APTI ijopp

Social Pharmacy- The Current Scenario

Claire Anderson*

Division of Social Research in Medicines and Health, School of Pharmacy, University of Nottingham, Nottingham, NG7 2RD

**Address for correspondence: Claire.Anderson@nottingham.ac.uk*

Abstract

This article considers the discipline of social pharmacy in the context of medicines and health and in the Indian context. It attempts to define social pharmacy and differentiate it from pharmacy practice. It then considers social pharmacy in the curriculum including the new Indian Pharm D curriculum. Social pharmacy research methods are then examined. Finally, the author's research on emergency hormonal contraception is discussed as an example of social pharmacy research.

We live in a rapidly changing economic, political and social world with widening inequalities in health. Disease patterns are changing and with an ever increasing older population and communicable diseases like HIV, AIDS. Malaria and TB continuing to prove difficult and costly to prevent and treat, the cost of providing health care continues to escalate. Adherence to long-term therapy for chronic illnesses is estimated to be 30-50%.[1,2] Non-adherence is often not discussed during pharmacy consultations, but may lead to worse health outcomes for the patient and to an increased economic burden. The World Health Organisation[1] highlight the need to develop strategies to improve medicines adherence as an essential element in reducing the global burden of disease. Studies on preventable medicines-related hospital admissions[3,4] indicate that problems occur at all stages of the medicines use process: prescribing, dispensing, administering, monitoring and seeking help. This is usually due to inadequate communication, knowledge gaps and errors. Around 4% of hospital admissions in the UK are due to medicines.[3,4] It is clear from research that patients' beliefs and attitudes influence how they use medicines.[5,6,7] Also, in many countries, significant changes have taken place with respect to healthcare systems and pharmacy profession. There is increased corporatisation of community pharmacy with respect to pharmacy contracts including the payment of cognitive services such as home medication reviews, minor ailment services and smoking cessation schemes. There has been a blurring of roles between healthcare professionals, for example, pharmacist and nurse prescribing in the UK[11] leading to increased competition. It is evident that the pharmacy and health care world involves complex human interactions that can rarely be studied or explained in simple terms, this is very interesting to social pharmacists and has implications for both teaching and research.

If we consider India, there are a wide variety of models under which people obtain medicines, it may be from a village health worker and they may never see a pharmacist, they may buy medicines from a pharmacy operated but not necessarily run by a diploma trained pharmacist, at the other extreme they may receive pharmaceutical care from a highly trained clinical pharmacist operating as part of the healthcare team in a 'high tech' privately funded hospital. How people obtain their medicines and the advice they get may affect how they feel about and if they actually take their medicines and ultimately if they recover from an acute illness or maintain good health with a chronic condition. This and similar issues are some of the issues that social pharmacists like to research.

Social pharmacy draws on the theories and methodologies of the social and behavioural sciences. It can thus be conceived of as part of a socio-environmental or bio-psycho-social approach to understanding health and illness as distinct from the commonly accepted biomedical approach[12]. Social pharmacy might include for example theories and concepts from the areas such as communication, public health, sociology, ethics and behaviour. Social science based understandings are utilised to improve clinical practice, promote informed political awareness, develop professional and

Indian Journal of Pharmacy Practice
Received on 05/09/2008 Modified on 25/09/2008
Accepted on 27/09/2008

managerial competencies, inform ethical judgements and engender a critical approach which encourages change and improvements in services and health care delivery.

There have been several calls for a definition of social pharmacy and to distinguish between social pharmacy and pharmacy practice, but, this does not seem to have been achieved.[13,14,15] Several authors have attempted to define social pharmacy, clinical pharmacy and pharmacy practice. For instance, Harding and Taylor[16] suggest that, in Britain, pharmacy practice provides the umbrella under which social pharmacy exists, whereas Mount[17] suggests that, in the US, social pharmacy (or social and administrative pharmacy) is a subset of the social sciences in pharmacy. Ryan and Bissell[18] call for more applied theoretical work in social pharmacy that could help with the development of a theoretical and conceptual knowledge base to inform research and teaching in the discipline.

