

Fitness to practise, pharmacy education and the role of the pharmacist

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Everything in pharmacy is changing, and that includes education. Three events will trigger a radical alteration in both undergraduate and postgraduate education.

- The regulator has commissioned a group from the pharmacy school at Aston in the UK to review the five-year education and training programme
- In concert with the introduction of the fitness to practise (FTP) regulations and annual recertification, the regulator must decide how and what to require and arrange for Continuing Professional Development (CPD)
- And after a long, and presumably troubled, gestation the report of the review of the Irish Centre for Continuing Pharmaceutical Education (ICPE), which was sent to the HSE in March, should be published shortly

While so much is happening and so much remains uncertain in pharmacy, many pharmacists probably feel that education isn't directly relevant to them or to their practice. But this is wrong, on both counts. That view is symptomatic of what we in Trinity College have come to know as 'restructuring fatigue'.

The Pharmacy Act 2007 establishes the regulator's role in responding to alleged poor practice through comprehensive FTP procedures that are modelled on internationally accepted best practice in the healthcare professions. The harrowing details of cases of catastrophically poor and in some instances malicious practice, has heightened the concerns of the public and the politicians to prevent any healthcare professional from causing harm. The 'old' PSI, under Ronan Quirke's leadership, consulted the profession and engaged a wide range of stakeholders to aid the formulation of the FTP procedures. However, the fact that none of the notorious cases so far have been the result of poor practice by a pharmacist, has meant that this work seemed to pharmacists to be disconnected from the process of improving the health service. Nevertheless, this necessary but daunting development will protect the public from failing practitioners and provide a mechanism to offer suitable help or administer appropriate sanctions where necessary to the pharmacists concerned. FTP has been the focus of much discussion because, in order to be both fair and reasonable, the rights of the individual have to be respected as much as the health of the public has to be protected. In this way, the profession can be confident that it will also shield the profession from the damage to public trust and confidence that such cases cause. But the majority of poor practice is not of the seriousness or nature of Shipman; it is several

orders of magnitude less serious and is often a combination of questionable judgement and poor execution.

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To assist practitioners in coping with the perplexing situations that arise in practice, all of the professions deploy Codes of Ethics, Standards of Practice and Postgraduate Education. This is the framework for practice against which fitness can be assessed. Once again, in the past, the old PSI laid the groundwork for FTP by drawing up a Code of Ethics and by producing the Practice of Pharmacy Guide. Under the new Act, the regulator must draw up a Code of Conduct for pharmacists, rather than a code of ethics or standards of practice. However, conduct is guided by ethics and moral reasoning, as Cicely Roche's articles in this publication illustrate. The Code of Ethics of the old PSI was just that: 'a guide to morally informed behaviour'. It was not prescriptive, because every potential situation cannot be foreseen and accounted for. Just as our legal system is based on stated principles and developed through their application in case-law, so the Code may be considered as the principles that must be interpreted and acted upon within the

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circumstances of each case. In comparison, the medical regulator in Ireland, the Medical Council, issues 'A Guide to Ethical Conduct and Behaviour' and does so in preference to drawing up a Code:

"In giving guidance to the medical profession about questions of ethical conduct, it is not the intention of the Council to issue a Code, but to provide a Guide by which the individual members of the profession may judge particular situations."

Although the Guide deals with issues such as independence of judgement and trust and privilege, it also covers practical issues but it does not attempt to describe "how doctors should behave in every circumstance". It does, however, deal with the withdrawal of services. It will be interesting to see whether the regulator devises a Code as a set of guiding principles, a Code which is really a Guide – a practical advisory – or a Code in the form of a comprehensive catalogue of situations and expected behaviours. Under the Act, the regulator is concerned with 'retail pharmacy business' and also with pharmacists. A Code that concentrates on 'retail pharmacy business' will be of much less value to those whose main practice is not 'retail'. The transferability of such a Code of Conduct to hospital practice and its influence on the undergraduate pharmacy curriculum will be much less than a Code drawn up for all pharmacists. And whichever option is taken, it will be interesting to find out what the Competition Authority makes of the proposed Code of Conduct.

