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 discourses 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 antibiotic and 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 diagnostics, 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


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-