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Strengthening Pharmacy, Globally. Looking Outside the Box

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Abstract
To strengthen pharmacy practice globally, new and more efficient strategies are needed. Pharmacy has traditionally viewed medicine as its reference group. This commentary questions the appropriateness of medicine as a benchmark for pharmacy and suggests the need for new thinking on the professionalization of pharmacy. Useful lessons from outside the medical field, in matters of professional training, practice and autonomy, are highlighted. The commentary concludes that, strategies that focus on the consumer are more effective in transforming practice globally.

Keywords: pharmacy education, reference group, professionalization, specialization, practice

Introduction

As professions are universal, the development of pharmacy must be uniform globally. The contemporary mission of pharmacy is the provision of pharmaceutical care. The full and uniform implementation of pharmaceutical care around the world has not been realised; different nations enjoy different levels of pharmaceutical service. However, as a chain is as strong as its weakest link, the development of pharmacy must, of necessity, be uniform the world over. To this end, the trend has been to replicate, in the developing world, the strategies employed to professionalise pharmacy in the developed nations. Given the slow diffusion of pharmaceutical care even in the developed world, it can be concluded that these strategies are largely ineffective. New and more efficient strategies are needed to bring the developing countries up to speed and to continue to develop the profession, globally.

History of pharmacy

What is a profession and who is a professional? A profession has been defined as a dominant occupation that is autonomous and self-directing. This implies that occupations can gain professional status through a process of *professionalization*. Not surprisingly, professionalization has been used, to strengthen younger or weaker professions. Sociologists define professionals as individuals who use knowledge to assess and manage risk to protect consumers from uncertainty. From the foregoing, the consumer has a central role in the definition of a profession.

Medicine, law and clergy were for many years considered the only 'true professions' (ideal professions) against which any occupation aspiring for professional status had to weigh itself. In health care, medicine is the oldest and most dominant profession. In its endeavours to professionalise, pharmacy, like other crafts in the health sector, has tended to borrow extensively from medicine. This is curious, considering that pharmacy and medicine have a common origin-the apothecaries. In truth, pharmacy may have predated medicine and it would be interesting to find out how the pharmacist ended up being an auxiliary to the physician.

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Influence of medicine on pharmacy

Pharmacy has traditionally drawn all its inspiration from medicine-medicine has been the undisputed benchmark for pharmacy. Pharmacy has relied on four strategies to attain a greater status, three of them inspired by medicine: The most important strategy has been reforms in curriculum development and delivery leading to longer and more 'clinical' education programmes. The second strategy is the increased prominence given to professional guilds and their role in promoting the expanded role of pharmacy. The third strategy is the use of legislative reforms to secure and give legal force to the expanded role, responsibilities and privileges of pharmacists. The last important strategy is the use of internships, residencies and fellowships and other forms of mentorships and apprenticeships to offer hands-on preparation for practice. Pharmacy, like other professions in the health sector has expanded its turf by encroaching on the territory traditionally controlled by the medical profession. The journey travelled by pharmacy is a familiar one-it is the path trodden by the nursing profession, which literally emancipated itself from medicine.

Pharmacy has traditionally regarded medicine as its reference group. This means that pharmacy seeks the validation and even approval of medicine. In its basic form, this thinking is reflected in the length of pharmacy education programmes, the adoption of pharmacy internships and the inclusion of pharmacy departments in faculties of medicine. The promotion of pharmaceutical care as a philosophy of practice and patient-oriented practice as the only real practice is the most glaring manifestation of this thinking. How is this a problem? First, by

trying to match or fit into medicine, pharmacy risks undermining its own autonomy – it reinforces the assumed or perceived superiority of medicine vis-a vis all other healthcare professions. Second, there may be problems in medicine that we ought not to import into pharmacy. Third, by embracing medicine as our reference we impair our ability to learn from other professions.

Why medicine is no longer an appropriate benchmark for pharmacy

Medicine has the tradition of lengthy training under apprenticeship followed by specialisation. It also stands tall in its latitude, which is the 'power' that practitioners wield over their clients. This power is derived from two things: the information asymmetry between the two parties in favour of the practitioner ('the doctor knows best what is good for the patient') and the secrets about the client held by the practitioner. Should pharmacy reproduce the paternalism and over-bearing latitude of medicine?

Pharmacists, around the world, repeatedly complain of being under-utilised. This under-utilisation is worse in less developed countries where medicines are not freely available, are of poor quality and generally unaffordable. On this premise, is it reasonable to increase the duration of undergraduate pharmacy training programmes or create roles in pharmacy that require post-graduate training to fill? Does specialisation necessarily mean or require more years of training? Must pharmacists undergo internship? Can we include internship in the undergraduate training programme? Can we combine internship and specialisation? By giving precedence to clinical pharmacy, are we not promoting the under-utilisation of pharmacists? Do we need a hierarchy amongst pharmacy practitioners?