What should follow from a code would be standards of practice. In the absence of powers to enforce standards, the old PSI drafted practical guidance in 1999: the Practice of Pharmacy Guide was collated, by Dermot McDermott, the Chief Inspector, from the content that was appropriate at that time and distributed to pharmacists with the generous support of ICCPE. The regulator has been commendably quick to produce the Pharmacy Practice Guidance Manual, in essence, the successor to the Guide and the intervening self-assessment tool, 'Standards and Guidelines' of 2007. It prompts each pharmacist, pharmacy and corporate body to consider their premises, their pharmacist(s) and other staff, their procedures and services and their quality assurance and governance. While the majority of pharmacists and pharmacy owners will have addressed most of the items in the Manual, the explicit statement of their importance by the regulator clarifies the scope of current practice

and will serve as a framework for the development of standards of practice by practitioners. Equally heartening is that the Guidance Manual is an interim document and that the regulator has invited pharmacists and pharmacy groups to comment upon it. In other words, it is open for discussion. The activities and standards that comprise the final version of the Guidance Manual will be fundamental not only to FTP, which will apply to the few, but also to the operation of annual recertification, which will apply to one and all.

As pharmacy in Ireland embarks upon annual recertification, a comprehensive, highly practical approach to postgraduate education is needed in order to support pharmacists in meeting the new requirements and to ensure that the standards of practice benefit patient care and service delivery. Thus, one of the regulator's other functions is "to ensure that pharmacists undertake appropriate continuing professional development". In Ireland, in the past, professional development equated to Continuing Education (CE). This was at first honourably provided by the old PSI, supported by the staff of the then only School of Pharmacy, and subsequently also for a while by committed practitioners from community and hospital practice through the College of Pharmacy Practice. Then, through the vision of the IPU negotiators of the 1996 Contract, the ICCPE was established and this consolidated the notion that CE was the responsibility of a contract holder (and their pharmacist staff members) and was to enable pharmacists to meet the responsibilities set out in Clause 9. By implication, contract holders were under an obligation to facilitate their staff's commitment to education. CE is necessary because knowledge is essential to build skills and confidence for practice, and ICCPE has provided the basis for this through its careful selection of stand-alone and supporting materials in hard copy and electronic form, as well as its courses. The ICCPE's specific role was to provide 'therapeutic update' and this it has done more thoroughly and to a greater proportion of pharmacists than ever before. However, these arrangements had a drawback; ICCPE had no remit to meet the needs of other staff in the community sector, nor those of hospital pharmacists or of the hospital pharmacy service, and so it could only address some, not all, of the needs of pharmacy. Furthermore, CE has drawbacks of its own; it can make learners passive. ICCPE picks the topics and the means of delivery, albeit bearing in mind the feedback that it receives and issues that are of immediate importance, but this limits the users' involvement. In countries and professions in which CE was a mandatory requirement to continuing membership or certification to practice, research showed that it did not influence practice behaviour and therefore did not realise the objective of maintaining practice quality. As this became evident, the distinction between acquiring knowledge and skills through education, and becoming proficient and competent through practice-based education, was being highlighted. And the realisation that each practitioner might identify their needs and meet them using any combination of a variety of methods and providers also opened up the possibility of a

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more individualised, flexible approach to the process in contrast to the uniform, often centralised, offering of CE.

One alternative, CPD, seems, from the experience of others, to meet these requirements. Its character has been defined as "an ongoing, self-directed, structured, outcomes-focussed cycle of learning and personal improvement". And its link to competency was explicitly made by the International Federation of Pharmacy (IFP) in its policy statement, "The responsibility of individual pharmacists for systematic maintenance, development and broadening of knowledge, skills and attitudes, to ensure continuing competence as a professional throughout their careers." CPD includes both self-assessment and self-selected and self-driven learning programmes. ICCPE has already set the scene for CPD by providing pharmacists with tools via its website to enable anyone interested to get started.

The emphasis on the individual and in particular upon self-assessment poses problems for CPD. Validating self-assessment and self-development is difficult for a regulator and the reflection that self-assessment requires is difficult for practitioners. Many people are uncomfortable with reflection, i.e. thinking about what happens in practice and asking why and what if, and they become more uncomfortable if they are asked to write this thinking process down and to state what they have learned from it.

