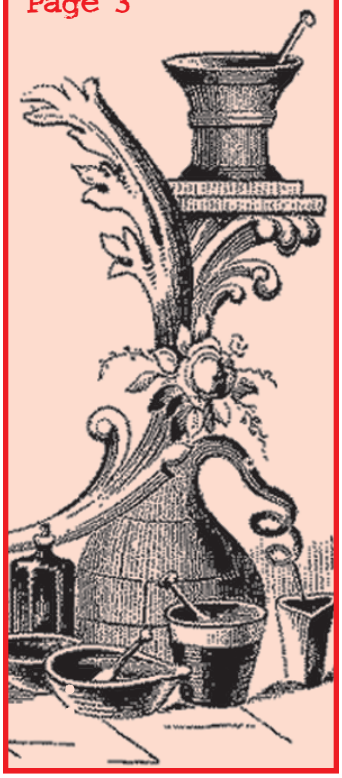


occur in the practice of pharmacy very soon. My "crystal ball" is no better than anyone else's and I actually hope that my prediction is wrong. But let's consider some of the consequences of a surplus and actions that pharmacy needs to take to best meet the needs of patients and advance our profession.

Consequences of a Surplus

I wish to be clear that my comments are not provided for the purpose of maintaining a shortage of pharmacists or avoiding a surplus. Rather, they are offered to demonstrate the important ways these issues are intertwined in influencing the provision of pharmaceutical services to patients and the future roles of pharmacists. The consequences of a surplus of pharmacists by 2015 include, but are not limited to, the following:

1. **Failure to attain recognition of the expertise and services of pharmacists.** The provision of comprehensive pharmaceutical services to the tens of millions of patients who need them will require the participation of many more pharmacists than we will be able to supply for at least several decades. If a surplus of pharmacists occurs as early as 2015, it will mean that our profession is failing in its efforts to convince those paying for health care, as well as other health professionals, that the expertise and services we are capable of providing are valuable, needed, and worth paying for. Many pharmacists will continue to be employed in traditional practice responsibilities, and these positions, in which a shortage currently exists, will soon be occupied by the significantly larger number of pharmacists who are graduating from colleges of pharmacy.

2. **Unemployment and lower salaries.** The clear implications of a surplus for individual pharmacists are greater difficulty in obtaining a position, unemployment, and lower salaries. There are important questions as to which pharmacists are most likely to be hired for practice responsibilities if a surplus of pharmacists exists. Would it be those pharmacists who are the most highly motivated in providing services to patients and extending the professional role of pharmacists, or would it be those pharmacists who are content with the status quo and would not "make waves" when working for an employer that is content with having its pharmacists carry out just the traditional dispensing responsibilities?

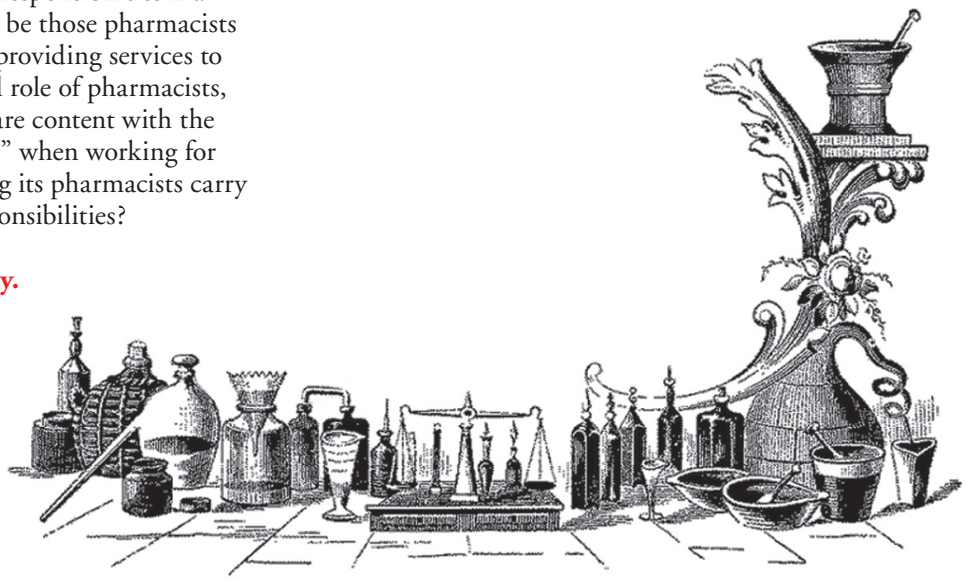
3. **Closing of some colleges of pharmacy.** In the last 20 years, approximately 40 new colleges of pharmacy have opened or are well along in the planning process. Prior to the late 1980s, the number of colleges of pharmacy in the United States had remained constant at 72 over a period of many years. The number is now 112 and is continuing to increase. The vast majority, if not all, of the new schools (and additional campuses for some older schools) have identified the shortage of pharmacists as the/a primary reason for which the new school is needed/justified.

