GPs, community pharmacists and shifting professional boundaries

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ABSTRACT

AIMS: In the context of expectations regarding role evolution, including increased interprofessional working, this study aimed to gain insight into how GPs and pharmacists understood the professional role of the pharmacist and its expansion, extension and calls for increased collaboration.

METHODS: Qualitative interviews with 16 GPs and 17 pharmacists were conducted in the Canterbury region. Data were analysed using descriptive thematic analysis.

RESULTS: Both groups were generally supportive in principle of more collaborative forms of working. GPs seemed more comfortable with collaboration that involved pharmacists being under the umbrella of the general practice. Pharmacists welcomed greater meaningful collaboration with general practice. Pharmacists did not express any particular view about what types of collaboration they preferred. They did discuss tensions resulting from the need to contact doctors over minor prescribing errors.

Extension and/or expansion of pharmacist roles were met with caution by GPs, although there was greater acceptance of medicines management. Pharmacists had mixed views about role expansion. Most were keen on role extension, particularly in relation to medicines management.

CONCLUSIONS: Attempts to encourage one professional group to expand or extend their practice may be perceived as a threat by those adjacent. Mitigation strategies involve clear communication and acknowledgment that interprofessional trust takes time to establish.

Introduction

Interprofessional working, integration between agencies, disciplines and teams, and an environment in which health professionals are working at the top of their scopes of practice are key themes in New Zealand as the health system grapples with the challenge of rising health services demand in a context of resource constraints. Greater collaboration between general practitioners (GPs) and community pharmacists to better use the skills of the latter in caring for those on multiple medications has been seen as one partial solution to addressing the problem. The aim is to foster greater compliance, reduce wastage, and manage health conditions better both from the point of view of the patients and the health system as a whole.

Pharmacists are highly qualified health professionals, but now that nearly all medicines are mass produced and pre-packaged they have been described as “overtrained for what they do and under-employed in relation to what they know”. A number of countries have implemented initiatives to encourage greater collaboration between GPs and pharmacists in the care of patients. In essence this involves the pharmacist taking an extended and enhanced role in providing advice and monitoring patients where this is deemed appropriate by the pharmacist and relevant GP. National structural reforms have taken place in Britain that emphasise the role pharmacy can play in improving the health of people with long-term conditions. Pilot projects encouraging extended roles for pharmacists in collaboration with GPs were instituted by the
Department of Health in 1997 and supplementary prescribing by pharmacists from 2003. Successful collaboration between primary care practitioners and pharmacists, particularly for patients with diabetes, has also been reported in Canada, Australia, and the United States.

Changes to community pharmacy in New Zealand are broadly similar to those introduced elsewhere. They emphasise the need for close collaboration between GPs and pharmacists in a team approach to the monitoring and management of patients on multiple medicines. Role evolution in community pharmacy has involved many pharmacists becoming qualified to offer Medicines Management Services (MMS) (formerly Medicines Use Reviews). Other services such as INR (international normalised ratio, designed to measure the clotting tendency of the blood in order to assess an appropriate anti-coagulant dosage), testing, influenza vaccinations, and blood pressure and blood glucose monitoring by pharmacists have also been introduced in some places, with pharmacists still maintaining the traditional dispensing, advice, and retail functions.

In Canterbury, particularly, changes have been given extra impetus as a result of the Christchurch earthquakes of 2010 and 2011 which resulted in more strain being placed on health services of all types, but a specific need to keep people out of hospital due to reduced bed capacity. Extended MMS were expanded rapidly, initially using mobile pharmacists and in-home visits, to allow earlier discharge of patients from hospital. Canterbury also saw the first introduction in New Zealand of an electronic shared care record accessible by GPs, pharmacists, and community nursing services to support greater continuity of care for patients who relocated either temporarily or permanently.

In July 2012 a new funding model, The Pharmacy Services Agreement, was signed between community pharmacists and District Health Boards, changing the existing model which had operated for more than 60 years. Consistent with the above shift in philosophy, the new model was designed to encourage patient-centeredness and integration between prescribers and pharmacists, to incentivise pharmacists to better use their medicines management skills and to attempt to limit pharmacy dispensing costs. It is important to note that the funding model changes and the introduction of extended services have not been interdependent. Many pharmacies had already implemented some or all of the extended services and were carrying out in-home MMS well before the funding model changes.

While, at a political level, it may seem straightforward and even common-sense to argue that a range of practitioners should be working collaboratively and that they should be working at the top of their respective scopes of practice, how this is operationalised is less clear-cut. Not the least of the complexity surrounding this issue is the respective groups' differential positioning within the healthcare arena, both in terms of power and employment structure.