In a way this is surprising – most management courses propose procedures and structures for individuals, teams and organisations to utilise experiential learning via reflection. It may be that since pharmacists and other professionals can still function some of the time in self-contained practices, they regard the writing down as publication of their thoughts, the potential revealing of their shortcomings as well as those of their practice. Most pharmacists are also happiest when they are dealing with concrete knowledge, rather than conjecture, and this leads them to be

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reductionist in their thinking habits, so they take the short cut to the 'answer' and spend little time thinking about the path that led them there. However, reflective practice is a hallmark of advanced clinical reasoning and of astute management appraisal. Since the value of reflection is undeniable, it is up to the CPD institution to support the learner and provide facilitation and examples to ease the learner's path to this practice.

Consequently, CPD can be effective when it is provided and delivered by an organisation whose purpose is education, whose methods are supportive and whose remit is accepted by all. Hence an ICCPE-type organisation is the logical vehicle for this.

Furthermore, education for regulation is not, by any means, the same as education for development. There is likely to be tension between the requirements of the Code of Conduct or of a practice inspection visit by the regulator that inevitably leads to conformity, with those of practice which is characterised by atypical cases, conflicting demands and continuous change. Whereas responding to change, acquiring clinical skills, undertaking personal development and enabling moral reasoning all require an understanding of how to apply fundamental principles and the adaptability, creativity and courage to do this, applying standards of practice via a strict regulatory process can be conceived as the antithesis of this. Much of the impetus for CPD individualises the learning and experience of the practitioner but if the requirements for annual recertification are too rigid, this autonomy and the personal development aspect of CPD could be lost.

There is also a danger in the present climate of opinion within the profession that the association of CPD with the regulator and with more demanding annual recertification, with FTP, and a Code of Conduct vetted by the Competition Authority, could be regarded as a necessary evil, rather than a personal opportunity. Moreover, experience elsewhere, from those who moved to implement CPD some years ago, is that assessment in CPD, whether by practitioners or by third parties is complicated, time-consuming and consequently expensive to implement. In Ireland, it would be surprising if the regulator considered that it could establish its CPD programme, annual recertification and FTP operation without additional funds. Given the present constraints and demands on health service funding, the regulator may be told to transfer these costs to pharmacists, tarring CPD with the brush of meanness.

These issues are the challenges that the ICCPE Review, the regulator and each of the stakeholders in the professional development of pharmacists and pharmacy must meet. CPD will only be able to effect practice behaviour change if an independent educational body, with a clear mandate founded upon adequate authority and secure funding, is established.

Although annual recertification and CPD constitute important parts of the education and quality assurance framework for professional development, more is needed. Studies of underperforming clinicians and organisations also show that only if practitioners are introduced to

reflection and self-development, so that they become part of the culture and practice of learners in their undergraduate career, will they use it to full effect in their autonomous, independent practice. In the UK the inquiry into the problems in paediatric surgery in Bristol led directly to changes in both the practice and funding of undergraduate education and postgraduate training for medical and nursing practitioners in the health service, whatever their speciality. While the majority of pharmacy undergraduates, like their medical, nursing and dental colleagues, go on to practise patient care, they do not have the same opportunities to develop their patient care practice skills. Yet the evidence is clear cut; without adequate preparation and experience the culture of professional practice will not be established to a consistently high standard.

Pharmacy undergraduates do not take responsibility for the provision of a sustained period of care for a group of patients. Other health science students do. They spend a substantial part of their degree course providing care and being assessed in the provision of that care. As a consequence, when those students complete their degree, they can be considered as knowledgeable and 'fit-for-practise' even if that is at a basic level with some supervision. Pharmacy students can claim to be knowledgeable but not to have equivalent practice experience and competencies to their counterparts in the health service.

