

As pharmacy moves towards 2020, will it remain a profession of equals?

In this ninth and final article leading up to a consultation about the Royal Pharmaceutical Society's Pharmacy 2020 project, Clive Jackson, chief executive at the National Prescribing Centre, lists the questions to be considered in developing a cohesive, effective strategy for the profession

Pharmacy has been evolving slowly, for more than a century, into the profession we know today. In that time, there has been a range of major professional challenges that pharmacy as a whole, and each pharmacist as an individual, has had to adapt to.

For example, since the NHS was born, we have seen:

- Professional practice moving from predominantly in-house compounding of medicaments, towards the dispensing of bulk manufactured and prepackaged products
- Professional freedom being impacted upon by implementation of the Medicines Act regulations, from 1968 onwards
- Greater clinically oriented pharmacist input into the monitoring and optimisation of patients' medicines, after prescribing by doctors
- Increased variety and potency of medicines being made available for sale over the counter
- More systematic use of pharmaceutical skills to improve the strategic management and use of medicines across the NHS — the pharmaceutical adviser role

The product-focused pharmacist

The response to all but the last of these challenges has largely involved the profession refining or expanding its primary and historical professional role, namely, ensuring the safe and efficient supply of medicines and advice to patients. It is true that there has always been diversity in service development and delivery between pharmacists practising in the community and those working in hospitals — our main historical intraprofessional division. However, the common professional bond remains the fundamental requirement to supply the right medicines to individual patients at the right time.

On the other hand, the challenge posed by the emergence of the pharmaceutical adviser role involved pharmacists moving off their home ground and into the less ordered world of health care management. This environment creates new challenges around doctor/pharmacist and pharmacist/pharmacist relationships, plus the discomfort of the pharmacist/cost-containment dynamic.

The population-focused pharmacist

This latter challenge has also seen pharmacists moving away from the usual, one-on-one patient/professional relationship towards



the requirement to consider optimum use of medicines and medicines funding on a population basis. In a small number of cases, taking this perspective when decision-making can mean that some individual patients (however few) might perceive themselves as disadvantaged.

Being a pharmacist employed to provide professional and management advice to health care organisations and other professionals has, on occasions therefore, put such individuals into potential conflict, where they have to balance their historical professional instincts towards individual patients (and the profession), with the strategic need to consider what is best for the population served as a whole.

The development of this advisory role also led such pharmacists into the area of local planning, development and management of the "contract" that pays community pharmacists. This has given rise to sometimes heated internal professional debates about capability for such a task and their broader loyalty to pharmacy.

The development and expansion of pharmaceutical advice in primary care over the past 15 years has, therefore, to some extent, inevitably divided the profession in a different way than previously seen.

Nevertheless, pharmacy overall has now embraced pharmaceutical advice as a new and strategically important development for the profession, which allows pharmacists to influence health care policy and planning at local (and often national) level to a much greater extent than previously possible. The fact that there have recently been up to 2,000 pharmacists providing pharmaceutical advice shows the perceived value of this role outside the profession and also the willingness of significant numbers of pharmacists to embrace the challenge on offer.

What is clear, across all the examples of challenges cited, is that pharmacy has ultimately achieved (albeit often slowly) the necessary internal change to accommodate them, usually by employing an evolutionary, rather than a planned, process. Fortunately, pharmacy has, by and large, remained united and

tolerant of a range of professional divergence. However, adaptation techniques that have worked moderately well for the profession in the past, may no longer be adequate for meeting the challenges of the early decades of the 21st century, some of which are already visible on the horizon.

The patient-care focused pharmacist

A number of forthcoming challenges are already starting, or have the potential, to change fundamentally the equanimity and delicate harmony within pharmacy in a way not seen before. Flux on such a scale could create the conditions where permanent fissures (as opposed to divergence) in the profession might occur, and this may ultimately lead to the demise of pharmacy as we know it.

So what are these forthcoming challenges?

- Development of new services and independent clinical roles
- Development of new diagnostic and examination (medical) skills
- Requirement for formal registration of new specialist competencies
- Development of a new regulatory framework and registering body
- Development of new professional leadership and development organisation(s) and support
- Emergence of active competition between clinical professionals, when developing and delivering patient care

The relative risk of any fundamental split in the profession (and therefore any damage or benefit), will ultimately boil down to the number of pharmacists who become clinical modernists compared with those who remain dispensing traditionalists. It will also depend on the vision, strength and timeliness of strategic leadership within pharmacy over the next five to 10 years.

We should remember that, in part, both medicine and pharmacy emerged, as separate professions, out of the original combined role of the apothecary — could we be approaching a new, equally seismic (and not dissimilar) fracturing of the pharmacist's role?