The very need to argue that all professionals should be working at the top of their scopes of practice implies that some degree of role change is needed. Any discussion of role change raises questions about potential conflict between different groups of professionals. While Adams is at pains to point out that it should not be assumed that interprofessional conflict will occur, she does argue that jurisdictional conflict is more likely when “occupational groups are less evenly matched in terms of power, status, and organisation”. Interprofessionally, in this regard, issues arise around, for example, the perception that pharmacists are ‘shopkeepers’ with conflicts between their health care and business roles. This was identified by general practitioners in the UK as being a key reason they did not support the extension of prescribing rights and other extended services to pharmacists. Fears about conflicts of interest, particularly as this related to dispensing self-written prescriptions, was raised by some of those concerned about the extension of prescribing to some pharmacists in the New Zealand context.

Corporate involvement is evident in the financial interest that companies, such as Green Cross Health, have in some general practices and pharmacies, but community pharmacists and GPs in New Zealand work predominantly under a privately owned,
small business model. In both cases, the government provides co-funding alongside direct payments made by patients.

In the context of potential for unproductive tension, the objective of the study reported here was to gain an insight into how GPs and pharmacists understood the professional role of the pharmacist and its current expansion, and their views of the emphasis on increased collaboration and integration.

Methods
Approval was granted for the study by the University of Otago Human Ethics Committee. A qualitative approach was chosen as the most appropriate method to gain in-depth data addressing the areas of interest. We chose to use semi-structured interviews as they work well with an inductive approach when new and unknown information is being sought. They also make use of the flexibility of the qualitative research process as understandings that are developed early on, can then be carried forward into subsequent interviews, thus drawing out more detail as new issues come to light.22 A purposive sampling strategy was used to select a range of interviewees, acknowledging such factors as age, gender and ethnicity; geographical location; socio-economic area served; and full and part-time workers. Sixteen GPs and 17 pharmacists in the Canterbury region participated, most being interviewed individually; however a flexible approach was taken where time commitments made a joint interview more practical. The interviews took place between March and November 2012 and all participants received a $30 petrol voucher in recognition of their participation.

Interviews explored past and current interprofessional relationships between GPs and pharmacists, as well as their respective views on current and proposed changes related to pharmacy, and the emphasis on increased collaboration between the two disciplines. All interviews were recorded and transcribed verbatim. The data were coded and then analysed using a systematic iterative thematic approach to identify recurring patterns, following the method described by Pope and Mays and others.23,28

We were satisfied that we had attained ‘data saturation' across the 16 GP and 17 pharmacist interviews.24 Data saturation occurs when no new themes are evident in the data. This can occur between 6-12 in-depth interviews depending upon sample homogeneity.24 The core theme discussed in this paper is to do with interprofessional understanding and the challenges of role change. Transcript data used in the following section are illustrative of the points being made and represent common points of view.

Results
Interprofessional understanding and the challenges of role change
Most GPs reported that they currently enjoyed cordial, even if not close, relationships with pharmacists and had developed smooth working arrangements. Some said they appreciated being contacted by pharmacists about potential interactions or safety issues and relied on pharmacists to be a back-stop for them in identifying inadvertent errors that came about through the drop-down menus in their prescribing software for example. Pharmacists were also highly valued in formulating medicines for patients who could not or would not take tablets and providing up-to-date advice on new medicines:

… pharmacology has just got so complicated that a good pharmacist is worth his weight in gold in peer support (GP)

Pharmacists reported a more complicated relationship with GPs. While most of them had built up a good rapport with the GPs whose prescriptions they most often dispensed, they treated the relationship cautiously and seldom appeared to feel on an equal professional footing. They particularly disliked their role in policing the regulations around prescriptions whereby they were required to check up on minor errors caused by the way the GP prescribing software was set up (for example, if the GP inadvertently selected 90 tubes instead of 90 tablets from the drop down menu). Pharmacists were very conscious that they risked annoying GPs by contacting them over small details and yet they were not legally able to make the change themselves:

… the interaction between a phar-
Pharmacist and a general practitioner would usually be on a problem basis with a piece of paper, which is not something that excites general practitioners. They really cannot understand why community pharmacists follow these up and there is a real professional disconnect between the pharmacist being able to convey why it's an issue for them and the general practitioner understanding why they need to do something about it. (Pharmacist)

This situation was reported to create a great deal of frustrating and unproductive work for pharmacists. Where there was a long-standing and more personal relationship between a particular pharmacist and GP practice it appeared that an efficient arrangement had been worked out to minimise the burden on both, as both GPs and pharmacists dealt with many different pharmacies and practices. However, this was not possible in all cases. Moreover, any change in staff, either in the pharmacy or the practice, could mean that relationships had to be developed anew.

