



A Piece of my Mind

Editorial Comment

Well done, students!

After a wonderful festive season with family and friends, I was jolted back into work mode by reading the paper on the community health rotation that pharmacy students at the University of the Western Cape experience. Two aspects challenged me to think seriously about what I was reading.

My first thought was that the students had been exposed to real life and were given the opportunity to make a difference to both the patients and the staff. But, and it was a huge BUT, my goodness, it was labour intensive. It required intense collaboration between facility staff, faculty and students. Clearly, this happened. Quietly, behind our backs. And if we take this experience and multiply it by 9, we'll have an idea of what is happening at pharmacy schools around the country. Obviously, the learning experience varies depending on the facilities and resources available, but I have no doubt that all pharmacy schools have undertaken to expose students to practice at some level. I'm sure it impacts on student learning and attitudes, and I'd love to hear from recent graduates about their experiences.

The other thought I had was about something I'd missed. Or rather I missed it in 2016, when a team of pharmacists in the Western Cape had evaluated the use of aspirin in the province and had identified ways in which savings could be made. The result was that the province saved R 5 400 000. Knowing the price of one aspirin tablet made me visualise a veritable mountain of aspirin that had not been consumed by patients, because it was not appropriate for those patients to take it. And that was just aspirin. What about their other medicines?

The outcome of my interaction with this article is to ask the authors to share the results of the 2017 MUE of amitriptyline. I'd take it as a personal favour! Thank you in advance!

Refloë's FIP report

Two items that in Refloë's presidential report resonated with me. The first was the discussion about CPD. Let me tell you that I think we are extremely lucky that council chose the current outcome based system (you know I've never believed in the points system) rather than the recertification processes. At the time that council made the decision, which is now about 13 years ago, systems around the world were evaluated. If we have trouble merely thinking about what we've done and recording the outcome thereof, can you imagine if we needed to undergo periodic recertification? I can already hear the voices of some of my colleagues – but we qualified in nineteen hundred and fish and chips, and we've been doing the work all these years. Why do we need

to prove that we're competent? (Try to resist the temptation to go to where my mind took me.)

The main reason that we didn't do it then was because of the serious strain it would impose on both the office and the profession. Some countries were already doing it or considering it. I could not imagine anything worse than writing an exam right now, even if (no, especially if) it were an open-book exam. I'm perfectly comfortable with analysing benefit received from CPD and identifying what else I need to do. Personally, I'm comfortable with saying that if your CPD recording shows insight, there's a 99% chance that you are competent. (NB there's always that 1%!)

The other thing that Refloë mentioned was expanding the role of pharmacists in primary healthcare through collaborative non-dispensing services. That made me try to work out which services were being considered. Do we still define ourselves and our value by dispensing? If we look at PHC services, other than dispensing, surely a good starting point is pharmacist initiated therapy? Not necessarily PCDT. Good old-fashioned management of minor self-limiting conditions. And then there are our other potential services, such as monitoring therapeutic outcomes and medicine utilisation review. Think about it – much of what community pharmacists do is appropriate in a PHC clinic. Even monitoring patients with chronic conditions – we dispense their medicines every month and surely we check on how they are doing?

The problem is not to identify possible areas of collaboration. I'm concerned about the collaboration itself. I'm not convinced that we're always capable of collaboration. Many of us are so accustomed to being the decision makers and, often, the "boss", that we probably can't naturally fall into a situation where we need to be a team player. (I put myself in that category.) What kind of learning or experience do we need to do before we can work in a team? I suspect that we need to learn to have more self-confidence in our knowledge and ability, and we need to ensure that there is mutual professional respect among the team members.

And a final thought for the month, should we wait until we're instructed to work in a multi-disciplinary team before we begin to prepare for it? Or should we be proactive and see where we can provide collaborative services right now? At the least, it may provide a useful addition to our current practice.

Lorraine Osman