

Baby clothes, sandwiches and T-shirts spoil pharmacy's professional image

What follows is based on the valedictory address to the Royal Pharmaceutical Society's Council on 10 October given by **Alexander Florence**, former dean of The School of Pharmacy, University of London, and emeritus professor of pharmacy. He told the Council that the profession has much to celebrate, but that pharmacy's image on the high street continues to let the profession down

The Royal Pharmaceutical Society has been part of my life for much more than the 40 years that I have been a member of it. It permeated my consciousness for many years before that, as my father, Alexander Charles Gerrard Florence, was a pharmacist, a product of the Royal Dispensary School of Pharmacy in Edinburgh, and for a time we lived above the family pharmacy. The particular aroma of a 1950s pharmacy and the sounds, too, permeated the home.

This connection undoubtedly influenced my son, who is also a member of the Society and senior lecturer in pharmaceuticals at the University of Strathclyde. Academic pharmacists, contrary to popular belief, do practise pharmacy, perhaps in eccentric ways, but they are also occasional patients, frequently parents, always observers and inveterate travellers. Their views outside their true and linked metiers of education and research therefore have some substance.

Practising pharmacy

I have practised community pharmacy although this was some time ago. But I have mainly practised elsewhere, where I have not been a direct danger to the public. In my daily work — and certainly on the Committee on Safety of Medicines as it then was — I practised pharmacy. Only recently I was discussing future trends in medication and in particular the need for dosage systems so that personalised medicines could be become a reality, and neglected groups like children medicated appropriately. Time was when we academics had difficulty to be regarded as practitioners at 1 Lambeth High Street.

A number of weeks ago, a paper bag fell out of my copy of *The Pharmaceutical Journal*. The bag was jokingly supposed to cover your embarrassment when you entered Superdrug to seek employment. Apart from the own goal of the wording and the fact that the bag was fit only for a *Homo floriensis* skull the bag is somehow emblematic of what I want to say. First, can one imagine such an object falling from *The Lancet* or the *BMP*?

In 2000, I gave a talk at the College of Pharmacy Practice, rather presumptuously entitled "The folly of presumption and Pogo's prediction". The presumption element related to the fact that in pharmacy we have made errors predicting the future, eradicating subjects like pharmacognosy and much practical work from our undergraduate courses so that



Sandy Florence: Sometimes "we are our own worst enemy"

now some graduates are terrified of doing anything remotely pharmaceutical. Even *The Lancet* recently (2006;368:260) had an editorial pleading: "Don't forget pharmacognosy!" Arguments rage as much as they do in academia about the value of practical dispensing. Once we misjudge it takes decades to rectify, but by that time others can jump into the breach. The title also quoted the character Pogo and his call to action: "Resolve, then, that on this very ground with small flags waving and tinny trumpets, we shall meet the enemy and he not may be ours, he may be us." His prediction, then, "we have seen the enemy and it was us" resonates with me in relation to pharmacy. The paper bag epitomises it, but by far and away the greatest issue I identify is that of the effect our community pharmacies, has on the public, fellow health care professionals, law-makers and others of influence.

Many community pharmacies are devoid of style, aesthetics, order, identity even. We are in this respect our own worst enemy. It is difficult to convey the image of the true professional through the baby clothes, the Coca-Cola, sandwiches and medium of the T-shirted pharmacist. Specious arguments are used to justify but not explain the extraneous items that infiltrate our pharmacies and confuse identity and purpose.

Those who spend time in France, for example, can compare French pharmacies with ours. In Corsica — which, although a French department, is perhaps not the most progressive in France — two pharmacies that I know in the small town of Porto Vecchio sport ro-

botic dispensing stations. One, in fact, has three. That and their distinctive appearance marks out these places as pharmacies.

If we believe that the image we project is of no consequence I can attest that it does affect perceptions. It certainly affected decisions at the Committee of Safety of Medicines, slowing down approval of pharmacist-reporting of adverse reactions, or the transfer of medicines from POM to P. One senior clinical pharmacologist not known for his wit once said, tongue in cheek, when I opined that the ability to buy medicines in filling stations was hardly the best way to proceed, that you get better advice in a garage.

The medical hierarchy's view of pharmacy has been difficult to change, possibly because of what they have witnessed. Through the efforts of clinical pharmacists in the NHS and their undoubted abilities, gradually but reluctantly changed the tone of some publicly uttered views, but fundamentally the view was of a profession whose motive was turnover and sales. This might be viewed as rather rich from a highly paid profession, but prejudices are rarely logical.

Rules can be stultifying

When are we going in our profession to act on gut-feeling, on inspiration? It is, of course, against the precepts of evidence-based practice to do any such thing. Historically we have been excellent at developing rules and regulations for ourselves. Some are convinced that following these to the letter is the mark of a professional, whereas rules can be stultifying. They are the refuge of the timid. We have so much to offer — as the Nuffield Inquiry report said 21 years ago — but the potential needs still to be unleashed. Drop the tinny trumpets. Hoist the massive banners.

Many pharmacists, unlike their community colleagues, work out of the public gaze and one feels that in our publicity we are too community-centric. Perhaps that needs to be but, if so, that image must be improved. There are, of course, many individual examples of community pharmacies with exemplary design and standards, but these are few and far between. We are the enemy. We must promote and enthuse pharmacists and strengthen the image of community pharmacy. Community pharmacists must be seen to be part of a community of pharmacists who work in industry, in hospital, with physicians, in government and in universities.

I have often been introduced in polite company as a professor of pharmacology, which I am not. A head of a medical school in London, since knighted, said to me, only a few years ago, that he could understand why we need pharmacists in industry and even in hospital but that he could not see the need for them in the community.