Social Pharmacy In The Pharmacy Curriculum

In 1975, in the US, the Study Commission on Pharmacy (Millis Commission Report) identified the need to develop the behavioural and social sciences in pharmacy alongside clinical practice.[19] From 1975, the American Council on Pharmaceutical Education included pharmacy administration, social and behavioural sciences in their indicative curriculum. The most recent educational statement from the American Association of Colleges of Pharmacy incorporates many social and behavioural topics as required outcomes of pharmacy programmes in the US.[20] A number of European countries introduced social pharmacy into their curricula in the mid-1970's. In the UK, in 1986, the Nuffield Committee of inquiry into Pharmacy[21] declared that behavioural science should be incorporated into the undergraduate pharmacy curriculum. This was endorsed by the Royal Pharmaceutical Society (RPSGB) Working Party on Social and Behavioural Science.[22] Teaching of social pharmacy is now undertaken in all UK schools of pharmacy in the UK and forms part of the RPSGB's indicative curriculum. In our recent survey[12], we used a web-based questionnaire to collect data on social science teaching in schools of Pharmacy. There were 62 responses representing schools of pharmacy from 17 countries. The social science disciplines appear to have gained in acceptance within the pharmacy establishment showing an advancing degree of sophistication and rudimentary development of a theoretical base. However, there was a wide range of subjects, from scientific to behavioural, being taught under the banner of social pharmacy suggesting that there remains a lack of definitional agreement.

It is very interesting to note that the proposed Pharm.D curriculum for India[23] does not specifically mention social pharmacy. However, the section on the internship states that an objective is "to provide patient care in co-operation with patients, prescribers, and other members of an inter-professional health care team based upon sound therapeutic principles and evidence-based data, taking into account relevant legal, ethical, social cultural, economic, and professional issues, emerging technologies, and evolving biomedical, pharmaceutical, social or behavioural or administrative, and clinical sciences that may impact therapeutic outcomes. I believe that the omission from the curriculum may prove to be a wasted opportunity.

Research Methods In Social Pharmacy

Social pharmacy researchers use social science research methods. These may include quantitative methods such as surveys, but often also use qualitative research methods like interviews, focus groups, observation, documentary analysis and conversational analysis. Policy decisions are increasingly informed by findings from qualitative as well as quantitative research. Qualitative research is useful to policy makers because it often describes the settings in which policies will be implemented. Qualitative research is also useful to pharmacy practitioners as they develop their services. Qualitative research involves the collection, analysis and interpretation of data that are not easily reduced to numbers. These data relate to the social world and the concepts and behaviours of people within it. Qualitative research can be found in all social sciences and in the applied fields that derive from them.[24] It looks at what is X, how does X vary? in different circumstances rather than how big is X or how many Xs are there.[25] Text-books often sub-divide research into qualitative and quantitative approaches and it is often assumed that there are fundamental differences between the two approaches. With pharmacist's who have been trained in the natural and clinical sciences, there is often a tendency To embrace quantitative research, perhaps due to familiarity. However, a growing consensus is emerging which sees both qualitative and quantitative approaches as useful to answering research questions and

understanding the world. Increasingly mixed methods research[26] is being carried out where quantitative and qualitative research are used together in the same study and the researcher explicitly combines the quantitative and qualitative aspects of the study to both develop and test theories.

