Why does supervision matter to us?

This fifth article on supervision has been written by Catherine Armstrong and Shilpa Gohil, members of the English Pharmacy Board, to stimulate thinking, as part of the planned process of engagement with pharmacists, to establish a position to inform any future debate on supervision.

Pharmacists who do not work in community or hospital pharmacy could be forgiven for thinking that the supervision debate does not affect them. Putting aside the fact that what happens within our profession should affect and interest us all, albeit to differing degrees, supervision is still important.

A pharmacist’s core role is the provision of pharmaceutical care. The setting in which that happens depends on where a pharmacist works. In industry, it is deciding new drug that will treat a patient is pharmaceutical care; without this input the patient will not improve or have to continue to take a drug that is less effective. In primary care, providing advice to a doctors about which medicine is best for their patients is pharmaceutical care. Likewise, managing the medicines budget for a local population is pharmaceutical care since the NHS only has finite resources and everyone needs to be able to access the most cost-effective and beneficial medicines.

Pharmaceutical care needs the input of pharmacists and with the best will in the world pharmacists cannot do everything and so supervision of elements of that care is needed. When the “supervision debate” is mentioned, everyone automatically thinks of supervision of the dispensing process but we think that if we are discussing supervision and clarifying what needs to be supervised and what can happen without supervision we should be thinking about every role a pharmacist can have and every aspect relating to medicines.

Every day pharmacists who work in industry supervise medicines-related procedures and processes. This may be different from traditional dispensing and supply of medicines and medical advice, but these pharmacists still take responsibility and provide a degree of quality assurance for the work that they supervise, even if it is not all done by themselves.

Likewise pharmacists working in primary care, either within a GP surgery or a primary care organisation, do not supervise in the traditional model but they do provide advice about medicines to the public, to fellow clinicians and to non-clinical colleagues. Is there any point in a pharmacist clinically checking a prescription if the clinician who prescribed it has no formulary advice to determine the best evidence-based medicine? Not every part of therapeutic management has to be carried out by pharmacists but their input is needed and they need to supervise the overall process.

Overseeing everything

Pharmacists are the experts where medicines are concerned so they should be the professionals overseeing everything that involves medicines. Pharmacists in regulatory affairs are responsible for the management of licences for manufacturing, wholesaling and medicinal products, therefore this, too, is a form of supervision. The Responsible Person or Qualified Person — who could be a pharmacist — has to supervise every step, which involves monitoring import permits for unlicensed medicines, manufacturing sites, suppliers of active pharmaceutical ingredients and excipients, product packaging, product storage, product recalls, pharmacovigilance and quality assurance in the product cycle, as well as monitoring for counterfeit drugs. These areas are currently covered by non-pharmacist regulatory professionals but, increasingly, more companies are seeing the benefit of having a pharmacist in this role as a result of persistent campaigning of the Medicines and Healthcare products Regulatory Agency by the Royal Pharmaceutical Society’s Industrial Pharmacist Group.

The current economic climate has affected research and development in the industry, reducing the number of drugs in the pipeline. There is a gradual progress towards orphan drugs, unlicensed medicines and off-label usage. Managing this process is another critical area where pharmacist input is vital and the pharmacist in charge is effectively supervising procurement, supply and pharmacovigilance.

Pharmacists qualified as prescribers take clinical responsibility for their prescribing, but they have the reassurance and knowledge that their prescriptions will be clinically checked by another pharmacist and then provided to the patient via a supervised process.

A small percentage of pharmacists work on special advisory boards for marketing or public relations campaigns for medicine reclassification or introduction of pipeline drugs. They are, effectively, supervising and monitoring pharmaceutical companies’ promotional, marketing and sales activities.

With increasing onus on patients to take responsibility for their own health through self-care and the wider access to drugs in the public arena, pharmacists play an important role in supervising the process. They take ultimate liability for ensuring that a prescription-only medicine is safe to take without a prescription.

So perhaps the debate is not just about supervision and what process or procedure is being supervised but also about where the pharmacist is located and ensuring that a pharmacist remains involved in pharmaceutical care.

One of the principles proposed by the English Pharmacy Board is that patient safety and well-being is paramount and this needs to be ensured via quality systems and processes. Surely this principle of supervision does apply within industry and primary care. In fact, surely this principle is paramount in all we do.

Ultimately the supervision debate as part of the whole consultation process should facilitate the final outcome and supply answers to the following question: What do we pharmacists want to do as professionals and how do we want to be recognised by the public and other healthcare professionals?