VIEWPOINTS

21st Century Issues in Pharmacy Education in the United Kingdom

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In the United Kingdom (UK) the discipline of pharmacy is clearly expanding, with student intakes into schools of pharmacy more than doubling in the last 20 years.¹ There are currently 16 UK schools of pharmacy, with a combined output of approximately 1600 graduate students per year. To contextualize these facts for the Journal readership, the UK population is 60 million people. The schools deliver the 4-year master of pharmacy (MPHarm) program that confers upon successful candidates the right to practice as a pharmacist subject to subsequent successful completion of the preregistration year and examinations.² MPHarm graduates also enjoy the right to mutual recognition of their pharmacy qualification across the European Union (EU), subject to completion of satisfactory “transition” procedures (normally peer observation). The MPHarm is the only qualification that the Royal Pharmaceutical Society of Great Britain (RPSGB) recognizes as suitable for entry into their preregistration year (the equivalent of the United States’ internship) and consequent entry into the register as a pharmacist. Normal practice is for students to take the preregistration qualification after completing the MPHarm program; however, 3 pharmacy schools have a gap-year program, which allows the students to spend a year in the field before completing their final year. Currently, 74% of MPHarm graduates become community pharmacists, 26% become hospital pharmacists, and 12% go into industry or academia, with the latter group normally also required to hold a relevant PhD.³ (The 112% total reflects that some pharmacists have two occupations, for example part time teaching/part time hospital pharmacy.) All 16 schools of pharmacy deliver a version of the “indicative syllabus,” a framework of learning outcomes that the RPSGB sets, and with which accredited schools must comply, based upon EU requirements. Until recently, the RPSGB was empowered to dictate the maximum number of students permitted to enter the MPHarm programs across the UK each year, effectively controlling the supply of pharmacists. This power has now been removed, making the supply of potential pharmacists deregulated and subject to market forces.

All the current schools of pharmacy are now expanding student numbers; however, this has not been mirrored by the number of preregistration places available. This is at variance with the stated shortage of qualified pharmacists in the hospital and community sectors, and is caused in part by the high training cost of the preregistration year to companies and hospital trusts. Several other UK universities are in the process of opening schools of pharmacy. In addition to these long-term chronic demographic issues, there are several more acute issues currently under debate.

Increasing student expectations of service delivery and how we might address them. We have observed that as students are directly paying an ever-increasing contribution toward their tuition (rather than indirectly by means of deferred taxation, as was the case previously), they are becoming more conscientious consumers. They are requiring increased input into their own destiny and more platforms by which they may express their wishes and views. We have aimed to address these with projects such as student focus groups⁴ and by enhancing means of student support, such as the personal tutor system.⁵

Complementary and alternative therapies. Complementary and alternative therapies are becoming more ubiquitous in the community, but may not be formally taught in the MPHarm curriculum.

The conflict between expanding student numbers and the maintenance of absolute standards. The mere fact that more students are being drawn from a demographic pool that is constant or shrinking leads to the ines-
capable conclusion that a higher proportion are going to be
academically less able to deal with the challenge of the
MPharm degree. Moreover, due to the shrinking number of
preregistration places highlighted by Taylor and Bates, an
increasing number of students are bound to be unable to
secure a preregistration place and will end up working out-
side the field or not working at all. Might this be the advent
of a two-tier system?

External legislation affecting current practice. The
process of increasing “federalization” of Europe has intro-
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is on occasions at variance with national and/or local legis-
lation. Moreover, national legislation can often follow the
“law of unintended consequences,” for example, the new
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examination answer papers but, incongruously, not the
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Research Assessment Exercise (RAE).3,9 The methods by which funds for research are allocated to schools are changing. The UK government-initiated “Roberts’ Review”10 recommends that more government funding go to fewer schools, meaning that many pharmacy schools may face the unpalatable prospect of being teaching-only schools.

Changes in student funding: the introduction of ‘top-up’ fees. Until 1998, the UK government set the level of tuition fees payable to universities, and paid them directly on a per student basis. Students were not required to contribute. For the past 5 years, students have been required to make a relatively small (£1000), annual contribution to their tuition fees. The government is now seeking to permit universities to directly charge students an annual, capped contribution (£3000) above the government contribution of funding per student. This is to be paid via a “soft” student loan, which in turn is to be repaid after graduation. This means that, whereas previously the cost of education should not have been a barrier to participation, in the future the cost of a university education may act as a disincentive to some students, perhaps those from disadvantaged backgrounds. This may discourage some otherwise able students from joining the pharmacy profession.

Perceived over-assessment by means of quality assurance (QA) measures in universities. In a 5-year period, a UK school of pharmacy may undergo 3 QA assessments; an institutional assessment in the form of a Quality Assurance Agency (QAA) Institutional Audit, a school-specific QAA Pharmacy Subject Review and an RPSGB accreditation (which will accredit the degree program for a maximum of 5 years). The increasing frequency and duration of these audits and reviews may discourage innovative practice in teaching and curriculum design, since the perception may be that “safer is better” so we proffer the question; does accreditation stifle innovation?9

The authors suspect that there are no “right” answers to the above issues and even if there were, what is right today may be less so tomorrow. There are clearly interesting times ahead for pharmacy educators in the UK, perhaps more so than at any other time – a challenge to which we must rise.

REFERENCES

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