Canadian “minor ailments” programs: Unanswered questions

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Introduction

Six Canadian provinces allow pharmacists to prescribe for ambulatory conditions (also sometimes referred to as “minor ailments”; see below). In 2007, Alberta became the first province to lay the legislative groundwork for a pharmacist-led ambulatory condition program (PACP) through its “Additional Prescribing Authority.”^{1,2} In 2011, Nova Scotia and Saskatchewan introduced their PACPs. In 2014, Manitoba, New Brunswick and Prince Edward Island followed suit.²⁻⁴ Most recently, British Columbia and Newfoundland have submitted proposals for PACPs.^{5,6}

In Ontario, despite advocacy efforts by the Ontario Pharmacists Association (OPA) and support from the Ontario College of Pharmacists (OCP), prescribing for ambulatory conditions was not part of the 2012 scope of practice changes.^{3,7} The Health Professions Regulatory Advisory Council (HPRAC), responsible for the scope of practice changes, reported that pharmacists had the necessary training, but suggested a working group be formed to discuss possible frameworks.⁷ To date, this group has not been convened.

This commentary highlights 5 controversies regarding Canadian pharmacist-led ambulatory conditions programs, all of which are important considerations for other jurisdictions moving forward with such programs.

Terminology

Davies and Tsuyuki suggest that using terms like “minor” ailments and “self-limiting” conditions are demeaning to the pharmacy profession.⁸ “Minor” is synonymous with “lesser in importance, insignificant, trivial,” and “self-limiting” implies that the condition would resolve on its own and any intervention by a pharmacist would have no clinical impact.⁸ Instead, they propose the term “ambulatory conditions.”⁸

We agree and share these concerns, as does OPA, who refer to “common ailments” in their advocacy efforts. As a profession, pharmacists have a history of adopting terms that

are suboptimal descriptors for our services. An example is the use of “cognitive services” to describe enhanced professional services extending beyond dispensing. “Cognitive services” implies that the act of assessing and verifying the correct and appropriate provision of medication does not require higher-order executive functioning.

The counterargument is that “minor ailments” has been accepted internationally and is used extensively in published literature. A change in terminology for the Ontario context may give rise to confusion among health care professionals and patients outside this jurisdiction. We do not propose to have the ideal solution for this dilemma but feel common terminology is important for moving discussions forward. In this article, we will use the terminology “ambulatory conditions” except when referring to an actual program name.

Additional training for ambulatory condition prescribing

Among provinces that currently have PACPs in place, Saskatchewan, Manitoba and Prince Edward Island mandate that pharmacists undergo additional training.⁹⁻¹¹ In the other provinces, pharmacists are expected to practise within their own competencies, so undertaking additional training is optional. Most provinces currently offer online training courses through universities’ continuing professional development programs.^{9,11,12}

Some pharmacists may believe that additional training is unnecessary, either because they have received adequate training in ambulatory conditions during their education or have extensive experience in providing such care and advice to patients. This is consistent with the Ontario HPRAC position.

However, including mandatory training as part of a proposal for a new service may facilitate acceptance of this expanded scope by other health professionals. In our work through the

Editor’s note: The authors and CPJ agree that “minor ailments” is a suboptimal and potentially demeaning terminology. However, because some programs have incorporated the term “minor ailments” into their names, we have used this terminology when referring to specific programs. Otherwise, we have held our noses and adopted the term “ambulatory conditions.”

Ontario Pharmacy Research Collaboration, we have observed that documentation practices for existing prescribing services are highly variable. As such, we support training with, at a minimum, a focus on standardized provincial documentation procedures, with the hope that this may enhance the consistency and quality of documentation of pharmacist prescribing activities.

Diagnosis versus assessment

Another controversy is whether pharmacists are assuming a role of “diagnosing” within PACPs. The Ontario Medical Association has stated that ambulatory condition prescribing involves making and communicating a diagnosis. They feel this is inappropriate because pharmacists are “not trained to conduct differential diagnoses or take a patient’s history during an examination.”⁷ Contrarily, the OCP contends that a PACP is consistent with pharmacists’ roles as medication therapy management experts. Furthermore, OCP states that assessing and recommending a medication for an ambulatory condition are distinct from communicating a diagnosis.⁷ Another view is that pharmacists, through recommendations for over-the-counter medications, collect histories, consider differential diagnoses and prescribe medications for many patients on a daily basis.