The pre-registration year is supposed to complete the pharmacist's education. It is the point of entry into the profession of pharmacy with its practice-based tutor, its stipulation of a minimum of six months in community or hospital (i.e. patient care practice) and its examination. Unfortunately, it is a period that is neither an apprenticeship nor a period of intensive practice education, and its quality varies with the practice in which it is undertaken and the commitment and experience of the tutor who supervises the student. Both in Ireland and the UK, the former pharmaceutical societies tried to revise and adapt it to make it work. But changes in patient expectations, health service policy and organisation, in undergraduate education and in other healthcare professions meant that the revisions and adaptations always fell short. Consequently, the pre-registration year remains somewhat disconnected from practice. Worse still, in Ireland it has never been recognised and treated as an essential stage in a pharmacist's development by anyone outside the profession. The fact that the community sector and the students themselves have paid all of the costs of the pre-registration years since it was instituted was news to the HSE, the Department of Health and Children and the Department of Education and Science during the recent problems that students had in finding pre-registration placements. In short, the pre-registration programme has no recognition, no resources, no capacity for substantial improvement and it is not delivering what is needed. It hasn't 'worked' for decades and its time it was abolished.

But all this bad news could be the best news for the profession.

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pharmacy graduates. They should be able to practise as independent practitioners from day one, and therefore should be competent, not only in terms of their knowledge and skills, but also have developed their caring skills, moral reasoning and professionalism.

During his time as Head of the TCD School of Pharmacy, Des Corrigan used to greet each incoming year of undergraduates with the words, "You are not pharmacy students; you are student pharmacists." It fixed in their minds that they had chosen not just a degree course but a vocational course, and that this was the beginning of a series of steps to being entitled to practise as pharmacists. Repeated surveys over the years in Trinity have consistently shown that student pharmacists come to learn how to be a practitioner who knows about science – not a scientist who might learn about practice later on. The changes that have occurred in practice have created a gap between the undergraduate degree and postgraduate practice that cannot be bridged by tinkering with the existing undergraduate programme and the pre-registration year. Preparing the profession for annual recertification and for FTP can be the stimulus to bring about revolutionary changes in education and lasting benefits to the profession, but only if the undergraduate degree course and the pre-registration year are examined and revised together to enable a seamless transition to professional practice. It is time to devise a vocational degree programme with the aim of producing a graduate with the knowledge, skills, attitudes, behaviours and competency to practice as a professional whose role is patient care.

A lot needs to be done with and to undergraduate education to bring this about:

- Patient care is the prime role of the pharmacist and the knowledge and skills to deliver that care to a standard that enables the pharmacist to practice independently must be the aim of the pharmacy degree. It is the possession of these patient care competencies and the pharmacist's performance in providing patient care in practice that must form the learning outcomes of the degree. Therefore patient

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care practice must be the centre of the degree because it is what a pharmacist is and because it is what motivates and energises students to learn. It must be harnessed from the first year to help students appreciate what they need to know in order to be able to practise as a professional. Pharmacy should become a vocational degree just as dentistry, medicine and nursing are already, so that Ireland can develop its health services to meet the needs of its people.

- The pre-registration year must be incorporated into the undergraduate programme to create a single scheme of education and practice placements that provides a phased, graded programme of academic and professional development over the five years, and results in a graduate pharmacist who is 'fit-for-practise', and who will be able subsequently to maintain themselves as 'fit-to-practise'. Simply tagging on the existing year, with a few cosmetic accommodations and labelling it the 'practice period' would not make it possible to meet any of these requirements and such an approach was not considered appropriate when nursing became a graduate profession.
- Putting patient care at the centre of the degree means that the curricula and teaching and learning methods used should provide much of the science through practice, and not the 'science then practice', two part, sequential development approach that still influences much third level thinking in pharmacy. Most of the 'basic' sciences in pharmacy, dentistry and medicine are no longer taught as separate subjects but through their application within the relevant health sciences. In order to be able to develop the pharmacy degree as a professional degree, equivalent to medicine or dentistry, some of the 'pharmaceutical sciences' will have to be taught in this way in the future. The separation of 'science' and 'practice' is a false dichotomy; it stifles intellectual development and inhibits educational innovation. Practice today is based upon the systematic gathering of information, its critical appraisal, the application of evidence and the exercise of professional judgment in situations of uncertainty. These are the same skills that the scientist uses. Pharmacy Practice academic staff can make practice links to the natural and social science disciplines that non-pharmacists cannot and they can make credible to undergraduates the need to understand these sciences in a way that non-pharmacists and also non-practising pharmacist academics cannot. A multidisciplinary approach can be used to maximise the contributions of each type of academic staff.
- Patient care requires more than just specialist knowledge and skills. Practising as a professional requires more than just specialist knowledge and skills as well. Research in other healthcare professions and in pharmacy has shown that the skills and values needed for patient care, and the professional behaviours and ethical understanding that are essential, can be

