Perceived interprofessional barriers between community pharmacists and general practitioners: a qualitative assessment

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SUMMARY

Background: *There have been calls for greater collaboration between general practitioners (GPs) and community pharmacists in primary care.*
Aim: *To explore barriers between the two professions in relation to closer interprofessional working and the extension of prescribing rights to pharmacists.*
Design of study: *Qualitative study.*
Setting: *Three locality areas of a health and social services board in Northern Ireland.*
Method: *GPs and community pharmacists participated in uniprofessional focus groups; data were analysed using interpretative phenomenology.*
Results: *Twenty-two GPs (distributed over five focus groups) and 31 pharmacists (distributed over six focus groups) participated in the study. The 'shopkeeper' image of community pharmacy emerged as the superordinate theme, with subthemes of access, hierarchy and awareness. The shopkeeper image and conflict between business and health care permeated the GPs' discussions and accounted for their concerns regarding the extension of prescribing rights to community pharmacists and involvement in extended services. Community pharmacists felt such views influenced their position in the hierarchy of health-care professionals. Although GPs had little problem in accessing pharmacists, they considered that patients experienced difficulties owing to the limited opening hours of pharmacies. Conversely, pharmacists reported great difficulty in accessing GPs, largely owing to the gatekeeper role of receptionists. GPs reported being unaware of the training and activities of community pharmacists and participating pharmacists also felt that GPs had no appreciation of their role in health care.*
Conclusion: *A number of important barriers between GPs and community pharmacists have been identified, which must be overcome if interprofessional liaison between the two professions is to be fully realised.*
Keywords: *general practitioner; community pharmacist; prescribing; barriers; qualitative research.*

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Introduction

PHARMACISTS are being challenged to become key players in the prescribing process, as well as becoming advocates for patients through optimising and monitoring drug use.[1-3] Clearly, this requires more formal integration of pharmacists into health care and the development of partnerships, particularly with general practitioners (GPs).

This may be realised through the Crown report on prescribing, supply and administration of medicines.[4] The report recommended extending prescribing rights to other professional groups, including pharmacists. It is envisaged that pharmacists will become dependent, or supplementary, prescribers (as opposed to independent prescribers, such as GPs and dentists, and to some extent, nurses), which will allow them to prescribe a wide range of drugs, after diagnosis by a doctor and within a clinical management plan. They will be responsible for continuing care for patients who have been assessed by an independent prescriber, e.g in the management of asthma or hypertension. Access to medical notes would be granted to supplementary prescribers.[4]

Clearly, such recommendations will have major legislative, training, clinical and professional implications, notably in primary care. Hospital physicians are familiar with clinical pharmacists, who are often part of ward rounds and are active in the drug management of patients.[5] GPs have become familiar with the role of prescribing advisers or practice pharmacists who provide advice on prescribing.[6,7] Links between GPs and community pharmacists, however, are less formalised. One issue raised by previous research in relation to the development of the role of the pharmacist is the perceived professional barriers between GPs and community pharmacists.[8] The Crown report recommendations implicitly demand greater collaboration between the two professions, and, if barriers exist, these must be overcome before comprehensive interprofessional working can be realised. Thus, the aim of this study was, through qualitative methodology, to identify and explore perceived (or otherwise) barriers between GPs and community pharmacists in relation to interprofessional working and the extension of prescribing rights to pharmacists.

Method

The study population included GPs and community pharmacists from three locality areas (A, B, and C) of a health and social services board in Northern Ireland. This board was selected, as there were a number of well-established

HOW THIS FITS IN

What do we know?

Pharmacists have been challenged to become key players in the prescribing process, and the extension of prescribing rights as recommended by the Crown report may help realise this goal. Professional barriers between general practice and community pharmacy may hinder this development.

What does this paper add?

The shopkeeper image of the community pharmacist emerged as the main barrier between the two professions and this was further reflected in the barriers of access, hierarch, and awareness. Acknowledgement of these barriers may go some way to pre-empt difficulties which could emerge with the extension of prescribing rights to pharmacists.

- Experience of professional contact with the other profession
- Views on the other profession
- Barriers to better professional relationships
- Attitudes to pharmacist prescribing as advocated by the Crown report
- Role of community pharmacy in primary care

Box 1. Topic areas for GP and community pharmacist focus groups.

