The interface between the community pharmacist and patients

Christine M Bond, Colin Bradley

This is the third of four articles examining the implications of the availability and use of non-prescription medicines for health services in Britain and elsewhere

Pharmacists play an important part in primary health care, and their accessibility is a key factor. Their NHS payments relate predominantly to the dispensing of prescribed medicines; to recognise the service element of their advisory role, an NHS funded professional fee could be built into the cost structure for pharmacy medicines. The increased number of medicines available over the counter has highlighted the need for training for counter assistants; it will become compulsory in July 1996, and some family health services authorities are providing this. The shift to care in the community could mean that pharmacists will have an even greater role in the primary health care team. Encouraging the public to seek advice from the community pharmacist may lead to a greater proportion of visits to doctors resulting from referrals from the pharmacist. Joint development by pharmacists and doctors of guidelines for advice on, and recommendation of, over the counter medicines is needed.

The constantly increasing expenditure on health care has forced governments to look at ways of reducing costs, particularly with respect to drugs. Initiatives have been directed at promoting rational and cost effective prescribing and have also considered how underutilised professionals can make a greater contribution to more effective use of medicines. Community pharmacists, "overtrained for what they do and underutilised in what they know,"¹ have been identified as one such resource.²⁻⁴ A key role is over the counter advice, the scope of which has been increased by recent switches of drugs from prescription only medicines to pharmacy status. As a result there are implications for the working arrangements in primary health care, particularly at the interface of the community pharmacy and general practitioner.

Organisation of community pharmacies

Currently there are just over 12 000 community pharmacies in the United Kingdom, of which 27% are part of large multiples (10 or more branches); the remainder are either small chains or owned by the proprietor. The system provides a network for the distribution of medicines and provision of advice to the public and other health care professionals. Pharmacists play an important part in health promotion, and their accessibility is a key factor. All pharmacists and premises are registered with the Royal Pharmaceutical Society of Great Britain (RPSGB), which ensures that standards are maintained. Pharmacists are independent contractors within the NHS and can apply to supply NHS related services to local family health services authorities. This restriction on the awarding of NHS contracts prevents overprovision of services in desirable areas but cannot ensure adequate provision in others. The resultant distribution of community pharmacies does not totally reflect need, and an Audit Office report recommended the closure of some pharmacies in areas where there was clustering.⁵ The government sponsored Essential Small Pharmacies Scheme provides financial support to allow selected

pharmacies, which otherwise would not be viable, to remain open.

Public expenditure on the community pharmacy service is little more than 2% of the overall cost of the NHS. The viability of pharmacies depends on some remuneration being provided by commercial activities. The dispensing of prescribed medicines is currently the basis of the major portion of NHS remuneration for pharmacists. A global sum, agreed by the profession's negotiating body and the government, is apportioned according to the number of prescriptions dispensed. In addition, pharmacies may be eligible to receive a "professional allowance" for which certain criteria have to be fulfilled: minimum dispensing workload, health promotion leaflets, practice leaflets, and in Scotland, provision of health related advice and audit.

In practice, payment for the advisory role is closely tied to the profit on any associated sale. This has led to accusations that professional judgment will conflict with commercial interest, although there is evidence against this.⁶ This conflict could be avoided if an NHS funded professional fee, recognising the service element of the advisory role, were built into the cost structure for pharmacy medicines.⁷

Training pharmacy staff

Pharmacists undertake a three year science based degree course (four years in Scotland), followed by a structured and competence based one year training period before professional registration. A four year undergraduate course will become compulsory for all of the United Kingdom from 1997. Emphasis has traditionally concentrated on theoretical pharmaceutical sciences, but schools of pharmacy are now placing increased emphasis on communication and counselling skills.⁸ After registration there is a professional requirement to complete 30 hours of continuing education each year.⁹ The pharmacist receives no individual financial recognition of this (in contrast with general medical practitioners, who receive a post-graduate education allowance), but national investment by the health departments resulted in the establishment of the Centre for Pharmacy Postgraduate Education in England and equivalent organisations in Scotland, Wales, and Northern Ireland. Provision by these centres is free of charge to community pharmacists. Membership of the postgraduate College of Pharmacy Practice requires evidence of continuing education activities as well as stringent entrance qualifications.

