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LETTERS TO THE EDITOR
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A new definition of pharmaceutical care: No, without consensus (Opinion on Barbate Document)

Redefinición de la Atención Farmacéutica: No sin consenso (Opinión sobre el documento de Barbate)

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Farmacia Hospitalaria (FH) has published an article that introduces a new definition of *pharmaceutical care* (PC) together with a rationale for the new definition and for revising the goals and procedures of PC. The authors of the article[1] believe that the concept of PC needs to be updated because medicines have become more complex and specific, new care frameworks have been developed, and a different society with more informed patients has emerged. They also point to the huge advancements achieved in the technological arena.

The CMO (Capacity-Motivation-Opportunity) methodology, introduced in 2014 within the framework of the MAPEX *(Strategic Map for Outpatient Care)* project, claimed that the traditional outpatient PC model had "reached its limit" and that the classical approach to hospital pharmacy outpatient care had to be redesigned[2].

In 2008, the increasing workload involved in dispensing drugs to outpatients resulted in a reorganization of the procedures used by hospital pharmacy departments. However, we do not believe that there is enough justification for carrying out a blanket amendment to the principles that have governed PC since the concept was introduced in 1990.

We believe that greater agility, efficiency and multidisciplinarity can be achieved without breaking away from the healthcare procedures and the doctrine that our profession has so painstakingly developed over the years.

The definitions used and then amended by international professional groups have always retained the core elements behind the change suggested by Hepler & Strand[3], which shifted the focus of pharmaceutical services from being drug-centered to being patient-centered.

The article published in *Farmacia Hospitalaria* states that "not much progress" has been made in this respect at an international level. Nevertheless, the PCNE working group (Alleman & Van Mil) in 2014 and Holland[4] in 2018 redefined a few concepts, though always based on the seminal tenets laid down by Hepler & Strand.

Lastly, it should be mentioned that the Resolution on the implementation of pharmaceutical care for the benefit of patients and health services adopted by the Committee of Ministers of the Council of Europe in March 2020 is also based on Hepler & Strand's definition, which is used for the application of PC in different health services, including hospital-based ones[5].

The Pharmaceutical Care Foundation was established in 1998 with the purpose of promoting scientific and professional activities related to PC. The Spanish Society of Hospital Pharmacists (SEFH) is one of the Foundation's founding members. Although the article states that the working group that authored it was "made up of members of SEFH and pharmacists from different healthcare units", it is surprising that the Foundation should not have been invited to support the document. What is more, none of the other relevant scientific societies feature on the list of adherents.

In our opinion, the definitions used by the different groups who have played a role in the advancement of PC, as well as the goals they have pursued, remain valid. Only procedures requiring a more extensive application of communication technologies should be redesigned and any changes should be discussed jointly by professionals at different levels of care. This has precisely been the goal of the activities recently carried out by the Foundation, with the participation among other of members of SEFH, which have resulted in a series of conclusions emphasizing the need for pharmacists across different clinical areas to team up and work in a coordinated manner.

The Foundation will always be open to considering potential alterations to definitions and procedures intended to optimize patients' health outcomes by improving their drug therapy. Such alterations should draw on the input of all the healthcare providers involved in pharmacological treatment, many of them represented in our institution.

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A new definition and a new approach to pharmaceutical care: the Barbate Document. Authors' response

Dear Editor-in-Chief,

We are grateful for the comments made in the letter to the editor about our article. However, we do not share the arguments put forward.

First of all, the authors confuse the origins of the CMO methodology in the hospital setting, the MAPEX project, with the scope of the proposal and the redesign of pharmaceutical care[1]. Even if our proposal does result from the problems that characterize specialized care, it in no way limited to that domain, as the CMO methodology is not specific to one particular kind of patient but represents a new model of clinical relationships applicable —as stated in the different sections of our article— to any patient[2]. This has been repeatedly corroborated by medical and pharmaceutical societies at all clinical levels, as well as by patient associations[2].

Although the authors themselves point out that *only procedures requiring a more extensive application of communication technologies should be redesigned,* they are in fact supporting our arguments by admitting that society, the health system, and patients themselves have undergone a radical change and, therefore, it is not advisable to apply a one-size fits-all approach or concepts such as that of "drug related problems," which are inimical to the creation of a long-term, longitudinal connection with the patient and with other stakeholders, based strictly on pharmacotherapeutic goals[3,4].

According to this approach, pharmacists should not only be *experts in medicines and their use* but, above all, *experts in curating the relationship of patients with their drug treatment,* who in the foreseeable future are likely to work increasingly as part of multidisciplinary teams comprising healthcare providers of different fields. These are novel aspects not taken into consideration up to now, and which have been absent from previous contributions to the subject.

We are fully aware of the fact that our proposal deviates from the traditional approach and that the diffusion of the changes in pharmaceutical care that we have been advocating since 2020 is still limited as compared with that of the established doctrine taught in graduate and postgraduate university programs and used in official documents. Nonetheless, scientific evidence, critical reasoning and the natural evolution of pharmaceutical practice are bound to set the scene for the development and expansion of a new kind of pharmaceutical care.

Our proposal does not demand a total break away from the previous model but instead, a recognition of the significance of the foundations laid in the 1990's[5] and of the valuable contributions of so many colleagues who have helped advance our profession. We believe that it is now time to implement a disruptive rather than gradual improvement of pharmaceutical care to adapt to the new times so as to avoid being left out of the rapidly evolving landscape around us.

Farmacia Hospitalaria will shortly publish a practical example of how the new methodology involves a significant improvement with respect to the traditional approach, even with regard to traditional variables such as adherence. This is the result of an innovative scientific design and a multilevel patient management approach, including patient stratification, pharmacotherapeutic objective-based care and, obviously, the adoption of such new technologies as may allow the longitudinal and coordinated follow-up that is required[6].

Lastly, far from wishing to claim ownership of such a significant concept, we would like to build bridges with other professionals to keep developing our profession and advancing pharmaceutical care, not just to homogenize the activities we perform as a group but, above all, to improve the health outcomes of the patients we serve.

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