Editorial: Patient education by pharmacists

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Patients with mental illness may have inadequate knowledge about their medications or may be dissatisfied with information received about medicines prescribed for their conditions.[1] Patients may not have an understanding of how their medicines work, the time needed to achieve efficacy, recommended duration of therapy, possible side effects and their management, and other factors that may affect medication usage. One study reported that 39% of psychiatric inpatients felt that their treatment had not been clearly explained to them.[2] In another study of 69 patients with schizophrenia, 46% reported they had not been warned about potential side effects of the medication(s).[3] Some data signal the possibility that increased drug-specific knowledge can translate into increased adherence. For example, the chance of discontinuing an antidepressant medication was 61% lower in patients who were simply told to take medication for at least 6 months, compared with those who did not recall being told this information.[4] In addition, previous research has found an association between satisfaction with information received about medications and adherence to those medications in chronic illness. This suggests that provision of information about medications that addresses patients' needs may play a role in supporting medication adherence.[5] In this issue of the MHC, we provide a summary of evidence supporting patient education as an effective means to increase adherence. However, on the whole, results in the literature are mixed as to whether patient education alone can improve patient satisfaction and medication adherence.[6-9]

It wasn't until a couple of decades ago that the words "pharmacist" and "patient education" would appear in the same sentence. However, in the United States, Congress created a statutory duty for pharmacists by passing the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). This act expanded the pharmacist's role in reducing the risks for prescribed drugs by requiring that pharmacists offer to counsel Medicaid recipients at the time of medication dispensing. Most states' laws have extended this, requiring that counseling be offered to ALL patients. Outside of the US borders, mission statements or codes of ethics from organizations including the Federation International Pharmaceutique (FIP)[10] and leading pharmacy professional organizations in Great Britain[11] and Australia[12] now declare that the pharmacist is responsible for ensuring that the patient has sufficient information to use his/her medication safely.

The expansion of the pharmacist's role into education and counseling has had a dramatic impact on our profession and our patients alike. One recent review of pharmacists' counseling practices in community pharmacies stated "There is evidence that through patient counseling, pharmacists may identify and resolve drug-related problems, empower patients to adopt positive self-management behavior, increase patient satisfaction with pharmacy care, and optimize patient quality of care."[13,Pg. 198] But, could we do more? This same review found that patient counseling rates in community pharmacy settings vary from 8 to 100% depending on the pharmacy, the patient, the newness of the prescription, and the research method used. Recent data from the American Society of Health-System Pharmacists' (ASHP) 2009 survey indicate that 89% of hospitals assigned primary responsibility for performing inpatient medication education and counseling to nurses, not pharmacists, and that the majority of hospitals (68.9%) reported that just 1–25% of patients received medication education by a pharmacist during their inpatient hospital stay.[14] These data seem to indicate that we could do more.

Should we do more? Maybe that is the better question. It has been documented that patients want as much information as possible about their medications.[15] However, at least in 1 study, there appears to be a discrepancy among older adults regarding who should provide the education-some preferring to hear the bulk of the necessary information from their physician rather than their pharmacist.[16] Time constraints and lack of reimbursement to pharmacists for providing education to patients represent two of the possible significant drawbacks to provision of more patient education by

pharmacists. It appears the benefits associated with providing education to our patients (including the impact of medication education on our patients, our knowledge as the drug experts, and our accessibility to patients) outweigh the potential drawbacks.

If, as a profession, we should do more, how then, should pharmacist-delivered education be provided? Prominent national and international pharmacy organizations have published guidelines for pharmacists in the provision of medication counseling and these establish recommendations for the content that should be covered by the pharmacist as well as the environment in which this education should take place.[12,13,17] More recently, Comprehensive Medication Management guidelines as developed by the Patient-Centered Primary Care Collaborative recommend that the pharmacist or other medication manager create a care plan that will allow him/her to "Design personalized education and interventions that will optimize each patient's medication experience."[18] Somewhat similarly, Medication Therapy Management framework stipulates that "the pharmacist supplies the patient with education and information to improve the patient's self-management of his or her medications" as a portion of a full Medication Therapy Review (MTR).[19] Both of these frameworks emphasize the importance of providing medication education in conjunction with the formulation of a larger treatment plan rather than the education occurring as an isolated incident, disjointed from any other healthcare experience of the patient. To my knowledge none of these methods has been directly compared.

An additional, less-documented method of patient education is that of patient medication education groups. Many in our membership are currently delivering patient education to groups of patients, likely taking a cue from other disciplines in our practice settings (e.g., psychology, occupational therapy) where group processes and therapies are well established. Three authors in this issue of the MHC comment on group medication education led by pharmacists: Innovative Practice, Pharmacist-Led Education, and Medication Education Group. Once again, it remains to be explored whether significant differences exist in the quality, impact, and patient-centered outcomes associated with individual or group medication education.

Clearly, the need and the opportunity for pharmacists to be involved in educating their patients is not going to go away any time soon. However, the profession still has much to uncover about the best ways to deliver patient education, whether in individual or groups settings, at the time of dispensing or in a more focused private encounter, and whether patient-centered outcomes are better achieved when patients have been educated by a pharmacist. In addition, questions still abound regarding reimbursement for patient education/counseling and whether this should be tied only to a product or not. Even the terminology used to refer to pharmacist-delivered medication education has been called into question of late, with some feeling that the word "counseling" is not appropriate for our profession, but is best left to licensed counselors, psychologists, and the like. A patient of mine with paranoid schizophrenia recently affectionately called my discussion with him our "meducation." I kind of like the sound of that...

This October, the month of the American Pharmacist, I would encourage you to reflect on your role as a pharmacist AND as an educator to your patients. Are you striving to give your patients power through knowledge? And taking it one step further, are you encouraging your patients to use medication knowledge to better their situations? For "knowledge becomes power when we put it into use." Anonymous

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