RECONSTITUTING THE PHARMACISTS' COUNCIL OF NIGERIA TO MEET THE PRESENT DAY CHALLENGES IN PHARMACY PRACTICE

BY

MOSES TOMBU IORNGURUM

Department of Clinical Pharmacy and Biopharmacy, College of Medicine, University of Lagos, Idi-Araba.
PMB 12003 Lagos, Nigeria.

SUMMARY

The Pharmacists' Council of Nigeria, as established by Decree 91 of 1992, is a specialized agency of the federal government that has the responsibility to regulate and control the practice of the pharmacy profession in all its aspects and ramifications. Its establishment marks both honour and independence to the pharmacy profession, but also confers serious national responsibility that must be effectively discharged, with efficiency and creativity, in serving the health needs of the Nigerian community.

Nigeria as a socio-political entity, and health care, globally and locally, have witnessed changes over the period since independence. Thus pharmacy has constantly been exposed to, and is still being exposed to, continuous change in its internal and external environment that affects its practice. Much progress has been made in the areas of knowledge, aptitudes and skills of practitioners of pharmacy in the country. This has naturally underscored the necessity for reorganization of pharmacy instructors in universities, and practice in associated university teaching hospitals, other tertiary care hospitals, as well as secondary care institutions. This is basically due to the fact that the old structures on ground today need review in order to effectively provide for highly specialized care, clinical instruction, research and support to primary health care (PHC), all aspirations of the national health policy, and objectives for establishment of tertiary care hospitals in the country. The old structures lack the capacity to deliver these. The job designs associated with the old structures also lack the capacity to utilize the high skills that have become available in the profession today. Thus they no longer provide a challenging job that is capable of motivating the experts and giving all practitioners a feeling of achievement, responsibility, growth, advancement, enjoyment of work itself, and earned recognition, whether in training, research, patient care, as indeed any other activity within the drug component of health care. The kind of change required in the profession at the present time is of a dimension that will require more than routine leadership skills to initiate and manage. The author therefore advises on the kind of considerations to be made while replacing the Chairman and Acting Registrar / Secretary to PCN.

Key words: Reconstitution, reorganization, pharmacy training and practice

INTRODUCTION

The Pharmacists' Council of Nigeria (PCN) is required, among other things, to regulate and control the practice of the pharmacy profession "in all its aspects and ramifications." This is indeed a broad objective. Thus the Council has more powers than the Pharmacists' Board of Nigeria, which preceded it. The Board merely played an advisory role to the Minister of Health, who was required to approve all significant actions in the pharmacy profession. With the promulgation of the Pharmacists' Council Decree No. 91 of 1992, however, the profession, so to say, was "given the knife to cut its own yam". This made the pharmacy profession independent, like any other profession in the country, to regulate and control its own affairs, as it ought to be. The obvious responsibility that accompanied establishment of a regulatory council for pharmacists lie in the fact that, Pharmacy as a profession would need to mobilize its internal resources to advance its practice; and to generally take responsibility for the entire role of drugs in health care, with efficiency and creativity. Thus pharmacists may no longer blame the minister nor indeed anyone else, within certain limits, at least, for any stagnation or lack of goal achievement in their affairs. The Pharmacists' Council, no doubt, has to plan a professional pharmacy agenda, adequate to meet the real and anticipated needs of the drug consuming public in Nigeria, and champion or lobby for its implementation. Thus, the achievement of excellence or otherwise in the effectiveness, efficiency, scope of responsibility, and the overall success of the pharmacy profession and its services, depends to a large extent, on the visionary power of pharmacists and their Council.

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This article has been motivated by a genuine, personal concern for improved health care in Nigeria and the African region, through greater utilization of the pharmacists' knowledge, skills and potentials. It introduces the central objective of the PCN, and highlights the past, present and future changes in the intrinsic and extrinsic environment of pharmacy practice. Necessity for reorganization of pharmacy education and practice is established. Objective suggestions are made, towards reconstituting a Council that is well positioned to add fundamental value to

health practice, first in Nigeria, and by induction, to other African countries. All these, for the greater good of humanity, and to the glory of God.