developed and taught through a combination of education in the humanities and in ethics and moral reasoning, as well as through structured practice experience with teacher-practitioners.

- Practice to develop competency in patient care and its supporting practice management activities requires intensive teaching, using methods such as problem-based learning; objective, structured clinical examinations; dispensing assessments; experiential learning and reflection; workplace learning; as well as group and individual practice assessments. Evidence from undergraduate pharmacy degrees in other countries and other professions, and from postgraduate and CPD evaluations, demonstrates that these methods can help students to become self-reliant, confident, competent practitioners. Pharmacy Practice in all three Schools already incorporates these teaching and learning methods but in every School there are severe limitations on their ability to do all that they consider necessary for Pharmacy Practice within the existing syllabi, and they could not possibly deliver the patient care programme that is required of a vocational degree.
- More pharmacists must be recruited as academic staff, and in particular more Practice staff are needed, with greater rewards and recognition for teaching and more flexible working arrangements on the part of employers, in particular within the community and hospital sectors but also within the third level institutions. Clinical and non-clinical preceptors (workplace tutors) will be required and they will have to be trained, and sufficient, suitable practice placements will have to be provided to a verifiable, consistent standard. This will require a substantial support infrastructure, not just to maintain it but to establish it in the first place.
- More flexibility is needed in the range of approved placements – both practice and the health service have moved on. Not every 'clinical' professional works as a clinician. In fact, health service policy in this country and abroad is based upon the assertion that "clinicians make good managers of clinical services". Therefore, it is logical to extend the scope and range of placements that can be experienced, in addition to the required six months in community or hospital, to include periods in some of the other organisations that form part of the regulatory and service management structure of the health service of this country. Management, like patient care, is best taught alongside practical experience. During the pre-registration year crisis recently, the regulator suggested just such an extension of placements and some of the potential participants have themselves proposed their inclusion.
- Individual Schools in the health sciences have done much to establish appropriate quality assurance for their degree programmes but the cost of this has usually been borne by the School, when some contribution from the institutions themselves should be provided. The importance of quality assurance of teaching and learning, of staff performance, of facilities and of governance, for a health

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science course, goes unacknowledged in third level. Although students are expected to learn ethics, and demonstrate the extent to which they have developed their moral reasoning and professionalism, these are not required of the staff. In fact they should be, since the staff are de facto role models and contribute to the organisational culture of the School. As academic staff are likely, in the near future, to be required to account for the adherence of themselves and of their research teams to the principles of research ethics, extending this to encompass professional standards and behaviour in teaching and learning activities should be easier.

- Health science degrees are resourced at a higher rate per student compared to science degrees, yet historically the HEA has resourced pharmacy degrees as science degrees. Furthermore, in each of the three Schools of Pharmacy in this country, Practice remains under-resourced in comparison to other academic disciplines. This is not to say that each of the Schools has not made substantial efforts to develop their Practice groups, but each of them for their own particular combination of reasons has had limited success. Resources for Pharmacy Practice must come from an historically inadequate base to meet the needs of a substantially extended and more complex Pharmacy Practice course within the vocational degree programme.
- Third level education policy incentivises research output by institutions and individual staff (the fourth level) to a disproportionately greater degree than the graduation of healthcare professionals who will work primarily in health service delivery. All of the

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healthcare professions need to address this issue if the quality of undergraduate degrees is to be maintained, and for pharmacy the situation is critical, since its access to resources for education is already disadvantaged compared to most of the other professions.