When looking ahead, most GPs had some positive comments about how relations between the two professions might change and develop. They recognised the expertise that pharmacists had and most welcomed the current approach that focused on a greater role for pharmacists in providing advice, particularly on medicines, to patients. Many were highly supportive of pharmacists’ efforts to encourage compliance and see that patients used their medicines properly. Some would have liked to have a pharmacist working within their practice:

I would like to employ a pharmacist to be a clinical pharmacist – two or three tenths of the time, seeing patients and going over their medication with them. There is community medicines management which is pretty good, but it could be even better if it was in that role. (GP)

Many pharmacists commented that advising doctors about medicines should be a core part of their role, but their ability to do this was limited by time constraints:

There's a lot more scope for pharmacists to be involved in helping GPs manage their patients, in particular certain types of patients as well, in terms of reviewing medications that they're on. Things that GPs just don’t get time to do. (Pharmacist)

GPs were considerably more divided about the increasing role of pharmacists in a range of areas, and for some this also included reviewing medicines through MMS encounters. Some were unreservedly enthusiastic, finding it saved time for them and benefitted their patient:

I must say it's been really excellent. ... my context is a largely immigrant population where English is a second language so the time and understanding required to explain the roles of the medications, their side effects, possible interactions, what to watch out for, what their roles are – we can’t generate that time for each patient. Forty-five minutes with three monthly follow up, so brilliant, brilliant idea. (GP)

Others were neutral though unconvinced they were either necessary or valuable, and a few GPs were directly negative, seeing the involvement of the pharmacist in managing their patients as an intrusion into the GP's core role. Pharmacists, although they welcomed the opportunity to take an increasing part in medicines management were also keenly aware of GP sensitivities:

You’re stepping into a more clinical report and we have to ... try and straddle that without stepping on too many toes. The service is still very new and there are some GPs that are very welcoming of the service and there are some that appear to be feeling threatened by it or haven’t perhaps have got as good a working relationship with the pharmacies and so they, for whatever reason, are not as open to receiving feedback. (Pharmacist)

One of the primary factors causing unease among GPs appeared to be that the MMS service could be initiated by the hospital discharge team, the pharmacist or the patient themselves without the GP’s involvement. The GP may then be unaware...
that the review was happening until they received the results. This made some concerned that, not only had they been uninvolved, but rather than encouraging integrated care, it was more likely to risk disrupting continuity of care. GPs could themselves initiate the MMS process but it appeared that only a few had done so.

This concern of GPs about fragmentation of care was even more pronounced in relation to other expansions of pharmacy into services such as INR testing, and providing influenza vaccines, although for some GPs, anything that increased influenza immunisation coverage was seen positively. There was a strong feeling that such functions were better to be kept within the medical centre, which had traditionally always provided these services. Even those who were the most positive about it would prefer the pharmacist to be within their team:

*The pharmacist should be as part of the team in this centre and not just randomly doing it because they don't have all the information potentially of what's going on with them (the patient). (GP)*

Additionally, some GPs noted that they felt unfairly excluded from accessing the funding that had been made available to pharmacies to provide INR monitoring. Most of the GP participants were also aware that pharmacist prescribing may become a reality. All of them had reservations. Most were opposed; a few believed it may have some place in very limited circumstances.

Fragmentation of care and the likelihood of deteriorating conditions being missed were the prime concerns cited:

*I can't be completely opposed because it's going to happen. But I want to make sure that we don't have people with significant illnesses missed and that doctors are allowed to keep a close eye on their elderly patients and not be seen as – oh, you don't really need to see us because the pharmacist can do it. And it's cheaper sort of thing. (GP)*

Some pharmacists expressed concern about new opportunities for providing extra services that required time away training, extra costs, and logistical implications about space within the pharmacy. Only a few were interested in providing vaccines and while there were some interviewees who were keen to do or who were already engaged in continuing education to become pharmacist prescribers, they did not see this as a core part of their professional roles:

*We're not doctors and whilst we can interpret things I think a lot of that should be left to doctors. ... basically managing people's medicine, I think is far more important than being able to prescribe. I think, do that, and do it well and prescribing on the more basic things. (Pharmacist)*

