

# The consultant clinical pharmacist's role

Pharmacists Brian Hebron and Emma Graham-Clarke and lead clinician John Bleasdale  
discuss the ideal qualities of a consultant clinical pharmacist

The Modernisation Agency has recently reported on the role of allied health professionals in critical care. The report supported the advent of consultant pharmacists who are experienced specialist pharmacists but do not sacrifice clinical input for managerial duties. "A vision for pharmacy in the new NHS" also seeks to build on the successful development of clinical and specialist roles in hospital by encouraging consultant pharmacist posts.

The developing specialist networks, such as critical care and cancer, require pharmacists of this calibre to develop the clinical role and take responsibility for training.

City Hospital in Birmingham has created a number of non-medical consultant posts and the most recent developments have been in the appointment of consultant nurse specialists. The proposed consultant pharmacist posts we would expect to be filled by exceptional clinical pharmacists. However we would not expect them to have wider general or corporate management roles.

## THE BASIC FOUNDATION

The foundation for consultant nurses was laid down in HSC 1999/217. This circular described four overlapping functions of a consultant nurse: an expert practice function, a professional leadership function, an education, developmental and training function, and a practice-based research and evaluation function. Let us now apply these functions to the role of a consultant clinical pharmacist.

**An expert practice function** Clearly consultant clinical pharmacists will be senior, experienced practitioners who are experts in their field. They will be recognised as a source of advice and information within a region and perhaps nationally. Indicators of this might be requests to act as independent assessors at interviews, or audit of specialties outside their own trust. They will be well integrated into directorate management teams and able to co-ordinate and manage the work of a multidisciplinary team to deliver medicines management. This will include a wide understanding of external issues to contribute to directorates' submissions to commissioners. Consultant practitioners will have the presence and credibility to undertake hospital ward rounds, and present information and advice to consultant staff of other directorates. As an expert, empowered to make judgements affecting patients' lives, consultant clinical practitioners should also have the presence and capability of developing an expert opinion for the courts.

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**A professional leadership function** Within the NHS workload demands will always exceed the resources available. A consultant practitioner will be able to take an overview across several directorates and assign priorities. This will probably involve innovative models of delivery of care and working within the directorate to implement these new models. The consultant practitioner will lead new models of pharmaceutical care, such as pharmacist prescribing. His or her role as a professional clinical leader will be an inspiration to others, in particular, by acting as a role model, and mentor for pharmacists allocated to the directorate. Consultant pharmacists will act as ambassadors for pharmacy. They will establish multidisciplinary links that establish channels for smooth communications, which give similar support to other professionals.

**An education, training and development function** As experts in their field, consultant pharmacists will be expected to share their knowledge and experience with other clinicians. As the training of practitioners in other professions becomes more specialised and they take on extended roles, such as prescribing, there will be a requirement to audit these functions and maintain current awareness of the multidisciplinary team at the leading edge of practice. By recording current practice, such as drug choice in formularies and treatment guidelines, they will move the directorate and networks towards best practice. They would be well placed to serve on local networks and peer review processes. This will add momentum to the continuous improvement of standards and quality.

Some posts may be established jointly with universities. Consultant practitioner posts will help minimise status and salary differentials and support career development between practice, education and research roles in trusts and universities. They will need to be responsive to the aspirations of the directorate, as well as the pharmacy and academia, and aim to reconcile any differences.

**A practice based research and evaluation function** Consultant pharmacists will expect to be the lead for pharmaceutical research and development in their specialty. They will have an academic commitment to teaching or guiding research at a university. To do so they will have developed a track record of scholarship, and the evaluation and application of research into practice. In many cases they will have had formal research expertise, to master or doctorate level, perhaps including successful applications for research funding.

Working as part of the clinical governance arrangements, consultant practitioners will have a key responsibility in pro-

moting evidence-based practice. This will include setting, monitoring and auditing standards to promote quality improvement. Since they will be working at the leading edge of practice innovation they will be able to resolve ambiguous or novel problems that may well create precedents.

Consultant practitioners will establish and develop links with networks to help translate research into widespread practice. This could be part of a local network group or nationally.

## CASELOAD

The above foundations should come together to form the expertise needed to undertake a consultant role. Debate has centred on the notion of "caseload" being attached to a consultant post. However, we believe that a defined caseload is not necessary to achieve consultant status.

Pharmacists, who lead outpatient clinics will be used to having their own caseload. This enables a measure of workload but not necessarily a measure of broad expertise that might be expected of a consultant.

There are an increasing number of nurse-led clinics that are not led by consultant nurses. Whether or not there is responsibility for particular packages of patient care cannot on its own lead to a practitioner developing into a consultant. Many consultant medical staff, such as medical microbiologists or clinical pathologists, do not have a distinct caseload. A more pertinent analogy might be to consultant anaesthetists, who might not have their own caseload but have an essential area of expertise in caring for patients.

## CONCLUSION

An exceptional clinical pharmacist will already be able to deliver packages of care in a patient-focused manner. The single most important factor whereby others judge a pharmaceutical service is whether or not the right medicine is available when needed. Consultant pharmacists will identify with this. As good clinical pharmacists they will have developed an expert brokerage function. They will manage the relationships to provide a seamless link from the supplier of medicines to the patient. This will require personnel management skills and professional leadership. Negotiating and arbitration skills will be important to ensure the multidisciplinary team functions to provide a full medicines management programme for the patient.

As legislation on prescribing catches up with practice, consultant clinical pharmacists will expect to lead in this area. The advent of supplementary prescribing heralds the next stage in the process.