- Teaching and learning about research and how to research must be a part of the education strategy of the profession and hence of its degree programme. Pharmacists, as healthcare providers, consume research – the skills of retrieving, of assessing critically, and disseminating research findings within their practice/organisation are essential to improving patient care. They also need to produce practice research – by developing audit skills and by utilising practice data and performance measures to assess the effectiveness and efficiency of their practices, and by facilitating the devising and testing of new ways of working and of the provision of new services. All three Schools in this country will soon find themselves in a similar position to those in the UK, who are reportedly so under-resourced that they have suggested some alternative to the undergraduate research project should be considered. This would be disastrous for the profession and for the Schools in this country since practice research capacity is inadequate to support the development of the profession and is much smaller than the research capacity of the other pharmaceutical disciplines.
- The regulator is the statutory body for accrediting pharmacy education in this country and it will revise the criteria that it uses to perform this function in the near future. It will need to ensure that competence in practice skills and fitness for patient care practice are the stated aims of the programmes and that the accreditation criteria address the teaching and learning outcomes of courses. In addition, the regulator's capacity to induce not only the colleges but also the HEA, the Department of Education and Science, the HSE and the Department of Health and Children to acknowledge and to meet their obligations must be one of its main priorities

For its development as a healthcare profession, pharmacy needs a clearly defined career structure, a means of progression and of specialisation developing from the pharmacist practitioner degree. Such a career structure and the associated postgraduate specialisation are also necessary to attract intelligent students who will perceive a range of opportunities and who will be ambitious for themselves and for their profession. At the moment, with the partial exception of hospital pharmacy, none of these exist. As Grimes, Allen and Delaney described recently, four grades of staff are recognised in hospital pharmacy but progression through those grades is not on the basis of qualifications or of the nature of service experience and level of responsibility of the pharmacist, but more upon years of service. Nevertheless, the hospital pharmacy sector, with its clearly defined services based upon medical and surgical specialities, has utilised postgraduate qualifications and membership of specialist practitioner groups as a means of differentiating its staff and organising

its operations. In community pharmacy, this is not the case. The lack of a defined patient care role within the health service means that the structure depends upon the professional and organisational culture of the practice and the employer with whom the pharmacist works.

This could, and should, be changed, however. The regulator has been given the option of considering specialisation and could, therefore, have a great influence on this issue.

The competency framework that has been introduced in the UK has enabled the pharmacy profession there to set out a career structure that encompasses professional development up to advanced/consultant pharmacist level. This has been recognised by the NHS as being compatible with its policies and strategies for staff development. In parallel, specialisation is being established and this too, could fit within the competency framework and enable the contribution of pharmacists to the NHS to be realised. Experience of students and staff with the framework in the TCD MSc in Hospital Pharmacy has been universally good, suggesting that it can be used in this country with only minor adaptations.

Since pharmacists are employed directly by, and contract with, the HSE, it is imperative that this organisation understands pharmacy and develops a strategy to utilise and encourage the advancement of pharmacy as a significant contributor to its work. Outside of the Schools of Pharmacy, most pharmacists with a role in education are located in hospitals and in the pharmacy groups, and, for many of these, education is only one component of their job description. Notably, AMNCH in Tallaght has a formally recognised pharmacy education post in the Pharmacy Department and this is funded by the public sector. The HPAI has organised and run its own education conference for many years and this continues to go from strength to strength, but this is based on unrestricted educational grants from pharmaceutical suppliers. There is no corresponding infrastructure in community pharmacy, apart from ICCPE, and within some of the pharmacy groups. In the UK and Northern Ireland, ICCPE's equivalents have the policies and infrastructures of both a pharmaceutical society and the NHS to engage with and respond to.

The policies of the HSE, and how education and training are to contribute to the 'transformation' of the HSE and to improving standards of practice, are not readily discernable from publicly accessible documents. It is apparent that the HSE is concerned with audit and quality assurance of its services, and it has set out its commitment to partnership, but so far it has not expressed an ambition to become a 'learning organisation'. This is hampering, and will continue to hamper, pharmacy's development, because a central difficulty for pharmacy education in Ireland is the absence of a corresponding education and training infrastructure in the health service, something that contrasts significantly with the UK's NHS.