BACKGROUND

Pharmacy roles in the region, which is known today as Nigeria, have witnessed continuous change: from the period of the colonial days, to the independent military Nigeria, through to the democratic rule of the present time. Over the years, many changes have occurred, and are still occurring, in areas of education, skills of key players, the emphasis of functions, as global events in health practice and pharmaceutical care.

The major cadres of pharmacy practitioners witnessed in Nigeria so far include the dispensers, chemists and druggists, pharmacy assistants, technicians, and university graduate pharmacists; there was an earlier B.Sc. programme in pharmacy, followed by the presently popular B. Pharm degree, which is gradually being replaced by the emerging Pharm.D programme. Each of these cadres or qualifications represents a set of skills of practitioners that were prevalent during different periods of time in pharmacy practice in the country. Patent medicine vendors, with zero (0) skills in pharmaceutical methods and practice whatsoever, have persisted as unqualified practitioners in pharmacy "practice" since Nigerian independence, to the present day. This is most undesirable, and is unique to Nigeria.

Thus the name "pharmacy" or "pharmacist" has been loosely associated with diverse groups of health workers, each with different levels of skills and scope of practice during their own times, over the decades. Over this period, therefore, pharmacy practice could be described by different people in various ways, depending on their perceptions and experiences, so that no single uniform conception really exists in the community of what elements constitute pharmacy practice. Many Nigerians have referred to pharmacists as people who "make medicines" or "give medicines", the latter obviously referring to institutional pharmacy practice. Another conception describes pharmacists as the people who "sell medicines". This usually refers to both patent medicine vendors and community pharmacists, since many Nigerians, especially the illiterates, cannot differentiate between the two. About two years ago, a supposed enlightened young health professional told the author that "you pharmacists make drugs but do not use them," obviously referring to the knowledge of application of drugs in therapy.

> *"Rational use of drugs encompasses a comprehensive process of overlapping health care services, in most cases involving more than one professional, but definitely having the pharmacist as a major advisor on safe and effective use".*

Some of the conceptions illustrated above might be true for earlier cadres of practitioners, but certainly not so with pharmacists of today. The dispensers, chemists and druggists dominated the practice during the early years after independence. Hence public understanding of the concepts of pharmacy and pharmacy practice has been shaped with their limited scope of operations as the background. Government policies and laws had also been influenced by similar considerations, and have remained largely un-reviewed. Thus the pharmacist of today has found himself surrounded by rigid government policies, structures for practice, and a community that has an inadequate appreciation of his level of education and potentials. This is reinforced by the way pharmacists traditionally practice, especially in government hospitals, where they are literally screened from conducive patient interaction, and see patients only through windows and pigeonholes. The fact that pharmacists are so few in the country does not help matters either.

The profession has been on a constant search to "find its own feet" in the face of continuous changes in its internal and external environment of practice. As of today, the profession is yet to marshal all its resources and potentials, gained over a long period of time; to apply "new" or additional knowledge and skills to the health need of Nigerians, to any satisfactory extent. Few cases exist of noble practice, however, these are exceptions rather than popular norms. Unacceptable wide gaps exist between learning and practice, with "mountains" of knowledge completely unapplied, while society silently groans, not knowing that such knowledge has already been paid for, and is lying waste. The older, more experienced a pharmacist becomes, the further he or she gets away from patient care. Academics and the professors are the farthest from patient care. Pharmacists themselves are robbed of the tremendous job satisfaction that would naturally be derivable from their functions if their knowledge were creatively challenged by practice, to the therapeutic advantage of patients. Research in pharmacy more or less remains with the academic institutions only, and centers more on the drug product. Clinical research, aimed at directly improving drug use is scarce, all because of an inadequate organization of professional training and practice. The recent demise of the Chairman and the Acting Registrar of the Pharmacists' Council in quick succession was very shocking to all pharmacists and Nigerians. May God comfort, and give the profession equally purposeful replacements.