GP–pharmacist collaborations already in place. Six focus groups (considered optimal to achieve data saturation), of GPs and pharmacists respectively, were planned (two uniprofessional groups per locality, one group having had experience of interprofessional working, and the other having had relatively little experience). The extent of this previous experience was based on information obtained from appropriate staff based at board headquarters. Focus groups were used in preference to individual interviews, as this was perceived to be a more cost-effective and efficient means of accessing the views of a large number of individuals. It was also believed that the group interaction would generate discussion and debate. Letters were sent to all GPs ($n = 140$) and community pharmacies ($n = 74$, letters addressed to the proprietor or pharmacy manager) in the three locality areas, which outlined the nature and format of the study, along with a reply slip and prepaid return envelope. Payment was offered (£110) to participants. A follow-up telephone call was made to those who had not replied to the original letter.

The focus groups were held in convenient locations for participants (local hotels) between May and September 2001. Each discussion lasted for approximately 70 to 90 minutes, was facilitated by the project leader (CMH), and anonymity was assured. The discussion was based around a topic guide, which had been compiled following an extensive review of the literature (using MEDLINE, Web of Science and International Pharmaceutical Abstracts) on GP–pharmacist relationships, collaboration in primary care, and the extension of prescribing rights to pharmacists (Box 1). During the discussion, the facilitator clarified the Crown report recommendations[4] and ensured that participants understood the terms 'supplementary' and 'independent' prescribing. All discussions were audiotaped and transcribed.

Analysis

All transcripts were independently checked against the original recordings (CMH). A researcher from a non-pharmacy background (SMcC; health psychology) participated in the analysis, to minimise any investigator bias.[9] The transcripts

were analysed independently by the authors using interpretative phenomenology.[10] Interpretative phenomenological analysis is concerned with the interpretation of an individual's personal perception or account of an object or event.[10] The transcripts were read repeatedly, recurrent themes were identified and coded (along with supporting quotes) independently, and consensus was reached by discussion between the two researchers. A network of subordinate and superordinate themes was established. The authors agreed on the major themes that arose from the analysis. The principles of grounded theory were used to develop explanatory theories for the emerging themes, to further understand the interface between community pharmacy and general practice.[11,12] This approach involved the use of 'constant comparison', whereby the aim of the research is the development of substantive theory and the emergent theory was tested in subsequent focus group interviews. Analysis of the transcripts yielded similar themes and, therefore, additional theoretical sampling was deemed to be unnecessary.

Results

Table 1 summarises demographic information pertaining to the focus groups. From the initial mailing to 140 GPs, 22 agreed to participate (distributed over five groups) and from the 70 community pharmacies that were contacted, 31 pharmacists participated (distributed over six focus groups). Eleven practices from a total of 63 practices in the three localities had accredited training status; of these, six had GP representatives in the focus groups. Twelve non-training practices were also represented.

Owing to the low response rate, it was not possible to hold a second GP focus group in locality B. The response rate had an impact on the constitution of the focus groups because GPs and pharmacists who had little experience of working with each other participated in focus groups with colleagues who had more experience of interdisciplinary collaboration. Analysis of the transcripts from the focus groups, however, revealed similar themes emerging from all discussions. Furthermore, Table 1 indicates that the groups were diverse. Although there were a greater number of males than females in the groups, this had no impact on the themes extracted from the data.

Analysis of the data revealed the emergence of a superordinate theme — the 'shopkeeper' image of community pharmacy — which was a common thread throughout all the transcripts, and which permeated the three subthemes of access, hierarchy and awareness (shown in Figure 1). All four themes represented barriers between the two professions.

Table 1. Focus group demographics.