All or most medical practitioners do the same thing-see patients. Pharmacy, on the other hand, is peculiar in having, in its mission, both patients and products as the objects of its endeavours. It follows, therefore, that pharmacists can and do practise in multiple settings and roles. At the end of their training, pharmacists must individually (and on *ad-hoc* basis) determine exactly when, where and how to use their knowledge and skills.

Unlike pharmacy training, medical training is very rigid. This may be related to the role of apprenticeship in medical training. Unlike medicine, pharmacy is characterised by flexibility, adaptability and un-ending innovation in matters of practice and training. The most unique thing about pharmacy as a profession is its dynamic (evolving) philosophy of practice; this is unheard of in any other profession least of all medicine. The novel entry-level distance-learning Doctor of Pharmacy (PharmD) programme offered by Creighton University (USA) since 2012 shows that pharmacy training is amenable to the use of innovative, learner-oriented strategies of instruction including distance learning.

The product is crucial to the identity and mission of pharmacy: pharmacists practising in different settings are united by their pharmaceutical knowledge-expertise of the product. The dichotomy between product-oriented and patient-oriented practice is unnecessary, as there are consumers on both sides of the divide. This needless dichotomy is the creation of those who believe that 'medicalising' pharmacy will strengthen it. It is my view that pharmacists should be encouraged to develop in both directions, always.

Rethinking the theory of professions; lessons from law and the lesser professions, occupations and trades

There is a lot for pharmacists to learn from lawyers, accountants, actuaries, engineers, the clergy, business consultants, designers, architects, technicians, mid-level clinicians, nurses, opticians, counsellors, information technologists etc. Here are some valuable lessons:

1. *Professionals solve problems, period.* The need to solve a recognised problem is key to the continued existence of a profession: alternative healers, who abound in the developing world, enjoy a lot of professional latitude because of their unique solutions for health problems. This goes to emphasise that professions must grow out of a known societal need rather than from the whims of an elite group. The case of modern day herbalists also informs us that there may be need for the professionals to create awareness on and seek legitimation of their 'unique solution'. In short, a successful profession will be one that is aligned to the need of the consumer. The more important that need is, the greater the need for the profession and hence the greater its latitude. Now, human needs are hierarchical; professions will never have the same worth to society or segments of society. It is important to know that different users have different levels of need. For instance, a Government health department may need pharmacists to assure the quality of purchased medicines but may not need pharmacists to oversee the dispensing of the same commodities in its clinics and hospitals. In the same vein, a consumer in a third-world country considers medicines to be of homogenous quality and generally safe; their perceived need for pharmacists is, therefore, lower than we should expect. In determining the value of pharmacy, reference must be made to the user. Consumer awareness and

autonomy is therefore an important variable in determining how important a profession will be in a given society. Not surprising therefore, the profession of pharmacy is better appreciated in more developed nations than in the rest of the world.

2. *Clients come in different shapes and sizes*. Increasingly, pharmacy leaders around the world assert that only those who practice in the so-called 'patient-facing'' roles have clients and practices. Is this really so? We need some definitions here: a client is anyone who seeks and uses the expertise of a professional, a professional being defined as one who predominantly earns his keep through his occupation. Pharmacists have different clients in different settings; the pharmacist-client relationship varies from one setting to the next: for instance, in a manufacturing plant, the pharmacist *inter-alia* plays the role of a consultant to the employer; in a pharmacist-owned retail pharmacy, the pharmacist may have patients as clients and in a hospital both the patients and the employer are clients. Suffice to say, all active pharmacists have at least one client. It is therefore erroneous to de-emphasize or diminish the professional status of the technical sectors of pharmacy- the notion of variable levels of practice is misleading and totally inappropriate. To borrow from a familiar scenario, structural engineers who construct homes and hospitals are not more important than structural engineers who design sewer plants. In the same light, a defence (criminal law) lawyer is not more important than a litigation (civil law) attorney. Ultimately, a broader definition of the client will allow us to retain the product within the province of 'practice'.

3. *The length of training may not necessarily affect the latitude of a profession*. For instance, unlike pharmacists who train for 5-6 years, opticians who undergo training for about two years enjoy relative 'protection' from quacks (In many developing countries such as Kenya, opticians are not recognised in law as professionals let alone health workers). It is possible to raise the status of pharmacy without increasing the duration of training.

4. *Legal sanction is not sufficient*. Whereas professions can be strengthened by statute, statute on its own succeeds only in creating an elite occupation. This position is exemplified by the following new 'professions' recently created by statute in Kenya: procurement professionals, dieticians and nutritionists, human resource professionals; and public health officers and technicians. Even with the benefit of robust legal backing, these *new professions* have never really taken off; they remain professions only on paper. It is therefore not sufficient to depend only on the law to strengthen a profession; legislation is not the most effective strategy to strengthen pharmacy.

5. *Professional guilds are indispensable for young professions but not the established ones.* For instance, whereas being a member of a professional association does not in any way influence the image and prestige of a medical practitioner or nurse, it is extremely important for pharmacists, herbalists, physiotherapists and journalists to be members of a guild. The influence of the guild will wane as the profession grows.