The foregoing background has underscored a dire need for a dynamic Council to be reconstituted, a Council that is capable of adapting itself and its professional practice to changes, within and outside the profession. Let us consider what the essence

of professional practice is all about.

PROFESSIONAL PRACTICE BASED ON SOCIAL NEED

All through history, professions exist to tackle human problems, or fulfil social demands. The unwritten definition of all professions is the problems they solve. This also defines their relevance. The more efficient and effective a profession is in this regard, the more relevant it is. Thus all professions ought to commit all the knowledge, skills and potentials of their members, towards solving collective social problems, or attending to needs of the general members of the public, as appropriate. The significance of research is to ultimately improve the state of knowledge application to practice, or to extend what is already known in a logical, systematic manner, drawing a link between the known and the unknown, or establishing what is currently known, with more evidence that is practical and reproducible. In the case of pharmacy profession, the goal should be to continually improve drug use knowledge and application to patient care. Patient orientation has been emphasized for a long time, and has been reflected in the curriculum of instruction. Pharmacists have even been trained based on principles of patient care. However, the following factors have, to varying extents, militated against full application of the pharmacists' expertise to patient care: -

I.) Inadequate structural organization for training in universities and practice in secondary and tertiary institutions of health care in the country.

ii.) Non-specialization of pharmacists to provide cutting-edge application of principles to practice.

iii.) Non-acquisition of clinical methods during training and in practice by professionals, even though pharmacy is a clinical profession. Pharmacy is the only frontline clinical profession where skills in clinical methods are not acquired nor applied.

Iv.) Lack of sufficient awareness by the general public about the potential benefits derivable from increased utilization of pharmacists in clinical care, has limited demand for such services, and possibly litigations.

v.) Misconceptions by other health professionals about the goals and essential focus of clinical practice by pharmacists.

vi.) The administrative structure at the Federal Ministry of Health and other Health Institutions do not permit adequate representation of pharmacists in decision-making posts and committees.

vii.) There are few pharmacists in the country as a whole, with even fewer in hospitals.

viii.) Comparatively poor remuneration of pharmacists in public service.

ix.) Poor state of national planning and uneven socio-political development, based on default, or shortsighted goals in Nigeria and other African countries.

x.) Others include lack of tactical approach by pharmacists, especially most leaders in the profession who had or have gained institutional or political significance.

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Non-application of the pharmacist's expert knowledge to drug therapy in a well organized manner has resulted into a significant gap in the health care services in Nigeria and other affected countries, contributing to poor overall performance of the health services. Last year, an acquaintance narrated a series of experiences, which the author believed to be attacks of hypoglycaemia. He had received glibenclamide, an oral hypoglycaemic drug, for several years from the hospital without ever being told to take it after meals. Thus he used to swallow his tablets early morning before going to work, usually before breakfast. This error was only discovered after a series of probing questions. At the time of this encounter, our friend had resigned to "fate", and accepted it as a fact that he had to endure this adverse effect for life or as long as he used that drug. The most surprising aspect of the story is that he is the head of a support service department in the university teaching hospital where he was treated. If this could happen to him, then it can best be imagined, what the incidence of such occurrence in the entire Nigerian community would be.

Majority of drug consumers in the country today do not have sufficient, if any, input of qualified pharmacists into their therapy. Rational use of drugs encompasses a comprehensive process of overlapping health care services, in most cases involving more than one professional, but definitely having the pharmacist as a major advisor on safe and effective use. To entertain any consideration that one may successfully use drugs without, or minimal requirement of the pharmacists' attention, is wrong thinking and should be seriously discouraged by all health professionals, and enlightened members of the public. It is tantamount to assumptions that a physician's expertise and attention are not necessarily required in order to recognize human illnesses and characterize them, or those good dental and surgical cares are possible without the appropriate experts in respective specialties.