**Discussion**

Overall, there was considerable enthusiasm among some GPs and most of the pharmacists for more integration and collaborative working that went beyond interactions focused around problems with prescriptions. A few GPs were noticeably unenthusiastic about the need for or the benefit of closer relationships. As well as this, some members of both professional groups raised concerns about where the limits of their professional jurisdiction lay. GPs tended to be supportive of pharmacist involvement in the management of patients who were taking multiple medications. There was much more limited support for other non-medicines related services, including among pharmacists themselves. In contrast to the international literature, this limited support did not seem to reflect GP concerns about conflict between the dual retail and healthcare functions carried out by pharmacists.20 Many pharmacists were reluctant to explore areas outside their traditional scope of practice and invest considerable financial and personnel resources for an uncertain return. All participants, even those most positive about collaboration, shared the range of concerns about the uncertain impact of the developments in pharmacy on workload, reimbursement and professional boundaries. Concerns appeared to have been further exacerbated by the apparent lack of a coherent and integrated communication strategy to promote the various changes to both professions. This latter point was commented on by almost all participants.
These concerns are consistent with those expressed in other countries that have undergone the same sort of changes, and even in Britain where the changes are now relatively well established, sensitive issues with professional boundaries are still being reported.\textsuperscript{25,28,29} It does appear, however, that as the changes bed in they are likely to become more accepted. In Australia where the Home Medicines Reviews (equivalent to MMS in New Zealand) have been in place for some years, for example, they have been reported to be successful in engaging GPs and pharmacists and resolving most medication-related problems.\textsuperscript{30}

Our data reveal some of the tensions that arise as different groups of professionals interact. These tensions are not inevitably negative and/or destructive but may be productive and result in new and improved ways of working.\textsuperscript{19} In the meantime, both professional groups are feeling their way through existing and new tensions. It is in the context of existing tensions that the new ones need to be negotiated. This was consistent with the mixed experience in Britain where interprofessional working was found to be “...a piecemeal process,”\textsuperscript{25} that had relied on goodwill and trust-based relationships that needed to be built up over time. As with this study, others have also noted collaboration tended to be person-dependent and could fade away if a key pharmacist or GP left their position.\textsuperscript{25}

The greatest acceptance and support for collaboration in Britain has been in situations where a pharmacist has been fully integrated into the healthcare team and available for consultation by the GPs or assistance to patients as required.\textsuperscript{26,27} Although the employment models for GPs and pharmacists in New Zealand are different from those in the UK, some participants in this study also believed that this type of arrangement was the ideal solution. There are emerging examples of co-location and pharmacists being integrated into existing practice teams on a part-time basis.

A strength of this study was the opportunity to build on previous work in New Zealand and gather perceptions from both GPs and pharmacists at a unique time of change in the relationship between them. The study was of a small number of GPs and pharmacists in a limited area of New Zealand, so does not claim to be generalisable more broadly. The study was conducted relatively close to the earthquake sequence in Canterbury. It is difficult to tell how this may or may not have impacted on our findings. The findings are, however, consistent with reports in the international literature and the insights they provide may give direction to where and how future intervention might be focused to support the positive aspects of interprofessional relationships and avoid further undermining those areas that are relatively tense.

**Conclusion**

This study was able to provide a new contribution to the field by gaining an insight into the perceptions of both GPs and community pharmacists at a critical point in the relationship between the two professions. In a context of ageing populations, increasing rates of chronic disease and constraints on health funding, it was clear that there was broad overall acceptance of the increased contribution that community pharmacists can offer via role, evolution and increased collaboration and integration between community pharmacy and primary care. Some GPs and pharmacists in Canterbury are already developing more collaborative, if not yet fully integrated, working environments. Realising the full potential benefit appears to be some way off while the attitudinal and practical barriers remain for both professions, reinforced by regulations that add to workload and hinder relationship building, an apparently inadequate approach to communicating the changes, and a high level of uncertainty as to what the long-term implications of the changes will be. Even those most negative about the changes appeared to realise that change was being driven by the wider health system and they would eventually need to work with it in some way. It is important to recognise that any change that has implications for more than one profession has the potential to be construed as a threat. Building trusting interprofessional relationships takes time. Effective communication, discussion and negotiation must be carried out with this in mind.
**Competing interests:**
Lee Thompson and Susan Bidwell received grants from Canterbury Medical Research Foundation, during the conduct of the study.

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**Acknowledgement:**
This work was funded by a grant obtained by Lee Thompson from the Canterbury Medical Research Foundation. We are very grateful to all the participants for willingly giving some of their time for interviews.

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