6. *The role of a code of ethics is apparently debatable* -it does not seem to be essential in all professions, and in many cases its existence and purpose is not known to the consumer. Apparently, what is important is quality of work: let us consider the case of business consultants and actuaries (currently not recognised as professionals in many jurisdictions of the world e.g. under the Kenyan law). The implication of this is that pharmacists will enjoy a professional status as long as they deliver good quality work. Thus, even at the lowest level of practice, pharmacists and other dispensers can claim a professional status if they can perform 'good quality work. 'In many surveys, of factors influencing retail pharmacy patronage, respondents have rated prompt and friendly services quite highly. For contemporary pharmacy, the 'good quality work' may include detecting obvious prescribing errors, minimising dispensing errors and offering accurate product-related information.

7. *Professions are not superior to occupations.* The distinction between professions on the one hand, and occupations and trade on the other hand does not help pharmacy to advance its cause. At the end of the day pharmacy, whether as a profession, occupation or trade, must be able to sell its value to consumers and buyers. In this day and age of consumerism and consumer rights, consumers and buyers are entitled to value for their money. There are mechanisms outside the professional relationship, for instance laws and regulations that mitigate the information asymmetry that exists between the pharmacist and the

user of the pharmacist's expertise. Professionalism should now be simplified to 'value for money'. Value for money is realised through provision of products and services of acceptable workmanship and value. It is therefore still possible for pharmacists to market themselves as the people who are most competent to offer good quality health products (and health information including advice on the appropriate and safe use of medicines).

8. *Duty of care is not the preserve of the professional*. As long as one practises in an occupation, the existence and operation of a duty of care is not dependent on the professional status of the practitioner (person offering a service or product). Although professionals will be held to a higher standard of care, all other persons in control of or practising in a profession have some level of duty of care, regardless of their level of training. For instance, if a residential building collapses due to structural defects, the building owner, the contractor, bricklayer, the electrician and architect can all be held responsible for harm, if the collapse is attributable to poor workmanship in the construction of the home. This implies that pharmacists do not necessarily require advanced skills to assume professional responsibility for the 'care' of the clients. The notion of 'advanced skills' is therefore misplaced.

In summary, the success of the pharmacist as a professional is not dependent on the maturation and status of his/her work-group.

Re-contextualising pharmacy training and practice: lessons from law and engineering

Contemporary pharmacy training is both too expensive and minimally effective. It is important for pharmacy leaders to think of more efficient means of getting the profession to the promised land and to ensure that future pharmacists are more effective in their work. There are important lessons to be learned from law and engineering:

Lesson 1*:* Professional training should focus on professional skills; training should prepare graduates to think and behave as professionals and solve practical problems. In the UK, it is now possible for one to acquire all the foundational skills of a law degree from a yearlong post graduate diploma in law. This diploma provides the prerequisite know-how for subsequent practical professional training under a qualified solicitor or barrister. In a similar pattern, pharmacy education could be shortened by focusing on practical skills. To achieve this, regulators could make it mandatory for pharmacy school applicants to have a broad-based first degree in pharmaceutical science. The degree would prepare the graduates to work in the industry and drug distribution while the post-graduate diploma or degree would focus on the skills required for clinical practice.

Lesson 2: Clearly, specialisation is important as it leads to greater mastery of the craft and improves one's chances of career success. To be a professional is to be a specialist. Pharmacists are, by definition, specialists. If it is necessary to have pharmacists further specialise, it might be more useful that they specialise during their initial training. This is what happens with the training of engineers who undergo initial training as specialised engineers viz mechanical, civil/structural, electrical/electronics, telecommunication, mining, agricultural, chemical, mechatronic, biomedical, automotive engineers etc. By the same analogy, we could train pharmacists specialised for industrial, hospital, community, clinical, drug information, regulatory and clinical research work. Another approach to specialisation is practice-based specialisation. This could be borrowed from lawyers- we have lawyers describing themselves as being *specialist* criminal, conveyancing, commercial or intellectual property lawyers, we also have members of the bench and bar; as well as defence counsel and state counsel. For pharmacy that would be mental health pharmacists, infectious diseases pharmacists, HIV pharmacists, oncology pharmacists or neurology pharmacists; regulatory, independent, hospital or community pharmacists; and so on.

Lesson 3: Battles of turf are non-existent where roles are truly complementary and mutually exclusive. For instance, Architects, Quantity Surveyors and Structural/Civil engineers work in a complementary manner, on a single project, each assuming professional responsibility for the delivery of one aspect of the project. This goes back to the point that pharmacists must be specialists in the strictest sense of the word. The expertise of the pharmacist is in the product; there will be no pharmacy without the product!

Conclusion

New ideas are needed both to accelerate the global implementation of pharmaceutical care and to take the profession to the next level. The place of the medical profession as a benchmark and as a source of inspiration for pharmacy is questionable. Pharmacy needs to look beyond medicine for new ideas.

Further institutional professionalization of pharmacy is not essential for the growth of the pharmacist as a professional. The greatest validation of pharmacy will come from the professions' consumers. Pharmacy leaders must put the consumer at the centre of all efforts to strengthen the profession.