Saskatchewan averted this issue by requiring that the patient “self-diagnose” their condition before approaching a pharmacist and restricted the authorization of ailments to those that can be reliably self-diagnosed by patients.¹⁶ In this case, we trust patients to diagnose but not pharmacists. Avoidance of the term “diagnosis” again belittles what pharmacists do every day. We do not profess to have an easy resolution for this debate. Ultimately, it is a core issue through which each jurisdiction will need to tread.

Impact on general practitioner workload

A proposed benefit of PACPs is that treatment of ambulatory conditions shifts from general practitioners (GPs) to pharmacists, thereby freeing up time for GPs to care for patients with more complex conditions.¹³ This would improve the efficient use of health resources and overall access to care.¹³

The Ontario Medical Association has expressed a counter viewpoint. “If the pharmacist authorizes an incorrect dosage or provides the patient with misinformation about their medication treatment, the physician’s workload significantly increases.”⁷ Reviewing the literature, we believe that this concern is not supported by existing evidence.

The United Kingdom is about 10 to 15 years ahead of Canada in implementing PACPs. A recent systematic review found that consultations and prescribing for ambulatory conditions by GPs decreased following introduction of the pharmacist-led minor ailments service (PMAS).¹⁴ This is consistent with results from an earlier systematic review by the National Public Health Service for Wales in 2007, which also found a reduction

in GP consultations for ambulatory conditions.¹⁵ Preliminary evaluations suggest that PMAS will provide GPs with more time to care for patients with more serious illnesses.

Reconsultation (i.e., visiting one professional and subsequently visiting another for confirmation of the diagnosis or management plan) is another metric of program performance. Paudyal et al. found varying rates of GP reconsultations (from 2.4% to 23.4%) following an index consultation with a pharmacist.¹⁴ One study included in the systematic review found that reconsultations were similar between patients who had an initial consultation with a pharmacist and patients who had an initial consultation with a GP.¹⁴ Mansell et al. found a 3% reconsultation rate in their 2014 Saskatchewan study.²

Therefore, controversy concerning the impact on GP load related to ambulatory conditions appears unwarranted. However, these parameters should be included when selecting which outcomes to measure during future evaluations.

Conflicts of interest

Physician groups have highlighted that involving pharmacists in both assessing (and diagnosing) a medical condition and selling the medication to treat the condition presents a conflict of interest.⁷ Furthermore, the Ontario College of Family Physicians is concerned that the relationship between pharmacists and drug companies may compromise their ability to prescribe patients the optimal, evidence-based drug therapy.⁷ These conflicts of interest are common “white elephants” for the pharmacy profession, and not unique to pharmacy. Physicians, dentists, physiotherapists, and so on are all subject to similar concerns whereby they diagnose and are remunerated for the procedure, surgery and follow-up treatments.

Aside from Alberta, Saskatchewan is the only province that remunerates pharmacists for the minor ailment program. However, the \$18 fee is only for assessments that result in a prescription.^{4,17,18} This ties the reimbursement to the product and theoretically could result in pharmacists choosing to prescribe when there may be equally appropriate nonprescription alternatives. Our concern is that by reimbursing the pharmacist for the act of prescribing, pharmacists’ expertise in performing the patient assessments is undermined and also might even encourage overuse of medications.

We support reimbursing pharmacists for their assessments regardless of whether the outcome produces a prescription. This mitigates potential conflicts and aligns our profession with others. For example, dentists are paid for their assessments separately from the unique products they provide. This approach is not without precedent in pharmacy, either. Alberta’s “additional prescribing authority” system reimburses pharmacists per assessment, and in the United Kingdom, reimbursement is capitation based but provides a fee per assessment. Efforts to minimize conflicts of interest when

offering this new service will not only increase acceptance by other professions but also increase the public's trust in our profession.