Where does one begin to answer and how is it that we have not put across the message that if we did not have pharmacy we would need to invent it? And if we did not have enforceable professional ethics we would need to invent them. One only needs to look at pharmacy in India to realise that to have pharmacy is not enough, but that high professional and educational standards are required. In Myanmar, having fewer than 100 pharmacists in the whole country led to illegal importation and sale of medicines by unqualified traders, no quality control, no regulation; one realised the need for us. Pharmacy as a profession is needed in regulation, in quality control, in manufacture, in distribution and in primary and secondary care. We need to use such basic arguments as a beginning, because people still question what it is we really do.

Where are our knights, our dames?

Where are our knights, our dames, our lords? Where is our influence in high places? Is this Society structured so that the luminaries of the profession have their say, or are we not allowed to have such because we are a humble profession? Or are we a profession that simply cannot decide what it is?

My elementary proposition goes as follows. The impact of pharmacy imprinted on the subconscious of the public derives from the community pharmacy. This, in turn, moulds opinion of what pharmacy is and attracts students who find that environment satisfactory, while it deters talented young people and especially young men good at science. Hence we attract undergraduates whose attitude to their studies is already biased and, while many of them are clever, many find their science too difficult or, more likely, unconnected with their image of the need, and stampede for topics where soft concepts abound and hard answers are difficult to define. The articulate among these students gravitate towards the British Pharmaceutical Students Association, become officers and, before they know it, are elected to the council. This leads to attempts to change pharmacy education from an excellent science-based course into a practice-based subject, without that rigorous definition of practice. It can be an alluring option, especially in these days of the shortage of highly qualified academic pharmacists and the mushrooming of schools of pharmacy. If they succeed, not only will our schools lose their international standing, the profession will not be prepared for the future that is only now unfolding.

Medicines are much more complex than they were or were perceived to be even 10

years ago and certainly when I was studying pharmacy. We find out much more each day about the human organism. It behoves us to tackle the future quickly. We predicate our decisions today on estimate of what the future will be. If we wait for the evidence, as our profession could do, it will be too late and others will be there in the breach. May I suggest that the Society urgently appoint a futurologist?

Think-tank needed

We need a think-tank speculating intelligently what the future might look like, not only in the way we use electronic communications to free us for our technical tasks but how medicines will change and how we are to prepare ourselves for that future of stem cell therapy, gene therapy, *in utero* therapy and personalised medication. What educational preparation do we need for that future? It is not, I would posit, one that starts with coughs, colds and haemorrhoids and GSL medicines for minor ailments, nor is it necessarily the possession of prescribing powers, because none of these are distinctive and unique to pharmacy.

I think we need to trumpet what we are and what we have achieved in health care: we must throw away our tinny trumpets for trombones. We must recruit our champions to the cause and enthuse our future pharmacists. We need a new intellectualism and robust debate. Where are the voices raised, for example, about the creeping corporate takeover of our profession? How many decisions on our future will be determined in board rooms rather than in the melting pot of professional debate? The truth would do no harm.

A profession unaware of its heritage is emasculated. What do David Jack, John Stenlake, Malcolm Stevens, Patrick Humphrey and Roy Brittain have in common? All are pharmacists, all discoverers of drugs. Asked another way, what have salbutamol, temazolamide, atracurium and sumatriptan in common? There were all discovered by pharmacists. How many on the Register are aware of all this? This is not an exhaustive list — only people I know or knew. How many British pharmacists are internationally known for their science? British clinical pharmacy is envied in Europe, and many of its practitioners are on the European stage at least. This Society through its publishing arm makes a huge intellectual contribution to health care. So we have much to celebrate. But still on the high street I sometimes look the other way.

We need our science more than ever. We need pharmacists who can do things, other than put their hands on fevered brows and counsel patients. They must be able to do things with their hands, even to make medicines. Surgeons after all get their hands dirty, bloody even, and have quite a reasonable standing in society. John W. Gardiner said: "A society which scorns excellence in plumbing simply because it is plumbing but rewards

mediocre philosophy simply because it is philosophy will soon become a society in which neither its pipes nor its theories hold water."

We need to reinject research as a norm into practice. The School of Pharmacy set up with committed staff at Great Ormond Street Hospital and the Institute of Child Health a Centre for Paediatric Pharmacy Research to provide an academic underpinning to practice and at the Royal Free and University College Hospitals instituted a chair of clinical pharmaceuticals. I believe we fundamentally need practitioners who can perform the exciting basic function of the pharmacist. Producing medicines for individual patients for the future must move in that direction. The folly of past prediction is to say that extemporaneous pharmacy is dead. The crude science versus practice debate needs refining. What is science and, more importantly, what do we mean by practice? That requires us to define what we are as a community of pharmacists and to appropriate the role as guardians of the quality of medicines and quality of outcomes.

Academics need to engage not just with the theory of practice but with bringing the science of medicines to bear on daily practice. And there is plenty for pharmacist of the future to do: undertaking highly technical analyses for patients (so analytical chemistry in schools of pharmacy is not dead) and preparing personalised technologies such as three dimensional printing or nanoparticle-based systems (similarly, extemporaneous dispensing and formulation are not dead). Ultimately a research-based ethos, this will allow each prescription to be the start of a mini research project, insisting on follow up to complete the picture.

Centre for health

Our pharmacies could be recognisable centres for health, where the public could tap into the broad scientific knowledge of our graduates and use their technical skills in ensuring the future of personalised medicines in the post-genomic era.

I am more and more convinced of the value of what we do collectively, but I am frustrated that we do not always convince those in high places. We must promote this community to which we belong and support those who wish to experiment with their practices. An impeccable, modern, clinical pharmacy near the Houses of Parliament might be the best advertisement that we could ever have. Then we would be not the enemy but the force that we should be.

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