   If a significant surplus of pharmacists occurs, not as many young people will consider pharmacy as a career opportunity, the number of applications will fall, enrollment shortfalls will be experienced, admission standards will be lowered, and some schools of pharmacy will close. These challenges that are associated with a surplus of pharmacists will be experienced not just by the new schools (some of which have innovative and dynamic programs that make them very competitive), but also by the older schools (some of which have not implemented progressive changes).

Actions Needed

The highest priority must be given to having a much larger number of pharmacists providing comprehensive services to patients and being paid for it. Past experiences and frustrations have taught us how difficult it is to do this. However, we must persist and we must be far more effective in attaining this goal than we have been in the past. Pharmacists are strategically positioned and have the expertise to optimize drug therapy outcomes and reduce the occurrence of drug-related problems. The frequency with which the media reports the occurrence of medication errors and other drug-related problems (many of which result in litigation) reflects an increasing outrage on the part of the public with respect to these situations. If the profession of pharmacy is unwilling and/or unable to effectively address these problems, someone else (e.g., physician assistants, nurse practitioners) will have to. We must not default on this opportunity.

Daniel A. Hussar



New Drug Review

Alvimopan
(Entereg – Adolor; GlaxoSmithKline)

Agent for Postoperative Ileus

New Drug Comparison Rating (NDCR) = 4

(significant advantages) in a scale of 1 to 5, with 5 being the highest rating

Indication:

For short-term use in hospitalized patients to accelerate the time to upper and lower gastrointestinal recovery following large or small bowel resection surgery with primary anastomosis.

Comparable drug:

Methylnaltrexone (Relistor).

Advantages:

- Is the first drug to be demonstrated to be effective in accelerating gastrointestinal recovery following bowel resection surgery;
- Is administered orally (whereas methylnaltrexone is administered subcutaneously).

Disadvantages:

- Use is limited to short-term use in hospitalized patients;
- Effectiveness in the treatment of opioid-induced constipation has not been demonstrated;
- Available only in a restricted distribution program.

Most important risks/adverse events:

Contraindicated in patients who have taken therapeutic doses of opioids for more than seven consecutive days immediately prior to taking alvimopan; use is limited to short-term use (15 doses) in hospitalized patients (boxed warning); a higher number of myocardial infarctions was reported in a 12-month study in patients treated with opioids for chronic pain, although a causal relationship has not been established.

Most common adverse events:

Hypokalemia (10%), dyspepsia (7%), anemia (5%), back pain (3%), urinary retention (3%); patients recently exposed to opioids may be more likely to experience adverse events.

Usual dosage:

12 mg administered 30 minutes to five hours prior to surgery followed by 12 mg twice a day beginning the day after surgery for a maximum of seven days or until discharge; patients should receive no more than 15 doses, all of which should be administered while the patient is in the hospital.

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NEWS - Line PUBLISHING

New Drug Review (cont.)

Product:

Capsules – 12 mg; was approved with a Risk Evaluation and Mitigation Strategy (REMS) and is supplied only to hospitals that have registered in and meet all of the requirements for the Entereg Access Support and Education (E.A.S.E.) program.

Comments:

Following major abdominal surgery and certain other surgeries, some patients experience postoperative ileus as a result of impairment of gastrointestinal motility. This may delay recovery from the surgery and hospital discharge. Opioid analgesics are used to relieve postsurgical pain in almost all patients who have undergone major abdominal surgery; however, these agents may prolong the duration of postoperative ileus. Alvimopan is a selective antagonist of mu-opioid receptors in peripheral tissues (e.g., the gastrointestinal [GI] tract) and it antagonizes the effects of the opioid on GI motility and secretion without reversing its analgesic action that results from its action at receptors in the central nervous system. The action of alvimopan is generally similar to that of methylnaltrexone, an agent that was also approved in 2008 and marketed shortly before alvimopan. However, the indications for the two agents are different, with methylnaltrexone having been approved for the treatment of opioid-induced constipation.

Although other drugs have been used to increase gastrointestinal motility, alvimopan is the first agent to be approved to accelerate GI recovery following bowel surgery (e.g., resections necessitated by colorectal cancer). Its effectiveness was demonstrated in placebo-controlled studies in which bowel recovery times ranged from 10 to 26 hours shorter for the alvimopan-treated patients compared with the placebo-treated patients. Patients receiving alvimopan had their hospital discharge order written 13 to 21 hours sooner compared with patients receiving placebo.

A higher number of myocardial infarctions was reported in a 12-month study in patients treated with opioids for chronic pain. Although a causal relationship was not established, this is the basis for a boxed warning in the labeling and restrictions regarding its distribution and dosage.

Daniel A. Hussar