Reader Feedback

Don't Drive Wedges Between Pharmacists and Other Practitioners

The article "Improving Lipid Outcomes for VA Patients Taking Nonformulary Statins," which appeared in the February 2009 issue (starting on page 20), describes a pharmacist-run lipid clinic that provides more expensive medications, more lifestyle counseling, and more frequent laboratory tests than are provided in standard, physician-run lipid clinics. Patients who were treated in this clinic showed improved low-density lipoprotein cholesterol (LDL-C) levels.

The article implies that the presence of a clinical pharmacist, in place of another type of practitioner, was the crucial factor in the patients' improvement. A description of the article begins, "Previous studies have demonstrated advantages for pharmacist-driven clinics over more traditional primary care models with regard to dyslipidemia outcomes." And the article's summary begins, "A lipid clinic managed by a clinical pharmacist was able to produce more favorable lipid outcomes for patients using high cost nonformulary medications as compared with usual care provided by nonpharmacist practitioners."

This repeated implication is disingenuous. To its credit, the article recognizes that the pharmacist-run clinic allocated more time—which allowed for more counseling and blood testing and, thus, more patient involvement—and more expensive drugs than are normally available to lipid clinics. But it fails to emphasize that these factors are the keys to the study's outcome, with each of them potentially contributing to the patients' improvement.

I work in a clinic with superb clinical pharmacists who, like me (a traditional nonpharmacist practitioner who provides, sadly, only usual care), are burdened by huge workloads. And I am certain that any practitioners, given the tools of additional time and more potent, nonformulary drugs, could reproduce the study's results.

The implication that lipid clinics run by clinical pharmacists are preferable to those run by other practitioners lacks support. It also drives a wedge between pharmacists and other practitioners—which seems contrary to the spirit of harmonious teamwork that *Federal Practitioner* should be working to foster.

—Everett Shocket, MD
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The authors respond:

We thank Dr. Shocket for his interest in our article and for sharing his concerns about its potential implications.

Our intention was not to imply that one particular discipline is more proficient than others in producing favorable lipid outcomes. Rather, our article describes the improved outcomes of a model of care that used a specialty clinic—in this case, one managed by a clinical pharmacist specializing in lipid management—in comparison to the outcomes of a usual care model. The term "usual care" has been used in many papers to describe primary care practitioners who provide comprehensive patient care, rather than focusing exclusively on a specific problem.[1–3] *The comprehensive nature of the usual care model involves time constraints that, as Dr. Shocket notes, may hinder optimization of patient goals. We agree that the success of our model—our patients' enhanced LDL-C goal attainment—most likely results from its circumvention of time constraints, which allows for more education and patient-specific monitoring, and its provision of more potent, nonformulary statins.*

The existing data suggest that the specialty clinic model of care may provide more favorable lipid outcomes regardless of the provider's specific discipline. Most published studies evaluating this model use a pharmacist as the care provider, and none of them compare the results of utilizing providers from different disciplines. Some of the studies provide evidence, however, that the specialty clinic model is associated with improvement in LDL-C goal attainment when the provider is a nurse

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practitioner, a registered nurse, or a physician.[1,2,4,5]

Finally, the results of our study should be used to emphasize the utility and necessity of the multidisciplinary team approach to achieving lipid goals, especially in patients with complicated dyslipidemia. Our clinic was established at the request of an attending cardiologist, who is available for consultation when necessary. The patients included in our study were referred to the clinic for both nonformulary statin approval and complete management of dyslipidemia by their primary care providers. Again, our clinic serves to circumvent the constraints typical of many primary care practices in order to attain lipid goals in these often difficult-to-treat patients—leading, ultimately, to improvement in patient care.

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