

BRITISH FORCES PHARMACEUTICAL CONFERENCE

Pharmaceutical services in the armed forces under the spotlight

"Managing risk in a risky business" was the title of the inaugural British Forces Pharmaceutical Conference held in Germany on 5 and 6 December 2002. Sonia Sanghani reports

Brigadier LOUIS LILLYWHITE, director of British Forces Health Services in Germany (BFGHS), emphasised the fact that clinical governance has implications not only for the National Health Service but also for the armed forces in both the United Kingdom and Germany.

BFGHS is an integrated primary, community and secondary care service similar to that provided by a UK local health authority, but with important exceptions. All secondary care is contracted out to designated German hospitals and monitored via Guy's and St Thomas' Hospital in London. There is a close partnership between agencies that set and monitor requirements and those that deliver. Clinical governance is integrated into service provision with standards broadly similar to those mandated for NHS and the Ministry of Defence.

One weakness of the current service is the lack of information technology to incorporate evidence-based medicine into daily practice. However, despite this, per capita costs are broadly equivalent to those for England and Scotland, with drug costs at around £2.6m.

Brigadier Lillywhite asked: "With respect to clinical governance, what standards should be used for peacetime, and are these applicable in wartime?" UK hospitals are not used to dealing with major trauma incidences: the side effect of this is that people die. If surgeons and other health care staff do not gain enough experience of dealing with wartime issues in peacetime, more people will die at the beginning of a war until health professionals go through the "learning curve" — NHS hospitals will appear to perform badly if all they deal with are small numbers of localised events over a long period. Therefore, although it is fair to state that peacetime standards should apply to the armed forces as part of the clinical governance agenda, training health professionals to achieve high standards during war and trauma must also be a priority.

Brigadier Lillywhite further criticised the emphasis of clinical governance on the process rather than the end result (outcome) and suggested that, although the process is often environment dependent, the end result should not be. Hence, a soldier being operated on in Iraq in non-optimal conditions should have as equal a chance of survival as a soldier operated on in Germany or the UK. He said that undue concentration on the process might therefore inhibit progress and innovation and be counter-

productive in wartime situations. Legally, courts are usually reluctant to interfere if there is a negative impact on operational effectiveness in the field.

Legislation has yet not caught up with Health Service changes and Brigadier Lillywhite urged health professionals to educate, and interact closely with, the legal profession rather than submissively accept laws that do not take into account the circumstances under which the armed forces, for example, operate. When asked his opinion on some medical professionals' stance that clinical governance and evidence-based medicine interfere with medical intuition, he stated he held no sympathy with that view. He agreed, however, that the concepts restrict experimentation but even experimentation had to be conducted in a proper, ethical and valid manner.

ARMED FORCES AND THE LAW

Major GRAHAM STEWART, SO1 Medical Policy Directorate, Defence Medical Services Department, London, stated: "Within the armed forces there are no absolute legal right or wrong answers for what we do. We have a professional responsibility and a legal responsibility and we have to be careful not to confuse the two." The legal aspect of pharmacy within the armed forces is a Pandora's box, he said. It is a multi-layered problem and often not one answered easily. UK legislation has been written in a piecemeal manner, dealing with issues as they arise and designed to put barriers in the way of untrained people acquiring products that may do them or others harm. The products we deal with today are indeed capable of causing harm, especially when inappropriately prescribed or prescribed off-licence. The Medicines Act is not static; it is possible to have amendments put in to reflect circumstances.

The situation for BFGHS is complicated. What does a forces pharmacist do when faced with an ethical question in Bosnia? Pharmacists and pharmacy technicians in the military have to be more reliant on their own judgement and personal ethics. Their



Brigadier Lillywhite: legislation has not caught up with Health Service changes

training has to enable them to be flexible in their approach to assessing clinical, patient and legislative risk. Which legislation should be followed —UK, EU regulations (these are automatically binding), professional codes of conduct and practice or German regulations? Although Crown Immunity was withdrawn from the Ministry of Defence in 1991, a clause was added (the Marleasing principle) which stated that legislation is not binding unless it specifically says that it is. The amended areas of the Medicines Act do apply to

BFGHS but the question remains "what are the chances of me being caught and what are the professional consequences?" The Royal Pharmaceutical Society's powers do not extend outside Great Britain. Ministry of Defence pharmacies are not registered premises and the Society's Code of Ethics is written to reflect UK practice. MCA powers cover the UK only. Neither of these bodies has international powers and will not send inspectors to regulate practices in Cyprus, Germany or elsewhere. This leads to a dichotomy: what is regarded as safe, acceptable practice in the UK and what is abroad? An example of this is the application of patient group directions in the military. At present there is no legal cover via a PGD for the role combat medical technicians (CMTs) perform in peacetime or will be expected to perform during wartime. The jurisdiction applies to the UK and not in Germany, but mobility of CMTs means that duties performed in one country suddenly become illegal in another. How are the skills and ability of UK-based CMTs to perform their roles in wartime situations to be kept to a high standard?