	Doctors' groups	Pharmacists' groups
Number of groups	5	6
Total number of participants	22	31
Sex		
Male	17	19
Female	5	12
Average years of registration	16.4	13.7
Location of practice		
Urban	15	23
Rural	7	8
Commercial status		
Fundholding/proprietor	17	14
Non-fundholding/non-proprietor	5	17

Shopkeeper image of community pharmacy

Many of the GPs in the focus groups saw community pharmacists as businesspeople, shopkeepers or specialist retailers, and believed this represented a conflict of interest in health care. Pharmacists felt the shopkeeper image influenced the attitude of GPs and had an impact on the development of the pharmacist's role:

'*I think that they are probably more businessmen than we are, probably more motivated by the business side of things than we tend to be.*' [GP13]

'*There is definitely a conflict between the NHS primary healthcare team effort that we all feel we are involved in and with pharmacists and their role as the shopkeeper and their role in looking for profits for themselves.*' [GP18]

'*They* [some GPs] *don't have any opinion at all about community pharmacists. They think we have no role, they think we are shopkeepers that are useless and who are grasping for greater things …The GPs see us as commercial and they have this idea that we make loads of money.*' [Pharmacist (P)8]

'*Well, that is the perception we have always had even by the medical profession. We are shopkeepers as opposed to professionals.*' [P16]

The commercial aspect of community pharmacy also influenced GPs' views on pharmacist prescribing. GPs considered that current systems created perverse incentives for community pharmacists to sell more medication, or if a greater role in prescribing was realised, to prescribe more; this conflict was also recognised by the pharmacists:

'*And many times you* [the patient] *don't need anything and while we are motivated to say that you don't need anything, the pharmacist, if he is making money by selling something, his motivation is going to be different and I see that as not necessarily to the patients' best advantage.*' [GP2]
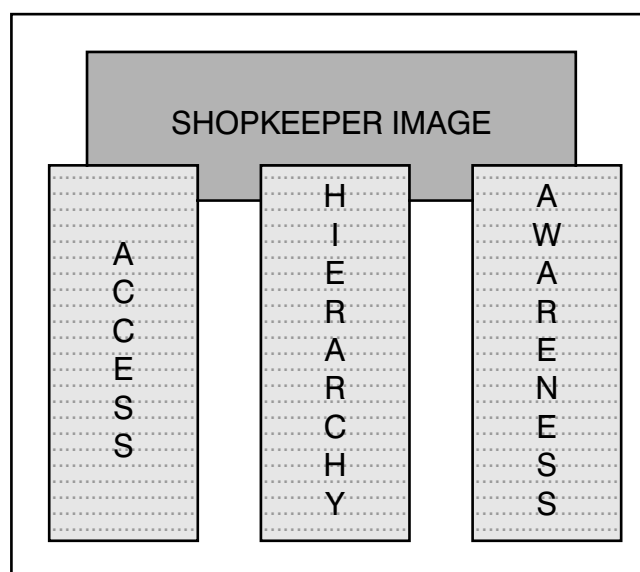

Figure 1. Overview of the main themes that emerged from the qualitative analysis.

'*I wonder if you leave it that the person who is monitoring the condition and also putting in the claims that they have dispensed the drugs and supplied the drugs, there is a probity issue there?*' [GP9]

'*But the difficulty I could see that they* [GPs] *would see is that we would be prescribing for our benefit.*' [P13]

Two GPs commented that, in their view, community pharmacy of today resembles the organisation of general practice 30 years ago, and while there was a commercial element to general practice, it was not as blatant as community pharmacy:

'*They* [community pharmacists] *may look upon each other the way general practice did 20 or 30 years ago, when it was all one or two-man shows. Everyone out there was your competitor, fighting for the same market.*' [GP9]

'*They do remind you of general practice in the 1950s when there were single-handed GPs working out of their premises, reasonably tightly regulated.*' [GP18]

'*As GPs we want to make a profit as well and we are healthcare providers, but I think it is all the commercialism around the chemists' shops.*' [GP20]

Many GPs saw a practice pharmacist (located within the practice and working directly with GPs) as the preferred model in terms of interprofessional working and prescribing support, owing to the absence of the shopkeeper image:

'*The pharmacist who is based within the practice does not have that commercial interest, is there purely to serve the patient and be interested in the wellbeing of the patient. They may well be salaried, so they do not have that commercial interest and it frees them up considerably.*' [GP16]

Access

Generally, GPs did not report difficulties in contacting community pharmacists. However, they expressed reservations about patient access to pharmacy services, especially outside working hours. This stemmed from GPs views' of pharmacists practising from a shop environment with set opening times:

