

General practitioners and community pharmacists: times they are a-changing

*Come senators, congressmen
Please heed the call
Don't stand in the doorway
Don't block up the hall
For he that gets hurt
Will be he who has stalled
There's a battle outside
And it is ragin'.
It'll soon shake your windows
And rattle your walls
For the times they are a-changin'.*
Bob Dylan, 1963.

AS general practice and pharmacy work towards delivering government modernisation policies in the NHS, service re-design and role re-configuration are high on many agendas — not least the primary care organisations. In many places general practitioners and pharmacists are working together to deliver new and imaginative professional developments and, in some cases, to share the care of patients in very different and ground-breaking ways.

Every week our professional journals contain examples of new and innovative services: pharmacists based in general practices and providing medication reviews^{1,2} and coronary heart disease clinics;³ schemes for the referral of minor ailments to community pharmacies⁴ and electronic access to patient records for community pharmacists.⁵

Mutual respect and professional trust between hospital doctors and pharmacists have grown over the last 20 years, born out of closer professional working and shared decision making.^{6,7} However, research, including a paper in this edition of the *British Journal of General Practice*,⁸ suggests that less progress has been made in primary care. The evidence to inform thinking as we take our first tentative steps towards closer professional working appears, at least at first sight, to be contradictory and equivocal.

Current changes to the national contracts in both general practice⁹ and community pharmacy¹⁰ will increasingly allow greater flexibility for our professions to work together and could therefore provide a helpful context in which these and other innovations will flourish as part of mainstream practice. However, if a culture of mistrust and misunderstanding thrives, as both professions struggle to overcome growing recruitment and retention difficulties, to meet rising patient and NHS expectations, and to deal with the fear of litigation and falling morale, any interesting innovations may wither on the vine.

It is possible, based on the current published literature, to and address three critical questions, which may help us to structure a meaningful dialogue and debate and to support general practitioners and pharmacists through a potentially difficult period of change:

1. Can a pharmacist currently undertake the main task of a general practitioner?

2. Can a community pharmacist work with a general practitioner to provide high-quality care?
3. Does the high-quality care provided by general practitioners and pharmacists meet the needs and expectations of patients?

If it is accepted that the main task of a doctor is determining what is wrong and why and then deciding what could and should be done,¹¹ then the answer to the first question is no, except in very specific and limited circumstances.

In terms of supporting patients to make the right decisions about treating self-limiting and non-life-threatening symptoms, community pharmacists and their staff already play a valuable and recognised part in determining what might be wrong and advising on what could and should be done.¹² They have demonstrated themselves capable of making appropriate decisions about what they can and cannot deal with and referring onto a general practitioner where necessary.¹³ In this role, pharmacists meet the needs of patients with regard to fast access to medicines and advice, provide re-assurance about when it is appropriate to consult a general practitioner, and therefore support patients who are reticent about making potentially unnecessary demands on their general practitioner and the NHS.¹²

It is unsurprising therefore that schemes to allow patients to consult with community pharmacists instead of general practitioners and still receive medicines through the NHS have proved to be appropriate, effective, efficient, equitable and acceptable to all parties.⁴ However, it should not be concluded from this that currently pharmacists could, should or indeed wish to take on the role of the doctor in determining what is wrong and why in any circumstances other than advising on self-limiting and non-life-threatening symptoms. Thus responsibility for primary diagnosis is unlikely to emerge as contested territory in the current developments.

It is accepted by general practitioners that, when working in practices alongside the doctors and other members of the team, selection of best treatments, monitoring of outcomes and recommending, and even making, changes to prescriptions is a largely uncontested role for pharmacists.¹⁴ This recognition of a pharmacist's capabilities holds true even when the pharmacist is employed on a sessional basis and practises predominantly in a community pharmacy setting.³

The answer to the second question: 'Can a community pharmacist work with a general practitioner to provide high-quality care?' is therefore 'yes' in deciding what can and should be done in relation to treatment with prescribed medicines, *but* only when based in the general practice setting.

It would appear, therefore, that it is not a general concern about pharmacists' knowledge, skills and capabilities, but is a more particular concern about the context or setting in which they are deployed that is important. The central issue appears to be a fear among general practitioners that, in the privately financed, commercially focused environment of a community pharmacy, a pharmacist may not be able to resist 'the temp-

tation to act, maybe unconsciously, in their own interests'.¹¹ It offers an unacceptable level of moral hazard.

However, in an ethnographic study, community pharmacists were observed making referrals and giving advice that did not involve making a sale.¹³ Where community pharmacists took on prescribing for patients in one general practice with a range of minor and self-limiting symptoms, the costs of prescribing remained the same.⁴ It would appear, therefore, that while pharmacists working in community pharmacy may be in a more vulnerable position, they do not automatically succumb to the temptation to act in their own interests. They are able to avoid the moral hazard.

Privacy in a community pharmacy is also cited as a potential barrier to conducting detailed consultations and therefore to eliciting appropriate advice and information.¹² However, research suggests that when deciding where to seek advice and from whom, patients make a series of trade-offs. In certain circumstances, particularly when the symptoms have been experienced on previous occasions, patients may forgo privacy in favour of easier access to medicines or to avoid examination.¹⁵ Even in circumstances which we, as healthcare professionals, perceive as being sensitive or even embarrassing, some patients experience no such feelings — the need for privacy may, like beauty, be in the eye of the beholder.¹⁵ In some instances, patients may even value the experience of other customers in the pharmacy¹⁶ — a situation which may compromise the advice that is being given by the pharmacist.

Perhaps a more straightforward reason why general practitioners and community pharmacists have not developed a trusting and respectful relationship is simply that they don't know one another very well. If this is the case, then it is hardly surprising that services involving community pharmacists working in a surgery are seen as being less controversial than those based in the community pharmacy. In the absence of trust and respect born out of shared professional values, experience and even adversity, the professional relationship between general practitioners and community pharmacists may just not be strong enough to sustain joint working in two geographically distant locations.

It may therefore be that if community pharmacists continue to undertake sessional work in surgeries, mutual respect and trust will emerge and the delivery of pharmacist-led services based in pharmacies, as well as surgeries, will become a universally acceptable development. The implementation of supplementary prescribing and local pharmaceutical service contracts, which require a named pharmacist, may act as a catalyst for more relationships to be developed and cemented. The introduction of new contracts and the development of shared learning may help to sustain integrated professional networks and offer opportunities for shared professional values to be identified.

However, if it is the case that getting to know one another is the key, then progress will be made more difficult by the trend in both professions, but particularly in community pharmacy, towards an increasingly mobile workforce, more locums and part-time working.

That leaves the third question about whether the high-quality care provided by GPs and pharmacists meets the needs and expectations of patients, and a second paper in

this edition suggests the answer is not necessarily.¹⁷ If patients are suspicious of the professional's motives they may feel their needs are not being addressed in the design and implementation of any new services offered. Research has shown that patients hold very firm views about who does what and why with regard to their care.¹² We need to be wary of being too introspective and excluding patients from our deliberations. If we work with patients and involve them in designing new services we may be surprised about the extent and pace of the change that can be achieved¹⁸ — without damaging any of the parties' confidence or sense of self worth.

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