The HSE has statutory responsibilities with regard to Medical Education since the staff and most of the functions of the Postgraduate Medical and Dental Education Board were transferred to it last year. Compared to medicine, dentistry and nursing, pharmacist

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education is not recognised as a part of the responsibility of the HSE nor does the HSE acknowledge that providing education is a part of the role of the pharmacist. A proposal to establish the Education, Training and Research Committee as a formal HSE Board Committee has been made, and if this occurs perhaps it might offer stakeholders an avenue through which to encourage the HSE's engagement with pharmacy.

If the intention is to create a health service that is truly world class, then education cannot simply be about FTP or quality assurance; it must be about standards of patient care and service development. Standards of patient care from a health service perspective are not the same as standards of practice from an individual practitioner perspective. To improve the health service does necessitate improving its practitioners, pharmacists, doctors and nurses as individuals, but it also means improving its working practices, and most professionals share responsibility for patient care and work in teams or groups. Team working and collaborative practice are essential components of high quality healthcare. Communication between health and social care professionals is often strained at the best of times. In Ireland, apart from professional prejudices, the extent of private practice means that there are few incentives to collaborate.

Enabling interprofessional education (IPE) and collaborative practice should be one of the aims of the HSE and of all of the organisations concerned with the education of professionals. Therefore it should also be one of the constituents of CPD. It is defined by the UK Centre for the Advancement of Interprofessional Education as "occasions when two or more professions learn from and about each other to improve collaboration and the quality of care". This distinguishes it from multidisciplinary or multiprofessional learning or teaching, because they can be synonyms for sitting in lectures together – they may provide economies of scale but they do not provide a learning experience that influences practice

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behaviour. The NEHB, the NWHB and ICCPE have all tried this approach in the past but as isolated initiatives. However, examples of interprofessional learning have been developed in the postgraduate arena. One that involves pharmacy is in the speciality of Palliative Care – the curriculum and delivery were developed collaboratively and the course is open to and has recruited participants from various backgrounds, and each is set learning outcomes tailored to their expertise and level of attainment. To develop interprofessional learning, the HSE, the regulator and ICCPE would need to work together with the third level Schools to devise a strategy and commit to a sustained, collaborative effort among the organisations. So far that does not seem very likely.

A notable finding of the inquiries into most of the cases to date, including that of Shipman, has been that the major contributing causes were the poor functioning, or lack of effective, procedures and operations within the health service. The HSE has recently highlighted the achievement of the Director of Nursing at Cork University Hospital, who was conferred as a Doctor of Governance at Queens University, Belfast. Her contribution to the discipline has been to demonstrate the importance of clarity of role to the creation and implementation of effective governance. Clarifying the roles of those involved in the care of patients with medicines is necessary to ensure patient safety and to embed collaborative practice in all aspects and in all settings of patient care. Clarity about the roles and responsibilities of pharmacists is needed to ensure that education can provide and support the pharmacists that the health service needs. Perhaps this is something to which HIQA will contribute.

The regulator is not solely responsible for pharmacy education; other stakeholders have significant contributions to make. To enable this, some new structures and some new policies will be needed:

- A Pharmacy Education Forum through which all stakeholders, the PSI, Schools of Pharmacy, HSE, IPU, Pharmacy Groups, HPAI, IMB, IPHA, wholesalers and HIQA can discuss and develop undergraduate and postgraduate pharmacy education policies, separate from their other concerns, is a necessity
- Although the regulator has the remit to allow experimental curricula, nevertheless, at undergraduate level, conformity of curriculum content with diversity of delivery and assessment should be encouraged, to ensure continuity with validated progression
- Professional specialisations are needed and these should be based upon a combination of postgraduate qualifications and competency assessment, of the type being developed in the UK at the moment
- Increased access to, and diversity of provision of postgraduate courses linked to professional specialisation will realise the potential contribution of the profession to healthcare and health services research
- An Irish Postgraduate Pharmacy Education

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Board is needed to act as a promoter of high quality postgraduate vocational education and training for pharmacists, as a partner with the HSE, and as an advisor to the Minister of Health and Children, on all aspects (including financial) of delivery and development of specialist courses

