THE CASE FOR COMMUNITY PHARMACY

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The presentation by Dr Brian Curwain (Member of the RPSGB Council and the English National Board) to the Southampton Branch of the RPSGB on Wednesday 15th October 2008 entitled 'Who will lead and who will regulate Pharmacy in the UK?' has brought certain issues about Community Pharmacy into sharp focus for me and wish to share these with the transitional committee (TransCom). In attempting to crystallise my viewpoint, I will make some generalisations, which I offer no apologies for. The main objective is to trigger a debate on these issues.

WE HAVE AN IMPORTANT ROLE TO PLAY

There is no doubt that pharmacists (across all practice areas) have a valuable contribution to make to patient care in the NHS especially within the context of a more complex and fragmented healthcare provision. I sometimes suspect that a significant majority of us don't believe this passionately enough and I have seen this in the area of Medicines Use Review (MUR). This is one of the reasons I started working with a number of my colleagues on the MUR project (1). The project is ongoing and we wish (in our small way) to engender that self-belief and confidence in what we do as community pharmacists. The lack of self-belief in our role is more prevalent in community pharmacy practice relative to the other practice areas. The reasons for these are numerous but I feel by far the most important reason is that we default to community pharmacy practice when we perceive that we cannot get into other practice areas like hospital, PCT or industry. This is akin to the perceptions that we are pharmacists because we failed in our bid to get into medical school. This fuels an inferiority complex, which has served to undervalue community pharmacy in particular and pharmacy in general. For the new professional body to fully discharge its duties, it must begin to instill a greater degree of self-confidence and value in its members whilst clearly outlining the importance of their roles. We all have choices and maybe we need to start devising methodologies for identifying those who choose to be pharmacists (in general) and community pharmacists (in particular) rather than those who just happen to be there by default.

THE TRIBAL PROFESSION

We are undoubtedly a tribal profession. When Dr Curwain talks about a bunker mentality, it resonates very much with my experience. As a former clinical pharmacist in Southampton General Hospital, I wore this badge of self-importance about the job I have to do. This is no big deal. What was important was that I was enhancing my patients' care. However, what is less helpful is if I start to perceive what I did to be more important than what a dispensary pharmacist in the same hospital does. Or if I were to stretch that even further and say my role, as a clinical pharmacist was more important than that of a community pharmacist. The perception that they (the hospital pharmacists) think they are better than the community pharmacist must be prevalent out there in community practice and may be based on evidence or the inferiority complex described above. The implication is that every tribe retreats into their bunkers and fails to engage constructively with one another. That serves no useful purpose for the patient who is after all at the centre of everything we are trying to do.

I guess some groups will feel threatened by the proposal to invite a wider range of experts to the new pharmaceutical society. These are real fears and must not be disregarded. Personally, I am quite comfortable with inviting a range of allied professionals to the society. This wealth of experience and talent can only add value to the new professional body. For this to work however, the interests of the community pharmacist must be safeguarded. I suggest that the interests of the community pharmacist must be one of the top considerations when decisions are being made. I will now describe why failures to put the community pharmacist's interest at the heart of decision-making in Lambeth (or wherever else we end up) will adversely affect the reputation of our profession, which we are all jealously guarding.

WE NEED A CONFIDENT COMMUNITY PHARMACIST

The community pharmacists are the gateway between the profession and the wider society. They are our representatives to the wider world, which includes our patients, government, media etc. A community pharmacist lacking in confidence can only reflect a profession, which is not confident in itself. To understand how to address the confidence issue, we must understand the needs of a typical community pharmacist patient. To do this I will draw attention to a critical finding from some unpublished work I did on waiting time whilst working as a pre-registration pharmacist in the hospital. It will come as no surprise that inpatients were happier to wait a bit longer for their prescription than outpatients. Outpatients and by extension, primary care patients have entirely different pharmaceutical needs and requirements which must be met. In order to discharge his duty, a community pharmacist must be the expert in understanding these needs and requirements and adopt strategies to satisfy those changing needs. It is only when a community pharmacist successfully does this that the profession start to reap the desired benefits. MUR is a tool, which the community pharmacist can now use to engage with their patients. The community pharmacist must understand its integral role in delivering quality service for the patient and enhancing the profile of the profession. The community pharmacist is the expert at interpreting complex drug issues and presenting it in a way that will be relevant to and make sense to his patient. This is no mean feat. He must not only be clinically aware but must also have the relevant 'soft skills' that will enable him to 'connect' with the patient. Only an expert can carry this off. The question must therefore be how do we make sure our community pharmacists realise their expertise?

To this end, I will offer this observation: A medical student, Mr ABC went to meds school, worked very hard and passed his exams then graduated. He becomes Dr. ABC. He is very proud of becoming a doctor (with the Dr title in front of his name). He continues to work hard and specialises in surgery and at this point he drops the Dr. title and now want to be called Mr. ABC. He will chastise you if you call him doctor. The message here is that something powerful happens to the mind when it becomes recognised as an expert. It stops trying to prove to people that it is knowledgeable but now focus on applying that knowledge to the benefit of its patients. The challenge to the new professional body is to adopt strategies, which will train and recognise the community pharmacist for their expertise. It is only then that the community pharmacist will become confident.

A community pharmacist expert is of great benefit to us all. A professional body, which is widely respected across the wider society, is powerful and various healthcare decision makers will seek its viewpoint. The new Royal Pharmaceutical Society of GB must look after all its gateways to the wider society and community pharmacy is an important component of these.

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1) http://medicines-use-review.co.uk/

**The transitional committee was set up in April 2008 by the Royal Pharmaceutical Society to take forward the recommendation of the Clarke inquiry. That inquiry, chaired by Nigel Clarke — the former chairman of the General Osteopathic Council — and also established by the Society, sought views about the roles and make-up of the new professional body for pharmacy that is being created in 2010.(http://www.pjonline.com/news/transcom_prospectus).