

Representation on Council

— the hospital pharmacy voice will be heard

By Colin Ranshaw, FRPharmS

Lack of hospital representation on the new Council of the Royal Pharmaceutical Society has been a concern expressed both in the pages of *The Pharmaceutical Journal* and *Hospital Pharmacist* since the results of the election were announced in April. I am a member of the new Council and have been an employee in the hospital pharmaceutical service for 30 years and I will try to address this concern in a constructive manner.

The Society's modernisation steering group spent many hours discussing what the composition of Council could, and should be, and started with an almost blank sheet of paper. One aspect was a given — there had to be more lay members than there had been. The remaining places and numbers were debated, with consideration being given to:

- Reserved places for geographical regions and specialist fields of practice
- Having a nominated/appointed group following Nolan principles
- A mix of the above
- Reserved places for the three chief pharmacists of the home countries
- Reserved places for academic and industrial pharmacists

This discussion was presented for consultation to the profession through the pages of *The Pharmaceutical Journal* in June 2002. I have no doubt that many individual hospital

Colin Ranshaw is principal pharmacist, quality assurance and control, St Mary's Pharmaceutical Unit, Cardiff and Vale NHS Trust and a member of the Council of the Royal Pharmaceutical Society

pharmacists and the Guild of Healthcare Pharmacists put forward views in a forceful and constructive way at that time.

Reserved seats

Hospital pharmacists represent 19 per cent of the workforce (65 per cent in community, 2 per cent in academia, 4 per cent in industry and 7 per cent in primary care), so should we always insist on having 19 per cent of the Council seats? To attempt to have all areas of practice and expertise reflected in Council would be impossible through an electoral system without having a disproportionately large Council and the enormous costs this would incur.

Council is a high level, strategic, policy setting, executive board which should demonstrate the qualities of visionary leadership and statesmanship for the good of all the profession. The minority specialist areas of practice underpin the majority areas of practice, and it is impossible to have one without the other. As the practice of pharmacy becomes more and more specialised, Council will have to find other ways of consulting and drawing on this expertise. Council members themselves must be the advocates and not necessarily the experts.

My vision, which I presented to Council in 2000, uses the model of a three legged milking stool. The seat of the stool is Council, the legs are the Welsh, Scottish and English executives (proposed boards). This gives a stable structure made even more robust with the spells between the legs being the expert groups and committees. For example, the Society has a practice division whose director is David Pruce. Hospital, community, industry

and veterinary sub-committees feed advice into the division's working. The required levels of expertise must come from the groups or, when necessary, ad hoc working parties.

We have the Council, rightly or wrongly, that the profession decided upon. If it is not what some would have voted for then we have only ourselves to blame. Only two pharmacists employed in the hospital sector stood for election. Why? Should the guild be more proactive in promoting nominations from their colleagues?

As the practice of pharmacy becomes more specialised Council will have to find other ways of consulting and drawing on this expertise

As the only hospital pharmacist on Council, I am not entirely sure what some people mean when they describe me as "not currently working in a clinical hospital setting" and "not involved in the delivery or management of clinical pharmacy services". My memory of hospital pharmacists on Council includes only managerial pharmacists rather than clinical pharmacists: Colin Hitchings (regional pharmaceutical officer), and Ann Lewis, Helen Howe and Alison Ewing (all chief pharmacists). Experienced pharmacists are not born overnight, and it was the insight these pharmacists gained from working in different areas

of practice that provided them with a broad perspective. Hospital pharmacists training today are not rotating through all specialties because of the introduction of the clinical diploma. It is surely time for us to consider a hospital pharmacy diploma seriously so that all pharmacists have a rounded experience before following what are now becoming the inevitable specialist posts.

Quality control

I hope that the preconceptions that people may have about a quality control pharmacist based upon their own experience in laboratories has not clouded their view. Quality control is not about some "nerd" being at the sharp end of a burette, but rather it involves delivering patient services to clinical areas. I am constantly being consulted by pharmacy, medical and nursing colleagues for advice help and support to meet the needs of patients in their care. I regard my job description more as a "clinical pharmacist" and pharmaceuticals is what makes us as pharmacists unique and indispensable.

Finally, may I remind readers of three greatly respected hospital quality control pharmacists: V'Iain Fenton-May, Frank Haines-Nutt and Ged Lee. These pharmacists have given so much of their free time to make the guild the respected organisation it is today. I hope to contribute as much to developing the Society. We do continue to have a voice on the Council of the Society, but I encourage all hospital pharmacists to continue to contribute to the decision-making processes through specialist committees and by voting in future elections.