The current supervision debate feels at times like the childhood game of stone, paper and scissors. In the game, the stone out-trumps the scissors, the scissors out-trumps the paper but the paper out-trumps the stone. At the call of three you had to draw out your hand in either the shape of a stone, scissors or paper. If you won you could hit the loser rather hard on the wrist or arm.

The supervision debate has three such components. The roles of the pharmacist in medicines access, public health, and medicines safety and resources (cost of medicines, pay of pharmacist, number of pharmacists, value for money etc.). For most of the time the game is not worth playing because one part is dominant or there is agreement about the relationship between the three. However from time to time something starts the game going (responsible pharmacist Regulations?) and unless we find a satisfactory resolution we all stand the prospect of suffering much bruising.

Complex issue
The issue of supervision is complex: there are competing interests in relation to the areas of patient safety, medicines access and resources, and we need to bring them into balance. There are mixed views about whether supervision includes the oversight of the therapy or just the supply, and there is a huge variation in views about what constitutes a “clinical check”. Also, rapid advances in technology are already enabling oversight from a distance (remote locations using webcams) and are seen to be undermining the spirit of supervision. Furthermore the first step in the process (the responsible pharmacist Regulations) has been badly received and one fears that disturbing the hornet’s nest further may result in something worse. Any change in the primary legislation governing the sale and supply of medicines that we agree upon now may result in something worse. Any change in the primary legislation governing the sale and supply of medicines that we agree upon now may result in something worse. Any change in the primary legislation governing the sale and supply of medicines that we agree upon now may result in something worse. Any change in the primary legislation governing the sale and supply of medicines that we agree upon now may result in something worse.

So far so good. There are remaining issues: supervision must not lead to an unacceptable increase in risk to patients or workload for pharmacists, or adversely affect the standing of the profession, and there must be adequate staffing levels to deliver the services required. These are issues for the profession to manage and oversee because they will require continual amendment.

Pivotal to that debate is the role of individual pharmacists and their role in overseeing various aspects of medicines management, a pharmacist is usually a part of a larger system or organisation. Much of the argument is around the scope of that individual as “supervisor”. However if it ignores and does not stipulate what components should be the responsibility of other parts of the system then pharmacists are likely to find themselves continually compromised.

Crucial role
These go to the heart of the debate and will inevitably evoke strong opinions. Once again it is extremely difficult to draw a line in the sand. We must establish some firm principles that do not stifle genuine innovation and development otherwise the profession will simply be dismissed as Luddite. This is a crucial role for the RPS.
Become more involved with the therapeutics associated with the prescription (thus improving patient safety)

Provide and clinically support the supply of a wider range of medicinal products or services (thus improving medicines access)

Become a leading provider of public health interventions and health advocacy

If we are to move on as a profession and fully embrace any of these three clinical areas then the supervision debate needs to look at whether these activities are undertaken safely and supervised adequately.

The second missing principle then is that supervision by a community pharmacist should not just be about dispensing and counter sales but also involve individual responsibility to minimise the potential harm caused by prescribed medicines by assuring their clinical suitability and safe dispensing; provide safe and effective individual patient-centred services; and to provide accurate and evidence based advice.

If a prescription is supplied with a clear risk to the patient and the pharmacist failed to intervene, or if the monitoring in a pharmacy of a patient with, say, diabetes is being undertaken poorly resulting in harm to the patient, or if the pharmacy provides poor health advice, there is a failure of supervision.

At the end of this debate the national pharmacy boards have to decide their stance and, hopefully, that stance will appear reasonable to most of the profession. One suggestion is that the boards agree an overarching set of principles and then establishes a practice committee of eminent and well respected persons from both legal and pharmaceutical backgrounds to pronounce on specific situations such as whether a single community pharmacist should be expected to check, say, more than 500 items in a day when it is clearly dangerous for there to be any major clinical involvement with any of them.

If such a community pharmacist were able to become as involved with the therapeutics of the prescription as the average hospital pharmacist there might be huge benefits in terms of patient safety. However, within the current terms of the contract it would be commercially unsustainable. Patient safety must at some stage over-ride the economics and, hopefully, such a statement would settle the debate.

A hospital trust has just announced that with the use of webcam technology it is moving to a pharmacist-free dispensary. Is this the end of the road for pharmacists or is it perfectly acceptable if there are pharmacists and medicines management technicians on every ward with full electronic prescribing systems?

If a supermarket chain were to decide to remove all its pharmacists from individual stores and operate using webcams it might not meet the necessary level of supervision for the provision of services and provision of advice to sell pharmacy medicines. But could it operate as a collection point for prescriptions that were being dispensed at a central warehouse dispensary?

Adjudicating these situations will not be easy. What if a local GP practice decided to employ sufficient clinical pharmacists to clinically check all prescriptions generated by the practice? What if it then sent them to a fully automated dispensary that delivered them within two hours to a person's home? Such an arrangement could meet all the requirements of the principles and is arguably in patients' interest (even if it did put five local pharmacies out of business). Where would the profession stand then?

Most pharmacists feel uneasy about such schemes because they affect their ability to feel “in control”. Yet, as a profession, we need to establish a mechanism that provides for change but at the same time creates opportunities for pharmacists. We need to have the professional body as the tribunal for such schemes and for it to have such a high standing that its agreements are accepted by the regulator. We cannot stand Canute-like against the tide of technology and innovation but we do need a system that gives us some control over our future.

In conclusion

So which is the winner? Stone, paper or scissors? Well the answer is none of them. We have to throw the constraints of the game out the window, break all the old rules and create a new paradigm in which all three are in an harmonious balance.

EIGHT PRINCIPLES

The eight principles the Royal Pharmaceutical Society has developed that could help shape the future of the profession are:

• Patients and the public have a right to access medicines (including prescription-only medicines, pharmacy medicines and general sale list medicines), quality-assured medicines information and pharmaceutical services

• Patient safety and well-being are paramount and these need to be ensured via quality systems and processes

• Patients should have their medicines supply overseen by a pharmacist and they should have a right to counselling about their medicines

• Patients have a right to expect that a pharmacist will perform a professional check on every prescription dispensed

• The need and respect for the pharmacy profession must be protected

• Any changes to supervision should not lead to an increase in risk and any changes in workload must be at an acceptable level for the profession

• A pharmacist can only be responsible for one pharmacy at any one time

• Supervision models may vary in different settings but there must be adequate staffing levels to deliver the services required