The increase in the number of medicines available over the counter has highlighted the need for training for counter assistants. Until recently there were no statutory requirements for this, and formal qualifications were held by only a few assistants. From July 1996 the Royal Pharmaceutical Society of Great Britain will require that all counter staff who sell medicines should have completed or be undertaking an accredited training programme.¹⁰ To ensure that sales of medicines with pharmacy status are subject to pharmaceutical control, all community pharmacists must now have a written supervision protocol agreed with their staff. The protocols, introduced by RPSGB in 1995, provide

University Department of
General Practice,
University of Aberdeen,
Aberdeen
Christine M Bond, lecturer

University Department of
General Practice,
University of Birmingham
Medical School,
Birmingham B15 2TT
Colin Bradley, senior lecturer

Correspondence to:
Dr Bond.

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WWHAM acronym

The WWHAM acronym, devised by the National Pharmaceutical Association, reminds pharmacy staff of five key points that should always be covered when dispensing over the counter medicines

- What are the symptoms?
- Who is it for?
- How long have they had them?
- Action already taken?
- Medicines being taken for other problems?

information to help assistants understand the risks associated with potent over the counter drugs and to know the questions that need to be asked routinely for certain specific products and which sales have to be referred to the pharmacist.

But the quality of advice provided in pharmacies by both pharmacists and their assistants has been questioned. Reports by the Consumers' Association and others¹¹ have found that many pharmacists fall short of their profession's standards, as well as those of independent experts. A further study showed that a self selected group of pharmacists (and their assistants) failed to deliver advice in accordance with standards that they themselves had set.¹²

Pharmacists and the primary health care team

In 1979 the Royal Commission on the NHS promoted the development of pharmacies in health centres to encourage more interchange between the pharmacist and the rest of the health care team. In 1991 integrated pharmacies constituted only 10% of the total number of pharmacies in England and 3% in Scotland.¹³ Formal links with general practitioners are still infrequent. Most interdisciplinary contact seems to be reactive and limited to queries about prescriptions.

Much of the interaction between pharmacists and general practices has developed on an ad hoc basis. Individual initiatives include the provision of formulary and prescribing advice, clinical pharmacy review of repeat prescribing, control of repeat prescribing, domiciliary visits, and—rarely—therapeutic drug monitoring. Some practices employ one pharmacist to provide a range of such services; in others, individual tasks are commissioned as needed. General practitioners' attitudes to such roles are generally positive towards the more traditional roles and negative to the more innovative.¹⁴ Contact with other members of the health care team is infrequent, although the shift to care in the community could mean that input from pharmacists will become greater.

Role of family health services authorities and commissioning agencies

The role of family health services authorities in monitoring of pharmacy practice is rather limited and is not dissimilar to their involvement in medical audit in general practice. Family health services authorities clearly have an interest in the quality of services provided by their contractors, but the assessment of that quality is still seen as coming from the profession itself. The standards of pharmacy practice are enforced by the Royal Pharmaceutical Society through its inspectors. In several regions audit facilitators employed by the family health services authority are helping pharmacists to develop self audit and peer review.

Some family health services authorities are sponsoring training for counter assistants to help their contracting pharmacists meet the new requirements.

Family health services authorities are also required, jointly with contracting pharmacists, to develop and monitor standards for pharmacy services to residential and nursing homes. They organise schemes for the disposal of unwanted medicines. Family health services authorities may also develop contracts with pharmacists over and above their basic NHS contract—for example, for needle exchange schemes. Clearly, sensible family health services authorities will build in service level agreements and monitor performance against these.

Family health services authorities have, since April 1995, negotiated local contracts for some pharmaceutical services, such as services to nursing homes. When the new unified health authorities take over from family health services authorities in April 1996 they will continue this function, and their role in local contracting with pharmacists is expected to increase.¹⁵

Patients' interests

Consumers have expressed a high level of demand for the pharmacist's "advisory" role, and pharmacists are perceived as the experts on medicines.¹⁶ Pharmacists need to be aware, however, that many customers do not know the opportunity costs or risks associated with the purchase of over the counter medicines. Community pharmacists and their assistants can minimise these risks by using measures already described. Pharmacists also need to be more aware that patients do not like discussing sensitive issues "over the counter." One way to address this would be to provide a private area for consultation.