'*If they want to be members of the primary healthcare team, I would welcome them on board, but if it's still a shopkeeper mentality, making money, open nine to five and not open on bank holidays and limited availability, which is what we have got at the minute, then I think that does not cross the boundaries very well.*' [GP9]

'*The GP has total 24-hour responsibility; we just cannot switch off at 6.00pm.*' [GP21]

In contrast, many pharmacists had encountered difficulties in contacting GPs and this was often attributed to receptionists. Pharmacists recounted instances where they had been kept on hold, or asked to call back which they found unsatisfactory while patients waited in their pharmacies for their medication:

'*Sometimes once you get the doctor they are very receptive, but it is getting past whoever is in between you and the doctor, be it a receptionist or whoever.*' [P12]

'*If you can get past the receptionist. Some of them are like biting dogs, you just back off … There are times when I have said that I have a patient here as well so does that mean that his patient is more important than the person who is waiting and who happens to be his patient as well?*' [P27]

In contrast to GP perceptions, pharmacists felt that they were very accessible, had a unique relationship with patients, had convenient opening hours, and were a source of health information for the public:

'*The pharmacist is bombarded day in and day out with people coming in and out. It's in your face. There's no appointments, you are directly accessible.*' [P24]

'*From feedback from customers, you know that they say "I come in to see what you say rather than them going and bothering the GP as it takes up to three weeks to get an appointment. Because I can't get hold of the doctor, I am coming to you."*' [P28]

Recognising that prescribing rights for community pharmacists would require access to medical notes, a number of GPs felt that patient confidentiality would be compromised. This was also illustrated by GPs' concerns over the design of many pharmacies and their suitability for giving advice:

'*If they are going to take on that role, they are taking on a consulting role and most of the premises were not designed for that. If you stand in pharmacies, the confidentiality is zero — you can hear what is going on.*' [GP9]

'*The other issue is the issue of confidentiality. When I am writing in patient records, the understanding has been between myself and the patient that these are confidential records.*' [GP11]

Furthermore, GPs felt that continuity of care would suffer with pharmacist prescribing because of the lack of patient registration and the turnover of pharmacists in community practice:

'*It is an aspect, definitely, that should be considered as to whether the patient should register with a pharmacy.*' [GP8]

'*You do not know who you are dealing with and you cannot build up a relationship with them* [employee pharmacists] *because they are forever changing.*' [GP20]

Again, the practice pharmacist model was preferred in terms of regular contact and easy access:

'*Ease of communication is very important and they* [practice pharmacists] *have access to the full patient notes. Within the practice we all work according to the same code of confidentiality and I am quite happy to speak to the practice pharmacist knowing that it stays within the practice.*' [GP16]

Hierarchy

Hierarchy in terms of professional standing and role in health care was apparent in all GP discussions. GPs expressed concerns about pharmacists assuming roles they considered to be general practice activities and were not enthusiastic about their involvement in prescribing:

'*A lot of repeat prescribing is not clinical. You are not seeing the patient, you are merely sorting out prescriptions. Perhaps the pharmacist can do that. It would free up our time to do other things.*' [GP2]

'*Oh, I think you can go too far and the pharmacist can give too strong an opinion as to what we should prescribe. I think they should leave the prescribing up to us.*' [GP7]

Pharmacists also believed that any extension of their role would be seen as an encroachment on GP activity:

'*We have not got pharmacy prescribing yet, … but that would be seen by some as an invasion of their territory and the thin edge of the wedge and some would see it as brilliant. A lot of GPs, with some justice, they feel that we are crossing on to their territory and taking away their territory.*' [P8]

'*GPs are very reluctant to relinquish any sort of control to us. The pharmacist is an outsider and to a certain extent is a threat to the GP.*' [P30.]