Conclusion

In conclusion, 5 controversies warranting discussion as new provinces consider PCAP are 1) terminology (i.e., what to call

the service), 2) additional training, 3) determining whether diagnosis (vs assessment) is necessary for these conditions, 4) addressing other practitioners' concerns over changes to workload, and 5) assuaging concern about pharmacists' actual or potential conflicts of interest. Addressing these concerns will facilitate the implementation of a successful, patient-centred and integrated program. ■

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References

1. Canadian Pharmacists' Association. Scope of practice summary chart. Available: www.pharmacists.ca/index.cfm/pharmacy-in-canada/scope-of-practice-canada/ (accessed November 19, 2014).
2. Mansell K, Bootsman N, Kuntz A, et al. Evaluating pharmacist prescribing for minor ailments. *Int J Pharm Pract* 2015;23:95–101.
3. Ontario Pharmacists Association (OPA). Expanded scope PHM427 lecture slides. 2013.
4. Canadian Pharmacists' Association (CPhA). Blueprint for pharmacy: cross-jurisdictional scan of legislative and policy framework. January 2013. Available: http://blueprintforpharmacy.ca/docs/kt-tools/blueprint_policy-framework_final---january-2013.pdf (accessed September 15, 2015).
5. British Columbia Pharmacy Association (BCPhA). Clinical services proposals: treatment of minor ailments. March 2013. Available: www.bcpharmacy.ca/clinical-services-proposals (accessed September 15, 2015).
6. Pharmacist's Association of Newfoundland and Labrador. The pharmacist option: leveraging Newfoundland and Labrador's pharmacists for cost-effective health care delivery. Available: www.panl.net/userfiles/files/The%20Pharmacist%20Option.pdf (accessed September 15, 2015).
7. Health Professions Regulatory Advisory Council. Pharmacy scope of practice review. Available: www.hprac.org/en/projects/Pharmacy_Scope_of_Practice.asp (accessed November 24, 2014).
8. Davies NM. Minor ailments and self-limiting conditions: NOT. *Can Pharm J (Ott)* 2014;147:137.
9. University of Saskatchewan, College of Pharmacy and Nutrition. Continuing Professional Development for Pharmacists. Available: www.usask.ca/pharmacy-nutrition/professional-services/cdp/ce-online-courses.php (accessed November 24, 2014).
10. College of Pharmacists of Manitoba (CPhM). Fundamentals of self-limiting conditions: prescribing for Manitoba pharmacists. Available: <http://mpha.in1touch.org/uploaded/web/PD/Self%20Limiting%20Conditions%20Jan%2009%20final.pdf> (accessed November 24, 2014).
11. Advancing Practice. Self-limiting conditions independent study program. Available: www.advancingpractice.com/p-78-self-limiting-conditions-independent-study-program.aspx (accessed November 22, 2014).
12. Dalhousie University. Prescribing for minor ailments in the Maritimes (2014). Available: www.dal.ca/faculty/healthprofessions/cpe/programs/live-programs/prescribing-for-minor-ailments-in-the-maritimes--2014-.html (accessed November 24, 2014).
13. Blueprint for Pharmacy. Our way forward: optimizing drug therapy outcomes for Canadians through patient-centred care. June 2013. Available: www.blueprintforpharmacy.ca/docs/pdfs/blueprint-priorities---our-way-forward-2013---june-2013.pdf (accessed September 15, 2015).
14. Paudyal V, Watson MC, Sach T, et al. Are pharmacy-based minor ailment schemes a substitute for other service providers? A systematic review. *Brit J Gen Pract* 2013;63:e472–81.
15. National Public Health Services for Wales. Rapid review of the evidence on the effectiveness of community pharmacist minor ailment schemes. September 2007. Available: www.wales.nhs.uk/sitesplus/888/news/14540 (accessed September 15, 2015).
16. University of Saskatchewan. Guidelines for minor ailment prescribing. Available: www.medsask.usask.ca/professional/guidelines/index.php (accessed November 24, 2014).
17. Saskatchewan pharmacists pleased with demand for prescribing services, but seek to expand assessments for minor ailments. *Can Pharm J (Ott)* 2013;146:17.
18. Blueprint for Pharmacy. News story: Saskatchewan starting minor ailment fees. Available: <http://blueprintforpharmacy.ca/news/news-story/2012/01/31/saskatchewan-starting-minor-ailment-fees> (accessed November 24, 2014).