

Dispensing — physical grind or holy grail?

The question of what constitutes dispensing is at the core of arguments about the future of our profession, says Philip Brown. He proposes a new definition for dispensing and explains why it should not end on handing the medicine to the patient.

As our profession struggles to find a way forward — are we to be barefoot doctors, public health experts, or merely pawns of the National Health Service — let me say a few words in praise of our fundamental and unique responsibility, which is to dispense medicines. I find it sad that the core activity in which we are engaged for most of our time is not seen as a basis for building the future of the profession as a whole, but rather something that is better handled by technicians and robots.

So what do I mean by dispensing? Rather than simply picking the right product and sticking the right label on it (in which case robots and technicians will rule) my proposition is that like many other activities, dispensing is evolving from being a physical process to one that is intellectual.

I find it curious that we pharmacists do not have a clear catechism-like definition of dispensing. I do not even know whether there is a legal one, although I am prepared to stand corrected on this.

The issue of what constitutes dispensing came to the fore recently with the introduction of the new Responsible Pharmacist regulations. Wide-ranging questions were asked about what work could and could not be undertaken in a dispensary in the absence of the responsible pharmacist. At the heart of these questions lay the issue of exactly what constitutes dispensing.

The matter was taken to ludicrous extremes. On the one hand it was suggested that everything relating to the dispensing process was covered by the new regulations and hence wholesaler deliveries could not be placed on the dispensary shelves without the responsible pharmacist being present. According to this view, the dispensing process starts when the products



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Philip Brown: Redefine dispensing

come into the dispensary and ends when the patient walks out of the door with his or her medicine.

On the other hand it was argued that the dispensing process involves no more than the delivery of the prescribed medicine, suitably labelled, to the patient by the responsible pharmacist. All tasks undertaken before that point could be performed without the responsible pharmacist being present.

I believe that the issue of what constitutes dispensing is at the core of arguments about the future of our profession.

Redefining dispensing

I suggest that dispensing requires a deep understanding of the medicinal products that are being provided and of the patients who are taking them. Indeed, perhaps we should be asking whether, after a doctor has diagnosed a patient, it should be the pharmacist who not only dispenses the

medicines, but routinely prescribes them and takes responsibility for their use beyond the dispensary. Hence dispensing could range from matching the pharmaceutical product to the illness, supplying it, and ensuring that patients benefit from their medicines through full compliance.

Allow me to put a historical perspective on this matter. When I qualified as a pharmacist 50 years ago, community pharmacists were mainly involved in extemporaneous dispensing — preparing mixtures, pills, creams and ointments from basic ingredients. In hospitals, pharmacists were also engaged in what one could call 'small scale manufacture'. There was some tablet counting, but that did not account for most of a pharmacist's time. There could be no doubt then that pharmacists were basically dispensers.

In schools of pharmacy, dispensing skills were important components of the degree course. The skills of the pharmacist lay in his or her knowledge about the mixing of ingredients and the stability of the medicines dispensed for the patient. Pharmacists also had a good understanding of the therapeutic activities of the medicinal substances they dispensed, limited as they were in their range and complexity.

Over time, most extemporaneous dispensing has disappeared. The pill making boards, the suppository moulds, the pestles and mortars have all gone, and tablet counters are used infrequently. Apart from some highly specialised dispensing in hospitals, manufacturers' packs have largely taken over, and even what remains of extemporaneous dispensing in hospital dispensaries is being handled more safely and effectively by robots.

I suggest that where pharmacists in the past had skills and knowledge based on the delivery of medicinal ingredients which were known and understood,

today in community pharmacy this is not the case. As dispensing became less skilled from a practical point of view, community pharmacists did not take up the intellectual slack by becoming ever more knowledgeable about the medicines they were providing for their patients (in hospitals, the situation is somewhat different with the emergence of specialist pharmacists who work far more closely with the medical teams).

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We pharmacists have been so busy providing the medicines for patients from our dispensaries that we have lost our curiosity about their activities and their actions to the extent that we have become unclear about our professional role as dispensers and the need to define clearly what we mean by the term.

Of course, there are some pharmacists in hospitals and the community who have pushed the boundaries and established themselves as experts in the use of pharmaceuticals, many of whom are regular contributors to *The British Journal of Clinical Pharmacy*. But there is a difference between what these individuals achieve and the special circumstances in which they achieve it, and what is achieved by the profession as a whole in primary, secondary and tertiary care.

When so many people, particularly the increasing population of elderly people, are taking medicines on a daily basis, there is a crying need for pharmacists who have an expert knowledge about the use of medicines. We need to be sure that the patient is getting the right medicine and that it is safe and effective at the right cost to society. We also need to ensure that the focus of attention is the patient, wherever he

or she is treated. There has to be a continuity of care across the primary and secondary care boundary, which is in question at this time.

I contend that if we had been faithful to our calling we would not find ourselves in the state of professional confusion in which we find ourselves today, with the new professional body searching for pharmacy's role in society. If we had expanded our role as dispensers, we would by now have developed far greater interest, authority and skill in therapeutics and not come latterly to the idea that we should be clinical pharmacists.

Could it have been different? I suppose that we missed the boat when it was decided what pharmacists should know, hence the curriculum for pharmacy as defined by the Royal Pharmaceutical Society and offered by universities. As a former Chairman of Council of the School of Pharmacy, University of London, I understand that there was a need for a broad base for pharmacists' education, but the central focus has not been on therapeutics and an understanding about the actions of medicines on sick patients. What is taught is worthy, but does it move the profession forward into new territory where there is a real need?

Let me return to my earlier point about the need for a definition of 'dispensing' and hence 'dispenser'. If we had taken full advantage of the revolution in the discovery and production of pharmaceutical products and understood that the profession was being liberated from the physical grind of dispensing, we could have realised that our role as pharmacists did not end when we handed the medicine across the counter to the patient or sent it off to the ward, but that it extended into monitoring the safety and effectiveness of the medicine for the patient. In hospitals this is happening, but even so in most cases the pharmacists' responsibility ends when the patient is discharged.

The questions: 'Is it safe?' and 'Is it effective?' are ones that every pharmacist

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should be asking if they take their dispensing role seriously. It is the medicine inside the patient and not the medicine inside the package that ought to be the real concern.

A growing problem is the failure of patients to comply with dosage regimens, particularly with medicines for chronic conditions that have to be taken regularly if they are to be effective.

We as pharmacists should be hugely concerned about patient compliance but, as reported last month, there are significant compliance and continuity failures when patients leave hospitals and return to the community (*The British Journal of Clinical Pharmacy* 2009;1:291). In the community it is no better. It has been estimated that at least £500 million is wasted annually because medicines are not taken as prescribed.

Research into patient compliance has thrown up some very startling results. We have situations in which seriously ill patients on life-saving drugs fail to comply with simple dosage regimens. I know of a patient who had remarkably high blood pressure that was well controlled by a regimen of antihypertensive therapy. After a while he decided that since he felt no symptoms he would stop taking the drugs. Six months later he suffered a stroke and was severely paralysed. Who is responsible for this state of affairs? Is it the pharmacist who should have kept an eye on the situation, providing advice and monitoring drug use? I doubt whether most pharmacists see their role in this light, but why not if they are truly dispensers of medicinal therapy to the community.

I contend that we must now become passionate about our role as dispensers and define that role in terms that are comprehensive and forward looking. We must ensure that the new General Pharmaceutical Council sees us in this light, that our educational establishments provide the necessary curriculum for undergraduates and that this is reinforced through ongoing continuous professional development.

Most importantly, we want our patients to see us as the people they turn to when it comes to getting the very best results from their medicines.

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