Major Stewart concluded that there was a greater need for audit and benchmarking as a justification and lever for change within the armed forces. He stated that the whole legislative and regulatory environment is in a state of flux. In most cases, the Ministry of Defence was ahead of the NHS (eg, use of standard operating procedures within dispensaries), but constant dialogue is required to ensure it is not left behind in case legislative immunity is totally lost or regulatory bodies' jurisdiction increases geographically.

Brigadier LILLYWHITE confirmed that armed forces health professionals must understand the difference in consequences of professional misconduct and a criminal act. The Ministry of Defence will only indemnify employees for activities considered as performed within the course of their duties.

THE WAR AGAINST DISEASE

SULTAN DAJANI, a member of the Council of the Royal Pharmaceutical Society of Great Britain, drew parallels between armed forces and health care professionals. He said that health care professionals are highly trained to fight the war against disease with more and more highly technological weapons. Our roles have also shifted over time; in some instances we adopt defensive strategies, ie, prevention, and in others offensive strategies, ie, cure. There are regulatory minefields in our path that have to be negotiated successfully and innovatively while reducing risks to patients. Pharmacists and pharmacy technicians within the armed forces and the NHS are an under-utilised resource and undervalued politically — their future roles are not just limited to dispensing. He said: “We are currently fighting the battle with only half the weapons in place,” and suggested that continuing professional development, audit, evidence-based medicine, risk management and revalidation are all part of our armoury. Winning a war is all about planning. He warned participants “if you fail to plan, you plan to fail”.

TECHNICIANS’ INVOLVEMENT

HELEN DALRYMPLE, education officer, Association of Pharmacy Technicians, UK, highlighted the issues of quality training programmes for pharmacy technicians in order to perform their future roles. There are a variety of providers and the question arises as to who should accredit these. Should there be local or national frameworks of accreditation to ensure standards are applicable and recognised by employers across the UK? The incoming registration



Sultan Dajani: fighting a battle with only half the weapons in place

and regulation for pharmacy technicians will be beneficial but will also bring about more responsibilities. There will be an impetus on trainers to provide evidence of maintaining their own training skills up to date to ensure that all pharmacy technicians registered are competent and responsible to take on appropriate roles.

CHEMICAL AND BIOLOGICAL WEAPONS

PATRICK DOYLE, regional pharmacist, Hohne Region, BFGHS, reminded participants of a quote from Professor Fritz Haber, pioneer of gas warfare, on receiving the Nobel Prize for Chemistry in 1919, in which he stated: “In no future war will the military be able to ignore poison gas. It is a higher form of killing.”

Chemical and biological weapons have been used since 1847 during the India mutiny when British soldiers threw blankets from corpses who had died from smallpox into the water wells of rebels. Their chequered history covers the 1914–18 and the 1939–45 wars, as well as more up-to-date events, including Tokyo 1990–95, events after 11 September 2001 in the United States and the current situation over accusations against Saddam Hussein stockpiling weapons of mass destruction.

Mr Doyle illustrated the similarity in symptoms of the main weapons (anthrax and smallpox) to common infections and asked participants whether they would be in a position to differentiate between influenza and anthrax or *Herpes zoster* and cutaneous anthrax. He saw the main role for pharmacy as an educational one to assist the general public and health professionals in understanding risks and initiating appropriate prescribing. He recommended more debate about how to prioritise treatments: in the case of attacks such as these, the first port of call is the health professional rather than police or fire services. Many questions remain unanswered regarding the logistics of product procurement and storage and pharmacists must get involved in disaster management planning from the outset. Community pharmacies may have to act as

distribution centres for treatments, vaccines etc. Current limited opportunities for training in such areas is restricted to the US and Mr Doyle challenged training bodies to be more proactive in fulfilling training needs of community and hospital pharmacists with regard to this issue.