For those who prefer to make an autonomous purchase, taking complete responsibility for their own health, pharmacists should offer the minimum control in such a way that these individuals do not feel intruded on, yet be open enough to encourage detailed discussion should the patient wish. They should also try to involve these patients in any choices being made on their behalf. The National Pharmaceutical Association and the Royal Pharmaceutical Society have produced a model patient handout or poster for pharmacists to use (fig 1), and a pharmacy awareness week took place in June 1995. Patients need to appreciate that the pharmacist has a professional responsibility for the correct

Fig 1—Model patient handout or poster for pharmacists to use

use of all medicines. Campaigns to inform patients about self education would be to the public benefit.

Good teamwork is essential

Encouraging the public to seek advice from the community pharmacist may lead to a greater proportion of visits to doctors resulting from referrals from the pharmacist, perhaps through formal referral forms. The change in status of prescription only medicines to pharmacy sale may also result in general practitioners referring patients to the pharmacist to purchase an over the counter medicine. The opportunities for team-working between the two professions will grow. One way to encourage good teamwork is for general practitioners, pharmacists, and others to collaborate in the development of clinical treatment guidelines for specific conditions—for example, dyspepsia.¹⁷ The process of developing such guidelines has resulted in better understanding of different levels of professional care and produced guidelines that were welcomed by community pharmacists. Other initiatives to help integrate community pharmacists to achieve a recognised place in the primary health care team must be formally pursued.

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North of England evidence based guidelines development project: methods of guideline development

Martin Eccles, Zoe Clapp, Jeremy Grimshaw, Philip C Adams, Bernard Higgins, Ian Purves, Ian Russell

This is the first of three articles on developing evidence based guidelines for the primary care management of asthma and angina in adults

*The evidence on which these guidelines are based appears in full in the BMJ's world wide web page:
<http://www.bmj.com/bmj/>*

There is increasing interest in clinical guidelines in Britain. With this interest has come increasing awareness of the methodological issues in the development of valid guidelines.¹⁻³ Practice guidelines are considered valid if "when followed, they lead to the health gains and costs predicted for them."⁴ When appropriately disseminated and implemented, valid guidelines can lead to changes in clinical practice and improvements in patient outcome.⁴⁻⁷ Conversely, the dissemination and implementation of invalid guidelines may lead to wasteful use of resources on ineffective interventions or, worse, deterioration in patients' health.

Validity has been related to three principal factors in guideline development—namely, the composition of the guideline development panel and its processes; the identification and synthesis of evidence; and the method of guideline construction.⁸ Though these factors have been discussed at theoretical⁹ and more practical levels,⁸ there have been few attempts to put them into practice in Britain. In this series of three papers we describe the methods used to develop evidence based guidelines for the primary care management of two common chronic conditions—namely, asthma in adults and stable angina—and summary versions of the two guidelines that resulted.^{9,10}

Guideline development groups

The guideline development groups were composed of relevant health care professionals and patients; a specialist resource (a consultant chest physician for asthma and a consultant cardiologist for stable angina) and an experienced small group leader; and members of the research team. All group members were offered reimbursement of travelling expenses, and general practitioners and practice nurses were offered reimbursement of any locum expenses.

Evidence review and synthesis

SEARCH STRATEGY

The search was carried out with Medline and covered the 10 years 1985-94. This was a pragmatic decision influenced by the volume of papers and the time and resources available. All searches were confined to studies of human adults written in English. For both topics we conducted medical subject heading and free text searches using the terms meta-analysis, randomised controlled trial, review, cohort study, and case-control study. For asthma we also sought the terms asthma, peak expiratory flow rate, obstructive lung disease, forced expiratory volume, and paroxysmal dyspnoea; for stable angina we sought the terms coronary disease and angina pectoris. Additional specific Medline searches were carried out by using the following terms: decision making, theophylline, terbutaline, antihistamine, isosorbide, myocardial infarction plus secondary prevention, and buccal.

The BIDS (Bath Information and Data Services, Institute for Scientific Information, University of Bath) electronic database was also searched (by using the terms "asthma+management" and "angina+management"). In addition, references were identified from two other sources. Firstly, if there was no recent evidence in a clinically important topic the specialist resource was asked to identify from personal knowledge key articles published before 1985. Secondly, the reference lists of non-systematic reviews were checked. We did not attempt to access the grey literature, nor did we identify letters in response to original articles.

ASSESSING THE LITERATURE

The sets of references generated by the searches were sifted for relevance to the clinical topic of the guidelines. The initial sifting was done by a clinically qualified health services researcher (ME) on the basis

Correspondence to: Dr Eccles.

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