- Research must be recognised as a fundamental part of professional and third level activity in pharmacy
- it forms a part of the competency frameworks in the UK, most notably the Consultant Pharmacist Framework
- in Australia the inclusion of a research programme in each agreement between the government and health service and community pharmacists has enabled them to demonstrate the value of pharmacists'

activities in the context of the Australian health service

- allied to this, a network of Research and Education pharmacist posts in the Hospital sector would provide part of the infrastructure for sustaining clinical and pharmaco-economic research
- the Health Research Board should provide pharmacy-specific research funding, analogous to that made available to the therapy professions

Linking education to competency and performance in practice must be the aim of the profession. If undergraduate and postgraduate education is organised and resourced to meet these objectives, it will affect directly the competence and confidence of pharmacists to realise their potential roles in patient care and

health service delivery. Appropriate aims and structures linked to the provision of supportive CPD are also crucial to role development, specialisation and research capacity, all of which are needed to sustain the profession as a body and pharmacists as individual practitioners. And only a vigorous pharmacy profession will be able to contribute its unique perspective to health service delivery and governance, to health service regulation and policy and to the growth and development of the pharmaceutical industry. If our economy, and thus inevitably our society, needs to be knowledge-based in order for Ireland to flourish as an independent, self-reliant State in a turbulent, interconnected world, then it must invest in pharmacy education.

Editor's Note: References available from author on request.

PRACTICE NOTICE

Supply of Products containing Paracetamol

The supply of products containing paracetamol, in both pharmacy and non-pharmacy outlets, is governed by specific provisions detailed in the Medicinal Products (Prescription and Control of Supply) Regulations, 2003-2007. The supply of a product containing paracetamol, from a pharmacy, must always occur by or under the personal supervision of a pharmacist, irrespective of the pack size or formulation provided.

The regulations provide that, except in accordance with a prescription, products containing paracetamol may only be supplied in the circumstances specified in the table below.

The supply of a product containing

paracetamol by or under the personal supervision of a pharmacist in a pharmacy, or from a non-pharmacy outlet, is restricted to the quantities as specified in the table below, in any one interaction.

In certain circumstances, however, in a pharmacy only, notwithstanding the fact that a prescription is not presented, a greater amount may be supplied. This supply is predicated on the requirement that the pharmacist personally interviews the patient requesting the product, and is satisfied that it is safe, in the circumstances, to supply the product.

For products where the dosage unit is in the form of a tablet or capsule, or other similar pharmaceutical form, the total quantity supplied may be up to fifty dosage units. For a

product which is formulated in any other manner two packs may be supplied.

It is a requirement that over-the counter supply of products containing paracetamol, which are formulated in a solid unit dosage form, must be supplied in blister packing or an equivalent, as determined under their product authorisation. The regulations also provide for particular statements that shall appear on the outer packaging of a medicinal product, or on its immediate packaging if there is no outer packaging, and also for statements that shall appear on the package leaflet.

Practitioners are reminded of these controls to ensure the safe and appropriate management of the supply of paracetamol-containing products in the interest of the health, safety and welfare of patients.

DOSAGE STRENGTH AND FORM	PHARMACY ONLY	NON-PHARMACY OUTLET
Dosage unit containing more than 120mg but not more than 500mg of paracetamol	Pack size of 24 units or less	Pack size of 12 units or less
Dosage unit containing more than 500mg but not more than 600mg of paracetamol	Pack size of 20 units or less	Pack size of 10 units or less
Dosage unit containing more than 600mg but not more than 1,000mg of paracetamol	Pack size of 12 units or less	Pack size of 6 units or less
Dosage unit containing less than 120mg of paracetamol intended for use in children under 6 years of age	Pack size of 24 units or less	Pack size of 12 units or less
Liquid formulation containing less than 120mg or less of paracetamol per 5mls intended for use in children under 6 years of age	Pack size of 140mls or less	Pack size of 60mls or less
Liquid formulation containing not more than 250mgs of paracetamol per 5mls, other than a paediatric product containing less than 120mgs per 5mls	Pack size of 70mls or less	Not available