To help answer this question, we need to consider the impetus and imperative for change, especially that emerging from the enactment of new regulations enabling pharmacists to prescribe almost any recognised medicine independently of another profession's input.

What is the issue? Well, in the short term, most pharmacists probably think that the emergence of independent prescribing responsibilities is broadly a good thing, and long overdue recognition of the detailed pharmaceutical knowledge and skills inherent within the profession. It is seen as something only a small minority of pharmacists are likely to be undertaking, in the short to medium term, and, as such, not of primary relevance to the mainstream of the profession.

Dismissing this major new opportunity as little more than a fringe activity for pharmacy could be a major strategic miscalculation. Why? Because health care provision in the UK is undergoing extensive reform and pharmacy will have to respond in a planned and proactive way to survive and prosper.

The relevant key driving principles of the reforms include:

- Regulating professionals in a more uniform and transparent way, which makes the patient and public interest paramount
- Removing unnecessary historical demarcations between the professions and their practices
- Changing payment for service delivery to a system based predominantly on quality and patient outcomes, rather than on volume and throughput
- Increasing the range of service providers and engendering competition between them (the “generic professional battleground”)
- Providing patients with much wider choice of high-quality service provision and, therefore, improving convenience

As a result of these reforms which are already partly in place (eg, the latest community pharmacy contractual framework), pharmacists' are having to extend their historical dispensing, supply and advisory roles. However, attention now also needs to be given to the likely (and necessary) emergence of a new style of clinical expertise and an alternative professional ethos in pharmacy.

To deliver pharmacy's true potential over the next 50 years, and build on the excellent work we have done in the previous 50, the profession needs to move its centre of gravity significantly towards delivery of “treatment-initiating, patient care-managing” clinical practice and rely much less on the “product- and volume-focused, patient supply and advisory” functions that dominate pharmacists' activities today.

This change would require broad acceptance and agreement among a substantial proportion of practising pharmacists, that the profession should become much more hands-on with patients and the public. Thus, there would be a requirement to develop and refine broad diagnostic and consultation skills, plus medical examination techniques, while linking them to new prescribing responsibilities and some of the more traditional pharmaceutical skills.



All pharmacists are equal . . .

All pharmacists are equal now, but some will become more equal than others. Many pharmacists (especially those who have been qualified the longest and, therefore, who are most likely to have influence over change in the profession) will feel, at best, uncomfortable by such a shift — patients are often seen as people best interacted with at arm's length, across the counter. Others will wish to see rapid and widespread movement in the hands-on direction.

If this shift does not happen, the current pharmacist's role could arguably become slowly redundant as it is (rightly?) squeezed between “up-skilled” and less costly technicians taking on responsibility and accountability for technical and professional dispensing tasks, and the clinical aspirations of other, potentially more outwardly ambitious and vigorously led professionals, such as nurses.

If accepted, the change would, however, require a fundamental revamp of the undergraduate curriculum, preregistration training programme and postgraduate development framework — in short, radical modernisation of part of the foundations of today's profession. Such modernisation would take time in the most motivated and focused of professions but, historically, even limited educational change has often taken far too long within pharmacy. The fact that our professional body is currently being forced to put much of its efforts and resources into reconfiguration could make educational change even harder to achieve.

The alternative to this radical change would be to split the undergraduate curriculum and preregistration training programmes into two distinct levels — although this

might be seen as a slippery slope to the profession fracturing permanently.

Probably of equal importance is our need to consider the impact of independent prescribing, together with the ad hoc, out-sourced development of new diagnostic and examination skills, on the dynamics within the profession and the potential for creation of an expanding elite in pharmacy. The flip side to this is the emergence of an underclass of pharmacists who work to a different level of competencies, and who increasingly become indistinguishable in practice from leading-edge (registered) pharmacy technicians, other than by salary.

How will these two elements of the profession decide to interact with each other? Will pharmacy find a way to maintain them under one professional umbrella in the longer term? Will the emergence of a new style of pharmacist be good for the profession as we know it, or will it lead to argument, mistrust and ultimate fracture?

A 20:20 vision for pharmacy

These are some of the questions we now have to consider in looking to develop a cohesive and effective strategy for the profession leading up to 2020.

Some decisions will not be comfortable and some will have detrimental effects on existing pharmacists and their current practice — that is the nature of the rapidly changing environment that we work in today.

On the other hand, if we get the direction of travel right, identify the major hazards in advance and plan to minimise them, the profession could emerge as a major player in health care delivery throughout the whole of the first half of the 21st century.