We need pharmacists with a vision

By Malcolm Almond

It has been said at regular intervals throughout my career that pharmacy is at a crossroads. There have been times when I have thought that a better analogy was that pharmacy was at a roundabout. Now many members of the profession believe we are in a cul-de-sac.

Over the past 40 years community pharmacy has moved from a profession undertaking extemporaneous dispensing and having the ability to react positively in any situation to a profession of robots, requiring guidance to do anything and everything. This applies to both professional matters and management duties. It has come about gradually because of the introduction of protocols and other restrictive practices. Motions at the Royal Pharmaceutical Societyís branch representativesí meetings have over the years often called for the introduction of practices that would provide uniformity within the profession.

I contend that the Council of the Society, the executive of the National Pharmaceutical Association and the Pharmaceutical Services Negotiating Committee have probably taken the development of community pharmacy as far as they can. The question is: who can take the profession forward into the 21st century?

Local pharmaceutical committees are not large enough bodies to take us forward and they do not have a monopoly of new ideas. To overcome their limitations, many local pharmaceutical committees or Royal Pharmaceutical Society branches have set up development groups to investigate the provision of local pharmaceutical services. Unfortunately, the response to the formation of development groups has been disappointing; not enough pharmacists have volunteered to take the profession forward. Pharmacists who are waiting for primary care trusts to take the lead in the development of new services are likely to wait in vain.

Community pharmacy is in a rut

Let us look first at some of the reasons why community pharmacy finds itself in something of a rut and why success is hard to come by.

A number of local services have been introduced in recent years, some of which do not seem to have been sustainable. I know of a blood pressure monitoring scheme that was introduced about 10 years ago that has fallen by the wayside. Whether this was due to the withdrawal of funding or apathy I am not sure, but such a service would fit well into the national service frameworks that have been introduced more recently.

Syringe and needle exchange schemes have been around for a long time but unfortunately they will always have a limited take up. The aggressive and dishonest nature of a lot of the clients puts many pharmacists off providing the service. The same applies to the installment and supervised dispensing of methadone and buprenorphine (Subutex). As the profession comes to rely more and more on a female work force, security of pharmacy staff will become a greater issue.

Training should not be a barrier

New initiatives usually require pharmacists to undergo training to ensure they are competent. Unfortunately locum pharmacists are often excluded from this training. This is unfortunate considering that at any given time a large number of community pharmacies are running on locums. I was working in a pharmacy one Monday recently when I heard an assistant telling a mother presenting with headlice to call back on Thursday because the locum booked for that day was trained to give advice on headlice. What message does this convey to the public? Do they have to scratch for another three days? Fortunately, I was able to intervene and provide the appropriate product even though I have not received the necessary training; it is hardly rocket science to provide a bottle of lotion and some advice.

There seems to be an explosion of pharmacists giving prescribing advice to general practitioners. Almost every practice seems to have a prescribing adviser. Unfortunately some of the advice being given is of doubtful value. Quite often doctors are advised to prescribe branded generics. I am not sure what this achieves but the Department of Health has been trying for years to get doctors to prescribe generically. We are now in a position where local advice is contrary to national targets.

Meanwhile, prescribing advisers in many areas have missed the opportunity to develop formularies for nurse prescribing. A situation has arisen where nurses within a small area all prescribe their own favourite dressings so that the local pharmacy has to stock or order a plethora of dressings that are similar in character. Ideally pharmacists should have taken the opportunity provided by the advent of nurse prescribing to install practice formularies.

Medicines management and pharmacist prescribing are two roles currently being discussed for the profession. Unless community pharmacists get involved at a local level these initiatives may never come to fruition. If they are put into practice it may be pharmacists with hospital backgrounds who get the jobs.

There is also a general shortage of ideas for local pharmaceutical services. Pharmaceutical development groups are desperate for ideas. They are looking for pharmacists to take a bottom up approach because ideas are not coming from the top.

Pharmacists should find out if they have a local development group. They should join the group and put forward their ideas for local pharmaceutical services. They should be prepared to identify potentially useful services, work out the cost of these services and submit their plans to the local group for approval. If the idea is approved they should be prepared to implement their plan and carry out a pilot study. If benefits can be shown, GPs will support the adoption of new services and cash will be found to expand them. The Government has introduced national service frameworks in certain areas of practice. Pharmacists should try to get involved in these initiatives although it could be that the Government is only paying lip service to these developments. I am always suspicious of plans that extend beyond the life of the parliament.

One problem in recruiting for local development groups may be the fact that the number of independent pharmacies is rapidly dwindling. Lack of finance makes it difficult for young pharmacists to aspire to proprietorship. Many proprietors are so overworked that they cannot find the time to join out of hours groups. It could be that the many multiple groups that are now developing have their own agendas. Another problem could lie in the fact that development groups are local. Pharmacists living outside the area in which they work may be reluctant to undertake the extra travelling that would be required to attend group meetings.

So for a whole range of reasons the development of community pharmacy has become frozen. Is there any route out of the cul-de-sac?

Whatís the network all about?

I think we need to give younger community pharmacists all the support we can. There are a few glimmers in some areas where young pharmacists are having some original ideas about developing pharmaceutical services. Their LPCs should encourage them to set them up and help spread the word, not find reasons for not helping them.

Community pharmacists with vision are needed to take the baton and run with it ó the alternative is a profession as influential within the Health Service as hospital porters and tea ladies. Community pharmacists often shout about the accessibility of the pharmacy network. They have always provided great value for tax payersí money, and done more than they were ever paid for. The question now is, accessible for what?

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