Many things about drug therapy are taken for granted, which actually account for morbidity in the long run. For an example, consider the popular use of paracetamol as a pain-reliever. How many times do health professionals ensure that consumers of this "harmless" analgesic use it cautiously in the presence of alcoholism, hepatic disease, viral infection, renal function impairment or cardiovascular disease? Who is it that even remembers to enquire about the existence of the above conditions each time a patient is thought to require paracetamol? Or how often are consumers of this drug told to avoid use for self medication of a fever above 39.5°C, a fever persisting longer than 3days or a recurrent fever? Paracetamol should not be taken together with non-steroidal anti-inflammatory drugs on a regular basis. Also adult patients should be warned not to take this medication for more than 10days without expert advice. How many times have patients on prolonged use of this drug been sent to the laboratory to monitor certain parameters, especially blood urea nitrogen (BUN), serum creatinine, liver function tests, and complete blood count (CBC)?

Is it not yet time to review the drug component of the health services, to give more careful attention to drug use in the community and health care institutions, as well as restrict use of prescription and other controlled drugs? Why not reorganize and upgrade institutional pharmacy services, for comprehensiveness, to the ultimate advantage of health care to the public?

NECESSITY FOR REORGANIZATION AND IMPROVEMENT OF PHARMACY TRAINING AND PRACTICE

We shall briefly review the goal and organization of the Nigerian Health Care System, and show why adequate structural changes in the organization of pharmacy institution and practice are necessary in order to achieve those goals. The desired change shall be ultimately linked to the capacity of the leadership at the Pharmacists' Council in the recommendations.

The author sincerely believes that the single most important change that health care requires so urgently in the African region, is a comprehensive review and upgrading of the drug component of health care. This is due to the simple logic that all activities in the health care system weigh heaviest on prevention, diagnosis and treatment of human diseases. Of these three, prevention and treatment rely most on safe, effective and efficient use of drugs. Even in diagnosis, many drugs find useful application. No wonder Dr. Hiroshi Nakajima, a one time Director General of the World Health Organization (WHO) asserted that "Without drugs, a health care system lacks substance and has no credibility...."

> *"In order to break away from the limitations normally associated with organizational culture, or traditions that might have existed among staff of the Council. Reorganization of the whole Council itself might be necessary for improved effectiveness.*

Thus, the centrality of drug use to effective health care cannot be over-emphasized. In Nigeria, and most of Africa today, the state of drug use, both in the community and institutional health care, leaves much to be desired. Qualified pharmacists are in extreme short supply, and the old structural organization of services only fits the skills of the dispensers that distributed drugs in villages and health centres when there were no pharmacists in the health care services. There is non-utilization of the pharmacist's skills due to the inadequate job design for dispensers that have been forced on pharmacists through the inaction of non-review of these structures. The objectives of the health system may not be attainable under these conditions, just like a tripod stand with two and a half legs, can neither stand, nor carry any flask.

The Goal of National Health Policy

The goal of the Nigerian Health Care System as contained in the National Health Policy (1988) is a level of health that will enable all Nigerians to achieve socially and economically productive lives. The health care system has Primary Health Care (PHC) as its focus. Nigeria has a 3-tier system of health care supported by federal, state and local governments in a coordinated manner. The health system in Nigeria is comprehensive in nature. It receives multi-sectoral inputs, involves community participation, and encourages collaboration with non-governmental providers of health care. An effective referral system is expected to operate within and among the different levels of health care as appropriate.

The primary level of health care serves as the entry point into the health care system, being closest to the communities. It provides general health services of preventive, curative and rehabilitative nature to the community. The local governments, supported by state ministries of health, are responsible for this level of health care, which is normally carried out within the context of the national health policy. Private and traditional health practitioners provide health care at this level. Community (public) pharmacy practitioners therefore fit into this level of health care, just like private medical practitioners, and traditional healers.