Pharmacists expressed strong views about how they were perceived by GPs in terms of hierarchy, with many com-

menting that GPs considered them to be subordinate in professional terms:

> 'The other thing which was quite interesting was during a dinner before a lecture was being given, a GP said to me, "Well I suppose prescribing advisers are the acceptable face of pharmacy". I said, "So that makes community pharmacists the unacceptable face of pharmacy?" and her silence told me everything.' [P10]

> 'The GP sits with his prescription pad and until he does something with it, we sit with our degrees, impotent, until we get the piece of paper. He is the instigator, the prescriber is the instigator of the whole thing. So, no we are not going to be equal.' [P18]

Community pharmacists were also considered on the periphery of the primary healthcare team and once again, the shopkeeper image influenced GPs' views:

> 'If you could get them linked in to the practice then you could put them under that umbrella, but they are seen outside that, as they are at the moment. That causes the division.' [GP21]

> 'If pharmacists want to become more integrated into the primary healthcare team, I think they are going to have to give up their small shopkeeper empire if you like, and become more integrated and more involved in health centres.' [GP18]

> 'We are not part of their team because we are outside the building and although we might be considered by the government to be part of the primary healthcare team we are not part of the "in crowd"; that is, round the surgery all day every day, so they see us as outsiders.' [P9]

> 'I don't think we are fully recognised as being part of it, the primary healthcare team.' [P19]

However, some GPs did feel that pharmacists were part of a wider community team and this was also reflected in the pharmacists' views:

> 'I suppose they are helping to service the team — would that be fair to say — without actually being part of it.' [GP16]

> 'We are secondary, in that we are not involved in the primary decision making, perhaps they [pharmacists] are sweepers-up afterwards.' [P23]

Awareness

GPs had some awareness of the community pharmacist's role in health care. However, many had little knowledge of pharmacists' training and their continuing professional development obligations and saw pharmacists working in a purely commercial environment (returning to the shopkeeper image):

> 'Pharmacists treat an awful lot of things … a lot of consultation and prescription happens already.' [GP2]

> 'I think it should be publicly known that the pharmacist can advise about minor ailments.' [GP12]

> 'They are not updated are they? Or maybe they are. Maybe they're not. After their three years, they are more into the business of dispensing and the rest of it.' [GP4]

> 'I don't know what their training involves, whether they are made aware of what is involved in a shop, a community pharmacy as you say, lipsticks, cough mixtures etc.' [GP8]

Pharmacists also reported that there were some important misconceptions and lack of understanding about pharmacy on the part of GPs:

> 'The GPs have a very poor understanding of what we do with the public, they think we dish out the medicines.' [P8]

> 'In my profession ... I am never going to be a doctor, but I think we have to be respected for what we do with medicines and I think at the minute GPs do not fully understand what we do. I think they think that we just put it into a bag and throw it out. I don't think they see the role.' [P17]

Such views had led to a sense of frustration and pharmacists felt undervalued in their work:

> 'I know I do a worthwhile job but I think only pharmacists appreciate what a worthwhile job we do. I don't think we are held in particularly high esteem by the public because they can go to any pharmacy. They have got one GP but they can go to any pharmacy. I see their attitude at the health centre where they have to wait for five or ten minutes, I see them queue patiently at the bank and at Tesco's and the post office and then they come into the pharmacy and want to know why their medication is taking so long.' [P18]

Joint training at undergraduate and postgraduate level of the two professions was suggested by pharmacists as a way to overcome barriers and increase awareness of professional skills and strengths:

> 'We need to work together, we have to start working as teams. We really do have to break down those barriers, we really should start our training together. The first year of pharmacy and medicine should be the same, the same as medicine and dentistry. So that you know those people, have the same training and same background knowledge.' [P9]

Discussion

The overarching theme that emerged from this study was the shopkeeper image of community pharmacy that permeated the three major subthemes of access, hierarchy and awareness. Participants reported problems only from their professional perspective, despite being part of the same healthcare system.

Limitations of the study

Although this study was conducted in a specific geographical region with a defined sample, it was broadly representative and there was nothing to suggest that the groups would be different from other practitioners in other parts of the United Kingdom. Although it may be suggested that those who participated in the study were more likely to have a pre-established interest in this topic, this did not appear to influence their views as evidenced by their comments. Conversely, it may have been the case that these individuals held very strong views and considered the focus group as a way of voicing concerns. Although the focus group facilitator was a pharmacist, this also appeared to have little bearing on the GP discussions, which were frank and wide-ranging. The facilitator had been introduced as someone from the university setting and was perhaps perceived differently to pharmacists from community practice. The discussions may also have been facilitated by having uniprofessional focus groups, as each profession may have been less forthcoming if the groups had been mixed in terms of discipline.

