

Professional body debate is heading off at a tangent

Much debate surrounding the establishment of the new professional body for pharmacy seems to be missing the point. Rather than becoming preoccupied with restricted titles, we need to concentrate on sector-wide collaboration to provide the best clinical care to patients, says Philip Brown.

I find it hard to believe that the powers that be in the Department of Health can be happy about the way our profession is making the transition from the Royal Pharmaceutical Society to the new organisation that is to be responsible for the professional development of pharmacy, and which will provide advice to the new General Pharmaceutical Council. Right now, the issue that threatens to be the ‘spoke in the wheel’ of progress towards the new professional body is pharmacists’ heartfelt concerns about the use of their titles.

Those who read *The Pharmaceutical Journal* will know that this issue has filled the letters pages for the past few weeks with the ‘great and good’ of pharmacy — particularly those at the senior end of the age spectrum, with gold medals and fellowships to their credit — adamantly putting their case for retaining the right to call themselves pharmacists to their graves and beyond!

This issue could lead to thousands of pharmacists refusing to vote in favour of the new professional body, thereby derailing it and leaving the *White Paper Pharmacy in England: building on strengths — delivering the future* sitting on the shelf with no one to push forward the reforms wanted by the Government. If the necessary quorum of members does not vote in favour of the new professional body, then there will be no successor to the Royal Pharmaceutical Society and the new General Pharmaceutical Council will have to work with individual groups of pharmacists in order to provide effective regulatory control.

Some, including me, think this would not be such a bad short-term solution, since it would lead to the formation of a new professional organisation that had



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evolved naturally, rather one that had been cobbled together to meet a deadline.

There is also concern in some sectors of the profession that, in the rush to set up a successor organisation to the Society, those responsible for the transition are losing sight of the aims and objectives of the Government’s White Paper. One senior member of the profession told me that there is too much “1 Lambeth High Street” thinking going on right now, and too little by way of new ideas coming in from the profession around the country. Another senior academic has complained that very little attention is being given to the future educational requirements of the profession, despite extensive evidence given to the Transitional Committee.

These comments, plus others, contribute to the fear that the new body will be a rehash of what already exists

and that it will be run by the same people, thinking the same things — but wearing the hats of the new organisation.

It is also being said that some, but not all, of the current Society Council members fail to recognise that they are simply members of a body in transition, and still believe that their job is to reorganise the chairs on the deck of the Titanic.

“Unless all parties involved in the delivery of healthcare to patients collaborate to a far greater extent, nothing will change”

Most of the profession recognises that pharmacy has to change and that its future lies in becoming a clinical profession focused on the welfare of patients. Without doubt, pharmacists working in hospitals understand this fundamental truth and are developing appropriate competencies and performance abilities based on a range of continuing pharmacy education (CPE) programmes, such as those developed by Professor Ian Bates and colleagues at the University of London School of Pharmacy for hospitals in the South East of England (under a joint grant from the NHS and the Higher Education Funding Council for England).

At the end of March, over 350 young pharmacists were being put through their paces at the School as part of the Joint

Programmes Board postgraduate diploma in general pharmacy practice, and according to Professor Bates the outcome was very satisfactory. This programme will be developed into a range of CPE programmes which, on the face of it, have far more relevance than the current Royal Pharmaceutical Society's requirements for CPD.

Becoming 'clinical'

However, the real question is how the profession as a whole will become 'clinical'. To answer this question we must look to some of the initiatives that involve collaborative efforts incorporating all sectors of the pharmacy community. An example of this is the local practice forum that met in February and March at the University of Huddersfield. This was attended by over 40 pharmacists from universities, hospital and community pharmacies, and NHS authorities.

There are powerful arguments saying that unless all parties involved in the delivery of healthcare to patients collaborate to a far greater extent, nothing will change. In the absence of this co-operation, the brave new world for pharmacy envisaged by Keith Ridge in his White Paper will, like many Department of Health initiatives, fade into obscurity.

The way forward

The way forward for pharmacy must be seen in the context of the big picture for healthcare in the UK. This involves providing far more patient care in the community, rather than in hospitals where costs are spiralling as ever more expensive equipment and technology is brought to bear on the effective treatment of life-threatening illnesses. Priority for hospital beds will be given to patients who need intense treatment. Those who can be cared for satisfactorily elsewhere will receive their treatment in the community or in other healthcare establishments, with clinical pharmacists in attendance. It is through this 'outsourcing of patient care' that the clinical pharmacy skills provided in hospitals will percolate out into the NHS community services.

There can be no doubt that the general and specialised clinical pharmacy skills developed in hospitals have a major role to play outside the hospital

establishment. Too many patients are being discharged from hospital into the community only to find that there is no real support for the condition in which they find themselves. I know of several cases in which patients have undergone surgery in hospital only to find that, while the surgery had been successful, there were significant after-effects which the hospital did not want to know about and local medical and social services could not cope with. In one particular case, a patient had a potentially fatal cerebral embolism effectively treated surgically, but post surgery he suffered the symptoms of a mild stroke, about which he had not been fully warned. He was discharged into the care of his GP, but required intensive physiotherapy to restore the use of the left side of his body. He also required psychiatric treatment for the severe depression that was a consequence of his post-operative condition. The hospital in which he had been treated did not want to know, and the medical, social and community services were unable to respond promptly and thoroughly to his deteriorating condition. It was only because this patient had access to funding for private healthcare that he was able to make a full and satisfactory recovery.

What this patient needed was continuation of the quality of medical and pharmaceutical clinical care that he received in hospital. However, all the evidence points to a void between the highly effective treatment provided in hospitals and the care of the patient back in the community. The assumption seems to be that if the patient can walk out of the hospital with a new prosthesis, a life-saving stent or a line of stitches, all will be well.

It is the real-life circumstances facing patients like these that should be preoccupying pharmacists and

the Royal Pharmaceutical Society today — not whether they will be called registered pharmacists, licensed pharmacists or chemists and druggists. As an aside, the issue of titles is not something that is within the powers of the RPSGB to resolve. It is a matter for the Government and the new General Pharmaceutical Council.

When I look ahead at the challenges facing pharmacy, I cannot believe that pharmacists are sufficiently aware of what the future holds to be able to decide on the exact structure required of a new professional body. We are a profession that can only muster a 20% turnout for key Council elections. We already have over 150 professional 'representative' bodies. We lack a representative union such as the one that doctors have in the form of the British Medical Association. We have not seriously considered the development of the profession for years. We find it very difficult to bring together our disparate components to consider the issues underlying our future professional development and therefore, by default, we rely on those who run the current power structure. And to top it all off, we are working in a fast-changing NHS environment against a backdrop of the worst financial crisis in a century.

Is now the time to decide on a new overarching professional body? Everything tells me that it is not. I suggest that we should be patient and work with the organisations that already exist. We should allow time, experience and events to lead us to a position where we can be far more certain that our new professional body has long-term relevance and brings together all the elements that must be built into the future professional structure.

I suggest that before we take the plunge we need some well-organised pilots, such as those under way at the University of Huddersfield, to establish what works best. If we want to arrive at the clinical destination set by the 2008 White Paper we must get the intellectual horse in front of the organisational cart — not the other way round, which is the risk with the current strategy.

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Agree? Disagree? *The British Journal of Clinical Pharmacy* would like to hear your views. Please contact the editor, Hannah Pike (telephone 0208 241 6592, e-mail hannah.pike@healthpublishing.co.uk).