Community Pharmacists' Perception of Supplementary Pharmacist Prescribing

Francesca Wirth, Marise Gauci, Lilian M. Azzopardi, Maurice Zarb-Adami, Anthony Serracino-Inglott

Department of Pharmacy, University of Malta, Msida, Malta

fwirt01@um.edu.mt

University of Malta

BACKGROUND

Various models for pharmacist prescribing have been implemented internationally varying on their dependency on protocols, formularies and collaboration with physicians. Supplementary pharmacist prescribing is based on collaboration between pharmacists and prescribers.[1]

AIM

To determine the perception of Maltese community pharmacists regarding supplementary pharmacist prescribing and its implementation.

METHOD

A self-administered questionnaire was devised and distributed to 50 community pharmacies from different localities around Malta chosen by stratified random sampling. More than one option could have been selected for each question.

Validity testing was carried out by means of a focus group consisting of 12 persons.

Reliability was tested adopting test-retest analysis using 5 community pharmacies.

Statistical analysis was undertaken using Microsoft Excel XP and the Biomedical Data Package Software (BMDP), where internal consistency was measured using Cronbach's alpha correlation coefficient.

RESULTS

Cronbach's alpha correlation coefficient was 0.8191 indicating high reliability of the questionnaire.

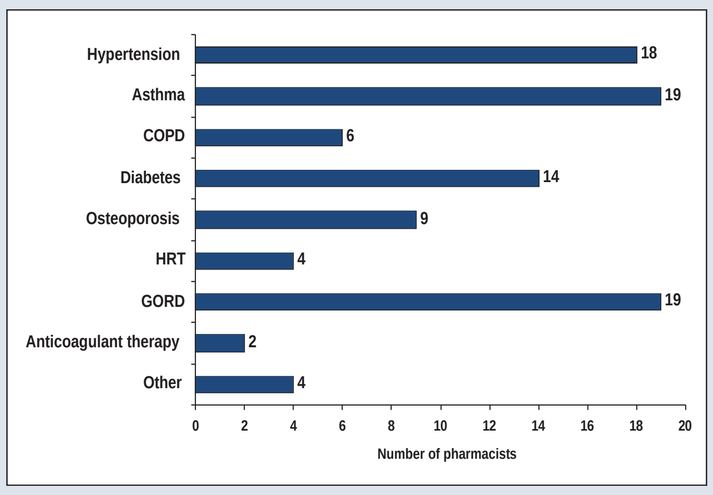
Forty-five pharmacists responded to the questionnaire. Thirty-four of these were managing pharmacists, 20 were between 30 and 39 years old and 30 were females. Twenty-three pharmacists were in favour of supplementary pharmacist prescribing.

Pharmacists accepted supplementary prescribing for a variety of conditions, the most common being chronic conditions namely gastro-oesophageal reflux disease and asthma (both 19). Pharmacists were most reluctant to accept supplementary prescribing for long-term anticoagulant therapy (2) - Figure 1.

Pharmacists envisaged the introduction of supplementary prescribing mainly by forming liaisons with general practitioners (20) and by keeping records of interventions (12) - Figure 2.

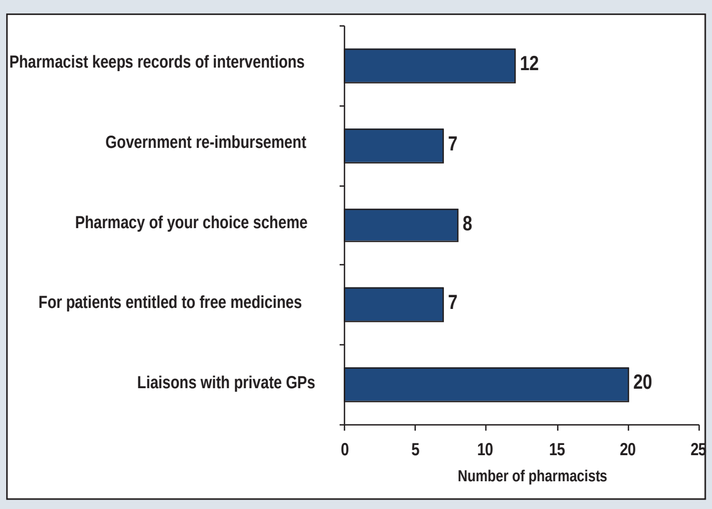
Reasons against the introduction of supplementary prescribing were the lack of specialised training and continuing professional development (16), the fact that patients would still refer back to their GP anyway (15), and no access to electronic patient medication records (11) - Figure 3.

FIgure 1: Conditions for which pharmacists accepted supplementary prescribing (n=23)



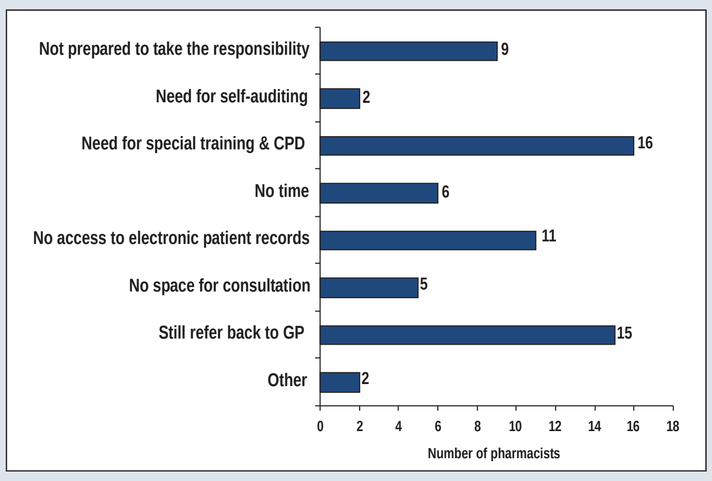
COPD = Chronic Obstructive Pulmonary Disease, HRT = Hormone Replacement Therapy, GORD = Gastro-Oesophageal Reflux Disease

Figure 2: How pharmacists envisage the implementation of supplementary prescribing (n=23)



GP = General Practitioner

FIgure 3: Reasons against the introduction of supplementary prescribing (n=22)



CPD = Continuing Professional Development, GP = General Practitioner

CONCLUSION

The limitations for the implementation of supplementary pharmacist prescribing include minimal computerisation, lack of access to patient medication records, lack of space for appropriate consultation areas to be set up, and lack of pharmacist motivation. The implementation of a consultation fee for professional services provided could be an incentive to promote evolution of supplementary pharmacist prescribing.

REFERENCE

1. Emmerton L, Marriott J, Bessell T, Nissen L, Dean L. Pharmacists and prescribing rights: review of international developments. J Pharm Pharmaceut Sci 2005;8(2);217-25.