INTERVENTION AND ERROR REPORTING

Dr RICHARD ALLEN JUNEAU, family practice pharmacist, Landstuhl Regional Medical Centre, Germany, illustrated the American approach to clinical intervention and medical error reporting developed by his team — CLIMERS, a networked software program enabling data entry via personal data assistants (PDAs), enabling mobility of pharmacists throughout medical centres. A major requirement was educating staff involved in the prescribing, dispensing and administration of medicines. Because of varying levels of staff computer literacy, the system was made as easy to use as possible. Since introduction, error reporting has gone up markedly: 459 medication errors, 122 clinical errors and 100 hours required to resolve issues. Patients are appreciative of the efforts made and have begun to interact more with pharmacists to assist clinical decision-making. For the most part, doctors are also satisfied but some still do not accept they make mistakes. Since the pilot phase, the system has been developed to fit the regional computer hub servicing 45 American forces pharmacies throughout Europe. It is, therefore, possible to track a soldier's medication history from Kosovo to Frankfurt and back to the US to inform health professionals of drug history, allergies etc. It is a good system clinically; the next area of improvement involves better assessment and projection of costs.

PRIMARY HEALTH CARE IN THE FORCES

Major LIZ MORGAN, SO2 Pharm, Primary Healthcare Implementation Team, Army Medical Directorate, Surrey, defined primary health care within the armed forces as including general practice, rehabilitation, occupational health, health promotion and environmental health, but excluding battle casualty management on operations. An investigative team looked at how primary health care services could best be delivered in the army and made over 200 recommendations. The structures are less than perfect with regard to information technology, medical centre buildings standards and accommodation as well as reports of practitioners working outside their competencies. During operations, 10 per cent of personnel are regarded as non-deployable; better rehabilitation facilities are required to remedy this. Cuts in infrastructure and training for health care personnel need to be reconsidered in order to improve recruitment and retention. The armed forces are divided into seven UK-based regions, five in Germany, one in Cyprus and one covering the rest of the world. The army's clinical governance framework closely models that of the NHS. The UK Primary Care Implementa-

CHURCH HOUSE

The 35 British, American and German pharmacists and pharmacy technicians (based in Britain and Germany) who attended the conference met in the historical Church House, located in Luebbecke. The conception of such buildings dates back to 1916 when their function was to train chaplains to survive the horrors of war. Church House in Luebbecke was built during the 1939–45 war for Hitler's purposes until Field Marshall Montgomery converted it into a training centre for the controlling Allied Forces in 1945. Since 1983, it has been used as a conference and training centre primarily by British Forces in Germany.

tion plan started in October 2002 and encompasses five phases. Lessons learnt from the pilot phase will be incorporated into future phases to improve processes and outcomes. The major pharmaceutical care problems are the lack of trained dispensing personnel, lack of awareness of medical officers as to their roles and responsibilities, limited PACT data and limited professional support to the primary health care team via pharmacists. Their risk management strategy has taken these aspects into consideration with the establishment of new posts: lieutenant-colonel and major posts at head office level, four major posts for regional pharmacists and civilian grade E posts for practice-based pharmacists. The final strength of the army primary health care pharmacy team will be 145, made up of new and existing posts — a mixture of pharmacists, technicians, and military and civilian

personnel. Each practice and region has been allocated pharmacy technicians and pharmacists providing practice-based prescribing advice, performing audit and identifying training needs. PGDs are also a way forward as could be outsourcing of dispensing or centralising to one GP practice.

Funding for the implementation plan is an issue but is being worked on. In developing the plan the army tried to take a pragmatic approach in deciding what was the gold standard, what was achievable and what was applicable to the Army Medical Services environment.

CONCLUSION

American pharmacists are recognised in all three services (army, air force and navy). Germany currently has 290 pharmacist posts within its forces. The Primary Care

Implementation Plan has opened up the forces to the pharmacy profession, with the Royal Navy and Royal Air Force coming around to the idea of trained pharmacy technicians and pharmacists within their services, but there is still a long way to go. The success of experiences shared within this inaugural conference will set the scene for further conferences, hopefully integrated with Air Force and Navy, in order to spread best practice throughout the three British services. SULTAN DAJANI said that forces health professionals have tended to be ignored by the Royal Pharmaceutical Society in the past and it was inspiring to see pharmacists at the forefront of quality improvement. The UK needs to catch up with other countries in the importance and relevance placed on pharmacists' abilities and their valuable position within the health care team.