The secondary health care level has been planned to provide specialized services to in-patients and out-patients referred from the PHC level. Health institutions at this level include hospitals for general medical, surgical, paediatric patients and community health services. Based at district, division and zonal levels of the state concerned, these institutions also serve to coordinate health care activities of the peripheral units. The General Hospitals, as they are popularly known, are the primary responsibility of the state governments. They have (adequate) supportive services such as diagnostic laboratories, blood banks, rehabilitation and physiotherapy.

Tertiary health care offers services that are highly specialized at university teaching hospitals and other referral centres. These provide care for specific diseases,

conditions of specific groups of persons, e.g. orthopaedic, eye, psychiatric, maternity and paediatric hospitals, evenly distributed geographically. Supporting services are provided alongside these facilities to effectively carter for referral services. Selected centres are encouraged to further develop specialization in the advanced modern technology, thereby serving as a resource for evaluating and adapting new developments in the context of local needs and opportunities. The tertiary care hospitals, as they are called, also have other objectives of training health manpower, research, and strengthening of PHC. The functions of training and research are under the responsibility of the Federal Ministry of Education.

All Health Institutions, whether at the Primary, Secondary or Tertiary levels of Health Care, are basically service organizations, providing health care services as their "product". A service has been defined as any act or performance that one party can offer to another, that is essentially intangible, and does not result in the ownership of anything (Hambagda, 1998). Institutions of health care, including primary health care centres, clinics, medical centres, hospitals of various descriptions, community pharmacies all offer health services, with profit or not, depending on ownership and the objectives for their establishment. Most public service organisations have social welfare objectives; hence they do not charge as much fees as private institutions that have profit motives. As with all service organizations, personnel, facilities and equipment constitute the most important internal factors of health service production. Other factors include an appropriate work environment, and a suitable management and service structure, among others. Thus personnel of required education and experience need to be attracted and retained, through use of both pecuniary and non-pecuniary compensation for the goals of the Health Care System to be achieved.

(b). *Adequate Structures Are Necessary*

For quality health care to be delivered, suitable job design (or work organization) must be made, within which service providers will function. Such structures should provide conducive working conditions, so that the skills of employed personnel will be fully utilized towards achieving established goals. The structures should also, very importantly, motivate the professionals to work effectively by providing a challenging job, which gives a feeling of achievement, responsibility, growth, advancement, enjoyment of work itself and earned recognition (Nwachukwu, 1988). Without doubt, if any job robs personnel of their needs for achievement, recognition, acceptance and self-fulfilment, such a job can never satisfy its holders.

Pharmaceutical services usually consist of two components - the provision of the physical drug product, as well as services that are drug related, patient-based and essentially intangible, e.g. therapeutic drug monitoring (TDM). Both are necessary for drug use to be safe and effective. Very simply unskilled persons may suffice making drug products available, but this proves hazardous, and the principle of learned intermediary in law contradicts such simple transfer of (especially) prescription drugs to patients. The provision of intangible services requires many years of pains taking study for trained professionals to acquire the required knowledge, skills and aptitudes necessary for such services.

During the late colonial era and early period of nationhood in Nigeria, the expansion of the health care services saw the involvement of many unskilled persons in pharmaceutical functions, especially drug distribution. The focus then was to make drug products ***available***, to citizens near their homes. There were no pharmacists in the health care services, and the dispensers' chemists and druggist operated with this focus, as a temporary measure. Thus the present work organization and pharmaceutical job designs were conceived with this calibre of personnel in mind. Since then however, the knowledge, skills and aptitudes of pharmacy personnel have continuously been reviewed and upgraded, to the full professional status of today. This is to say that, unlike the progenitors of pharmacy practice in the country, the pharmacists of today have been academically and professionally prepared to offer both the drug product, and provide patient oriented services that the Nigerian community has for long been waiting for.

