Overlapping General Practice

General practitioner and the pharmacist

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The general practitioner and the community pharmacist are both major deliverers of health care and the services that they provide overlap. Both depend greatly on the activities of the other, and the effectiveness of each may be increased through appropriate cooperation between them, yet at the moment the two function almost entirely independently.

Pharmacist's role as dispenser

Pharmacists provide various services to promote health to the community, the most important of which is supplying medicine and appliances. Most of this service is in direct response to written directions from the general practitioner. Now that approximately 97% of prescriptions are for ready manufactured drugs the role of the pharmacist in dispensing is principally that of checking the accuracy and appropriateness of the prescription and confirming directions to patients. Of the 300 million National Health Service prescriptions written each year by doctors, it has been estimated that 18 million cause problems for the pharmacist because they are incorrect or incomplete, and six million of these need to be checked by the pharmacist with the doctor before the prescription can be dispensed. Together with the clinician, the pharmacist has a professional and legal responsibility in safeguarding the health of the patient, and whenever the instructions from the doctors are inaccurate, incomplete, or open to misinterpretation the pharmacist must seek clarification. This responsibility was recently underlined in the High Court, when as a result of an inappropriate prescription having been written and dispensed the pharmacist was required to pay 40% of the very considerable damages of £100 000.

Often, particularly in cities, the pharmacist and the local practitioner are not well known to each other and what communication exists is usually stimulated by a "problem prescription." It is often difficult to contact doctors and interruptions are generally unwelcome. So establishing communication for this purpose may cause irritation on both sides and every effort should be made by the clinician to reduce such occasions to the minimum by writing prescriptions legibly and checking dosages and frequency of administration when in doubt.

Health care initiated by pharmacist

From the perspective of the doctor it is all too easy to imagine that the role of the practitioner is to diagnose and prescribe and that of the pharmacist to dispense. That this concept is inappropriate, or at least incomplete, was underlined by Dunnell and Cartwright¹ in their study of medicine taking, which showed that in a random sample of adults 40% had taken something prescribed and 60% an unprescribed medicine in the two weeks before the interview. Morrell² also showed that patients only consult their general practitioner for one out of 40 perceived symptoms, many of which are managed by self medication. Thus pharmacists perform an important function, both in providing the appropriate course of action for the relief of symptoms and in giving advice about general medical care.

Whereas in the 1960s much of the pharmacist's work was manipulative, today the role of the pharmacist is more of an advisory one, and many in the pharmacy profession believe that for several reasons this will gradually increase over the coming years. While there is some evidence to suggest that many patients may have some difficulty in obtaining an early appointment to see their own doctor,³ ease of access is a characteristic of the High Street pharmacy. Between 1955 and 1981 the number of pharmacies fell from 15 000 to just under 11 000 but the numbers are now stabilising. Since pharmacies are commercial enterprises that need to attract retail trade their premises tend to be located in areas that are used by the general public. Thus most people have a pharmacy readily accessible to them and the informal atmosphere in pharmacies is a good, if not yet ideal, setting for the public to seek advice on health care. Furthermore, both the medical profession and the government have been encouraging individuals to adopt a more positive approach to self care. Recently, a major campaign was organised by the Health Education Council in association with the Department of Health and Social Security and the BMA aimed at advising the public not always to visit their doctor for minor symptoms that could be dealt with perfectly adequately by a pharmacist. A relevant economic factor is that as a result of the steadily increasing costs of prescription charges it is now cheaper to purchase many over the counter medicines directly from the pharmacist rather than obtaining them by prescription.

Pharmacists are highly trained and as there are many in the profession who think that pharmacists' professional skills are not always being fully realised, much thought and discussion is taking place about extending their role. Approximately six million people go into a pharmacy every day and even those not directly seeking medical advice may be influenced by the information that the pharmacist displays or makes available. A recent report *Pharmacy, contraception and the health care role*,⁴ produced by the Family Planning Association and the Pharmaceutical Society of Great Britain with help from the Health Education Council, states that "In times of economic difficulty and immense pressure on the National Health Service it is vital that all possible ways of promoting health care are used to

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the full. The professional training and skills of retail pharmacists should be acknowledged and their ability to extend their role in health education and preventive medicine should be further explored."

The trend of increasing the pharmacist's role in the health care team clearly encroaches on the perceived role of the practitioner, and it is understandable that these developments have resulted in a certain amount of criticism and negative response from bodies that represent the interests of general practice. It is important, however, to remember that our principal task as providers of health care is not to defend territories, but rather to maximise the benefits to be gained by patients and clients.