Interpretation of findings

It had been thought that GPs who had had previous contact with pharmacists through interdisciplinary projects would have had a more positive view of community pharmacy. The commercial imperative of community pharmacy, however, seemed to be an important barrier for GPs. Indeed, it could be argued that contact with pharmacists in prescribing support may have only reinforced GPs' views of the shopkeeper image of community pharmacy. Adamcik *et al* noted that physicians who had had contact with clinical pharmacists may have attributed those pharmacists' skills and expertise as something unique to them, and by acknowledging the excellence of these so-called 'deviant clinical pharmacists', they confirmed the stereotype of the community pharmacist.[13] This may be the case with the GPs in this sample. Indeed, GPs preferred the practice pharmacist model because of the absence of the commercial trappings. Two GPs commented on the similarities between present-day community pharmacy and that of general practice decades ago. Ironically, present day general practice has also been likened to a small business,[14] although less overtly commercial than pharmacy and without the appearance of a retail environment. Other characteristics of the GPs, such as age, sex or the training status of their practice, had no influence on the emergence of the main themes.

Access was a barrier for both professions, but from different perspectives, with GPs expressing concern about restricted hours of services in pharmacies, confidentiality and turnover of staff, and pharmacists stating that receptionists limited their access to GPs. Arber and Sawyer reported that receptionists acted as gatekeepers between patients wanting access and doctors needing to manage the number of contacts with patients and reported that '… since the receptionist is a lay person, this can cause resentment in the minds of patients'.[15] Pharmacists could be substituted for patients in this comment.

Hierarchy was implicit in the comments from GPs in that they questioned the role and skills of pharmacists in certain activities and felt that greater involvement in prescribing would not be particularly appropriate. This has been interpreted as boundary encroachment.[16-22] This also raises the issue of professional autonomy and professional dominance — how certain professions not only control the content of their own work, but can also define the limits of work of other professional groups.[23] This is clearly exemplified by the relationship between pharmacists and GPs.[16,24] Pharmacists in this study were conscious of this hierarchical system as they articulated dependence on doctors to issue prescriptions.[25] Elston and Holloway reported that professional identities and traditional power structures created conflict between GPs, nurses and practice managers, and suggested that a new generation of professionals would be required to promote an interprofessional culture in the NHS.[26] This may also be reflected in medicine and pharmacy.

Lack of awareness emerged as a major barrier, with GPs reporting that they had little idea of the training and skills of pharmacists, and pharmacists reporting that GPs and their staff were not aware of their role in health care and believing that their contribution was undervalued. Thompson *et al* have stated that conflict between nurses and pharmacists arises through lack of trust, respect, competition between patient care roles, and lack of appreciation for each other as professionals.[27] Greenfield *et al* found that practice nurses felt that doctors' attitudes were the most important limiting factor in the expansion of the nurse's role.[28] Similarly, Bradshaw and Doucette considered that the reactions and attitudes of GPs could either hinder or facilitate an expansion of the community pharmacist's role, and the rarity of regular, face-to-face contact with doctors and other healthcare professionals represented a considerable obstacle to role expansion.[29]

Conclusion

Implications of findings for primary care

Awareness of barriers between the two professions may help to pre-empt some of the practical difficulties that could emerge during any pilot evaluation of pharmacist prescribing, such as the retention of dispensing duties by pharmacists in conjunction with prescribing rights.[4,30] On a more general level, the findings have implications for team-working within primary care. Williams and Sibbald described how the movement of healthcare work from doctors to nurses contributed to a culture of uncertainty and could affect the care given to patients.[31] This is also reflected in these findings and perhaps helps to explain why GPs struggled to see where community pharmacists could fit into prescribing. Continuing reorganisation of primary care may accelerate changes in roles and responsibilities, through a new GP contract[32] and a proposed new remuneration system for community pharmacy.[33] Multidisciplinary training at both undergraduate and postgraduate level may go some way to improving mutual understanding, trust and communication, and the literature supports this view.[34-37]

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