This development in the capacity or capabilities of pharmacists has naturally made the old patterns of organization of pharmacy instructors in universities and practice in secondary and tertiary care hospitals, particularly the University Teaching Hospital, both old fashioned and ineffective. Without mincing words, the "pharmacy departments" at university teaching hospitals are mere product dispensaries that do not fulfil any of the objectives of tertiary care hospitals in Nigeria. They provide mock pharmaceutical services at the best.

They fall short of all the objectives as follows:

Consultants or academics and professors, within an appropriate work environment, should provide the highest level of pharmaceutical care, training, research and promotion of primary health care. The Clinical Departments of the Faculty of Pharmacy, (including Community Pharmacy) under a School of Clinical Pharmacy, should overlap with those of the Teaching Hospital, making the whole resulting structure an academic institution, that is hospital based and provides highly specialized pharmaceutical care services to patients.

Thus the present service organisation, job design of the pharmacists does not adequately utilize available human resources, does not motivate pharmacists and so is wasteful. A well-motivated employee has adult characteristics. He loves independence and possesses longer, deeper and more consistent interest in his work. A frustrated employee, on the other hand, is forced to act like a child. Typically, he has dependence syndrome with erratic, casual or shallow interest in what he does. In order to motivate pharmacists, government must encourage job enrichment, which involves

making the job holder to appreciate meaning in his work, giving him satisfaction. The pharmacist should be able to derive recognition, a sense of achievement, growth and responsibility, whether in teaching, research or in practice.

A more comprehensive description of reorganization and upgrading of training and practice structure in the pharmacy profession is not the focus in this presentation, and has been given elsewhere by the author. The present work is chiefly to establish its necessity, especially as it relates to the task of the PCN by appointment of Chairman and Registrar/Secretary.

SCOPE OF PHARMACY FUNCTIONS

This should naturally cover all areas where drugs find useful application. Obviously, the profession should show more interest in the application of drugs to veterinary practice, as well as administration of drugs to patients in hospital care, and chemical toxicities. The reconstitution of injectables in hospitals, admixtures to intravenous fluids, doses of drugs actually delivered to patients, observance of dosing intervals, including other pharmacodynamic and pharmacokinetic considerations. More attention should be paid to therapeutic drug monitoring, cost effectiveness of drug therapy, herbal medicines and other functions that generally fall within the boundaries of the drug component of health care.

In conclusion, the following suggestions are hereby proposed.

RECOMMENDATIONS

1. The Chairman and Registrar / Secretary to the Pharmacists' Council should be guided by transparent objectivity, with due regard to the main issues that deserve urgent attention and direction, as highlighted above. The desired structural changes should be focused, and should constitute the major criteria against which the possible candidates should be evaluated. They should inspire confidence, and sufficient care should be taken to ensure that the issues to be addressed are very clear to their Understanding.

2. Emotional considerations like ethnicity or partisan affiliations should be voided by all means, since these have the tendency to cloud the sense of objectivity; neither should age be seen as limitations to an otherwise good choice. Council must be given clear directions.

3. In order to break away from the limitations normally associated with organizational culture, or traditions that might have existed among staff of the Council. Reorganization of the whole Council itself might be necessary for improved effectiveness.

Due to the fact that reorganization of the Council might be necessary to improve functions, coupled with the fact that major changes required for greater performance of the pharmacy profession in Nigeria, involve very high skilled manpower utilization, the author recommends that:

4. PCN itself as well as the entire pharmacy practice structures should be creatively redesigned by careful consideration of desirable models, within and outside the country.

5. The Council's Department of Planning, Research and Statistics should be made into a fully academic department, headed by suitably qualified academics.

6. Academics of repute should continue to head the Council until relatively stable structures become established.

7. More academics should henceforth be involved, probably on part time basis, in the running of functions at the Council. Various departments might require to be headed by suitably qualified academics, with relevant experience. This is in the overall interest of the profession.

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