Cooperation between pharmacist and practitioner

There are many areas in which the provision of services may be greatly enhanced by the appropriate cooperation between practitioner and pharmacist. In drug dispensing, for example, the steadily increasing potency and expense of prescriptions makes appropriate prescribing ever more important. The pharmacist, with his special expertise and training, has an important part to play and this is not limited to just checking prescriptions or giving advice when consulted. If the pharmacist was included as a member of the primary health care team it would open up interesting possibilities of both an administrative and professional nature. The pharmacist could identify possible drug reactions if he was provided with the details of the patient's general medication on a treatment card and could also inform the doctor when his patient is purchasing inappropriate medication over the counter. With regard to his role as health care adviser, he and the practitioner could, with benefit, discuss a common policy for the management of specific symptoms. In education for general practice the pharmacist can make an appreciable contribution to the learning of both trainees and

established principals and contribute to the development of programmes for auditing prescribing behaviour.

If such cooperation is to take place some administrative and ethical issues have to be considered. It would not be appropriate for the practitioner to direct his patients to a particular pharmacist because of the commercial interests concerned, and therefore the development of an exclusive relationship between the doctor and a local pharmacist is not now encouraged by the body that regulates the activities of pharmacists. If, however, it is accepted that much may be gained by close cooperation between pharmacists and practitioners and if maximum benefit is to be derived from some of the recent developments in primary care, such as the introduction of microcomputers, it seems essential that urgent consideration is given to ways of overcoming these difficulties. For this to be achieved, discussions need to take place both centrally and locally between the respective representative bodies, and it would be appropriate for a liaison group of local practitioners and local pharmacists to be established in each district.

It is important that practitioners recognise that the pharmacist is a highly trained professional person, who has a major contribution to make to the provision of health care. Similarly, the pharmacist needs to consider ways to escape from a system that is slowly eroding responsibility, skill, and ambition and to develop new ways of realising his full potential.

References

- 1 Dunnell K, Cartwright A. *Medicine takers, prescribers and hoarders*. London: Routledge and Kegan Paul, 1972.
- 2 Morrell DC. Teaching patients to look after themselves. *Update* 1981; 24:1187-95.
- 3 Cartwright A, Anderson R. *General practice revisited*. London: Tavistock Publications, 1981.
- 4 Meredith P. *Pharmacy contraception and the health care role*. Draft report No 3. London: Family Planning Association, 1982.

Diary of Urban Marks: 1880-1949

At the beginning of June McFetridge went to Dublin to take his MD degree. We were unsuccessful in getting a locum, either because they were scarce or because they had heard of the place and its iniquities. I had been in the house for 10 days doing all the work. Only once had I been out and that was to play bridge with a Dr Corder, and he was on the telephone in case I was wanted. Sunday came and with it the usual visit of the surgeons. They found a case and decided to operate at 2 pm. Now that afternoon I had arranged with a friend to go on the river boat as far as Holt, about six miles up the river, and have tea. Worcester is on the Severn and the hospital stands on its banks with a lawn sloping down to the water edge. The steamer started from a quay adjacent to the bottom of the lawn.

At 1.50 pm the three surgeons arrived but I did not meet them. They walked upstairs and Bates sent for me. I told the sister that I was not coming, but she entreated me to come and tell Bates myself rather than leave it to her to do so. Bates would inevitably "go" for her. I went up to the theatre and Bates said in a pre-emptory tone: "Give this anaesthetic." I told him I was going to Holt and would not assist. Bates: "Do you absolutely refuse?" Me: "I do." Bates: "Oh, very well then. I shall report this to the house committee tomorrow." Me: "You can damned well do what you like."

On the following morning I was going round the ward with D H Reed, the physician, when Mr Stallard, the secretary of the hospital, came to us and said that my presence was desired in the board room. Reed appeared to know why I was wanted and said "Stick up. Good luck." So, in I went. The board room was long and narrow, with the chairman's seat at the far end and the chairs arranged round. The Rev Mr Longhurst had been chairman of the board for 20 years and

therefore was of the same overbearing type as Bates. He asked me to come forward and offered me a chair. I said that I preferred to stand since I understood I was on trial. Unless prisoners in the dock were very weak they were made to stand, and I said that I felt exceptionally healthy. This rather flustered him, but he pulled himself together and then stated that Mr Bates had made a complaint that I had refused to give an anaesthetic. They therefore wished to inform me that a vote of censure had been passed on me. He got no further than that. I interrupted him, and with my voice full of wrath I told him to sit down and listen to what I had to say. I narrated the course of events during the last 10 days and said I had not been out of hospital during that time. There was no necessity for my presence at the operation. There was Bates, Gosling, and Pollard. In addition, there was the theatre sister and her staff nurse and probationer together with the sister of the ward. Surely that was sufficient for any one operation, such as they were at this particular hospital. Furthermore, they had condemned me in my absence and I asked them if that was their notion of British fairplay.

I then went on to say that all of them were obsessed by Bates but that I, personally, had no use for him. That he was the worst specimen of a surgeon I had ever seen and that his immediate retirement would benefit the hospital and everyone connected with it greatly. As regards the vote of censure, it did not interest me at all except that if it were put on the hospital's record I would walk straight out of the hospital and leave the place without a resident. They were so surprised that everyone sat in dead silence while I walked through them and out of the room. Stallard informed me afterwards that someone proposed the matter now drop. It did.