

Trust me, I'm a pharmacist!

The public consultation on the Foster and Donaldson Reports ended on Friday 10 November. Community pharmacist Noel Baumber penned a personal last-minute response to the review

It seems to me that the reaction to Harold Shipman's murders has been to adopt a counsel of perfection in every conceivable area of practice with neither judgement nor limits being applied to practicality or pragmatism. He should have been spotted long ago by the process of death certification and the Coroner's office, but he was not. Instead, pharmacists now have to spend more time after hours making long-winded entries and balancing the new Controlled Drugs registers in the hope that we might convict another mass murderer to justify our diligence and frustration, a one in 60 million chance, or less.

The adage of "a stitch in time saves nine" does not appear to work in the process of reviewing bureaucratic methods. Instead, crisis is followed by over-reaction then legislation which is difficult to amend. Indeed, the Foster and Donaldson reports could result in legislative changes that could have a tremendous impact on practice, could split the Royal Pharmaceutical Society in two and could introduce the concept of revalidation.

I suspect that most pharmacists working in the community sector will agree with me that there is hardly time in a day to complete the workload of primary dispensing without error and to respond to the real-time demands of the public to address the full range of diagnostic and health care service issues. Like many independent contractors I specialise in bringing pharmacy services to the elderly and to residential areas disadvantaged either by poverty or distance from health care services. That also takes an additional sustained effort of personal time, manpower and resources.

Pharmacists are already stretched with new commitments to staff training and responding to a service agenda under the new community pharmacy contract, both of which are unremunerated, low priority areas on primary care trust agendas. Every member of staff participating in National Vocational Qualification training will probably need time off to complete their heavy schedules apart from costing around £3,000 a piece. We have lost oxygen income, the rational location of pharmacies, suffered the Category M raid on margins and received none of the promised funding for the past two computer upgrades. I welcome the extra expenditure on locums that allows them time to be "practising" pharmacists and stay on the Royal Pharmaceutical Society's

Register, since they allow me time for management, caring and service development, but these all seem to have been unanticipated and uncompensated costs.

In my case, evenings are spent on three areas of public service insufficiently recognised by Government. The first of these is secondary dispensing, which involves the meticulous management of medication for the elderly living at home, visiting patients and providing domestic dosage systems (mainly at my own expense in spite of some Disability Discrimination Act funding). Second is helping to run and fund the local hospice (as co-founder and company secretary of GIFTS Hospice). And third is setting up the means to recognise, research and defend the independent pharmacy sector (as co-founder and company secretary of the Independent Pharmacy Federation)

I mention these solely to suggest that there is no appreciation of the workload or the diversity of involvement that working pharmacists already have in the community and, therefore, there is no concept of the cumulative impact of disparate demands on our time and resources. Overload heralds burn-out, stress and the disaffection of staff, which have repercussions for motivation and recruitment, and eventually the loss of services from the community. Without elaborating on the demands of local pharmaceutical committee work, continuing professional development and Centre for Pharmacy Postgraduate Education meetings, most of our spouses must feel that evenings are not our own.

Hospitals and accident and emergency departments are closing throughout the land. Coupled with the difficulties of recruitment, retention and retirement in primary care medicine we might surmise that there will be a collapse in the number of GP surgeries as they metamorphose into the alternative — community hospitals. There could then be tremendous changes in the viability and distribution of community pharmacies as a consequence. However, we do not know whether we are expected to integrate with surgeries, replace many practice functions, be replaced by doctor-owned pharmacies, or fight to retain the dichotomy between the two services as stand-alone professions.

I would advocate having pharmacies that remain in the communities where people live and not just end up with everything that is

practice-based. Pharmacies cannot survive on service provision without also dispensing large volumes of prescriptions, so I expect there to be enormous queues for prescriptions and pharmacy services in the remaining surgeries.

This question affects the direction of our education more than anything else. Even now, education needs to be multidisciplinary where possible, with a joint agenda that can be addressed at local level. This is a way of improving relationships between the professions. In future this needs to be focused on the overlap of pharmacy and medical service provision so that there can be a co-ordinated approach to learning the diagnostic and prescribing skills envisaged for the community pharmacist. The syllabus is already mapped out in the two Oxford handbooks on clinical medicine (6th edition) and clinical specialties (7th edition), although there needs to be a radically critical review of both pharmacy and medical degree courses.

Under this scenario, revalidation becomes a non-starter, echoing the failure of the accreditation method as a route to the provision of medicines use reviews. What is needed is not the Royal Pharmaceutical Society's idea of CPD, but a co-ordinated and sequential system of applied professional and service development. We might have time and patience for that as we need a sense of direction and good organisational support to achieve swift and appropriate change in the profession. Revalidation would be an arbitrary snapshot, adding stress to the workload with the attendant risk of depleting the profession of its membership.

The CPPE, which I find often contradicts medical opinion and propounds over-optimistic methods of teaching, should go. I would replace it by having the Society resurrect its branch structure for professional and clinical development in conjunction with the College of Pharmacy Practice. If the Society is forced to divest itself of its regulatory role in order for it to become effective in its representative role for the whole profession, then educational reform could form its core function and it would not be appropriate to have a majority of lay people on its board.

Pharmacy is the busiest most over-regulated and under-funded profession there is, and politicians are poised to make yet more impossible demands. Have they learnt anything from past bureaucratic failures (eg, the unnecessary reinvention of a complicated and inoperable repeat dispensing scheme), or taken on board the critical point made by Baroness O'Neill in her 2002 Reith lectures about not replacing trust with bureaucracy?

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