An Example of Social Pharmacy Research on Emergency Hormonal Contraception

One of the projects that I have been involved was the evaluation of the two initial schemes for pharmacy supply of emergency hormonal contraception (EHC).[27,28,29] I worked alongside a social scientist on this project. There was considerable political concern about these government funded schemes aimed at reducing teenage pregnancy levels. However, in keeping with my belief that pharmacies could be a unique forum for improving access to services, I immediately saw these schemes as setting down a marker for pharmacists' involvement in other areas of practice development and public health. We used interviews with pharmacists and stakeholders, surveys and focus groups with women and a form of participant observation, mystery shopping to evaluate the services. Our evaluation of these schemes indicated that pharmacists were enthusiastic about this role and that they supply emergency contraception appropriately. Surveys with 745 women who had used the service indicated that they viewed the service positively. However, 15 percent of those surveyed, mainly those who were under 20 years, would prefer more privacy- something pharmacists have subsequently addressed with the provision of consultation areas. Majority of the women who used the service were not teenagers. Our findings also demonstrated that the increased access to emergency contraception via pharmacy means that it is more likely that women are able to take emergency contraception sooner after unprotected intercourse than when they obtain it from other sources. The largest number of consultations was at weekends or on Monday mornings when other services are difficult to access. In particular, the women surveyed noted a welcome absence of judgmental attitudes when accessing the service. However, both the women using the schemes and the pharmacists had a number of major concerns about the schemes, centering on the potential for misuse, changes in contraceptive behaviour due to the availability of EHC and the impact on sexually transmitted infections. More research is needed to explore these issues. A number of participants questioned the wisdom of the pharmacist providing advice about long-term contraception needs and sexually transmitted infections in the context of the consultation. Some felt that the service should be confined to supplying emergency contraception rather than counseling individuals on their long-term contraception needs or the risks of sexually transmitted infections. In-depth interviews with pharmacists indicated that having a ten minute private consultation with women had changed women's perceptions of pharmacists, and possibly increased their professional status in the eyes of users. We have tried to seek an explanation for why pharmacists welcomed the scheme and also had strong reservations about it. Their positive attitudes towards the scheme may be a reflection of their desire to welcome and show competence in the delivery of new and innovative roles, important for the future development of the profession. We showed that providing a service which involved conducting a detailed and private consultation with women (and then supplying a product free of charge) was considered to be different to other services currently provided within community pharmacy. Not only did many pharmacists enjoy these aspects of practice, they also received remuneration for it without having to charge for the service. More than one participant argued that this potentially paved the way for the future delivery of other services, for example pharmacist prescribing and new funding streams. Others believed that the service had changed public perceptions of pharmacists, and this potentially enhanced their professional status. These factors are likely to be important to pharmacists, given the need to develop new roles and responsibilities in response to the historical threats to their professional legitimacy. Edmunds and Calman[30] have argued that the development of new roles and responsibilities is essential for pharmacy as a survival strategy. It is possible that pharmacists' attitudes to the schemes, at least to some extent, reflect these wider professional necessities. What we do not know is that the supply of EHC via pharmacy has met the policy objective of reducing teenage pregnancy in women from lower socio economic groups, many of the users were older women. However, our research has helped in the continued funding of these services and informed many primary care organisations in the UK who set up similar services for supply of EHC and Chlamydia screening and treatment services.

To the Future

So what is the future for social pharmacy? I believe it is still a young and developing discipline. So long as people are seeking treatment, taking medicines and attempting to improve their health, there remains a rich resource for social pharmacy research and teaching. It is important that we work in collaboration with social scientists to develop research and teaching skills in this area.

REFERENCES

1. World Health Organization. Adherence to long-term therapies: evidence for action. Geneva: WHO, 2003.
2. Horne R, Weinman J, BarberN, Elliott R, Morgan M. Concordance adherence and compliance in medicine taking. National Coordinating Centre for NHS service Delivery and Organisation; 2005.
3. Pirmohamed M, James S, Meakin S, Green C, Scott AK, Walley TJ et al. Adverse drug reactions a cause of admission to hospital, prospective analysis of 18820 patients. BMJ 2004; 329: 1519.
4. Howard RL, Avery AJ, Slavenburg S, Royal S, Pipe G, Lucassen P, Pirmohamed M. Which drugs cause preventable admissions to hospitals? A systematic review. Brit J Clin Pharml 2007; 63: 136-147.
5. Haynes RB, Ackloo E, Sahota N, McDonald HP, Yao X. Interventions for enhancing medication adherence. Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD000011. DOI: 10.1002/14651858.CD000011.pub3.
6. Carter S, Taylor D. A. Question of choice compliance in medicines taking. A preliminary Review. (3rd Ed) London. The Medicines Partnership, 2005.
7 Britten N, Ukoumunne O, Boulton MG. Patients' attitude medicines and expectations for prescriptions. Health Expect 2002;5:256-269.
8. Chen T, de Almeida Neto. A Exploring elements of interprofessional collaboration between pharmacists and physicians in medication review Phar World Sci 2007; 29: 574-576.
9. Pumtong S, Boardman H, Anderson C. Pharmacists' perspectives on the Pharmacy First Minor Ailments Scheme. Int J Pharm Prac 2008; 16(2): 73-80.
10. Blenkinsopp A, Anderson C, Armstrong M. Systematic review of the effectiveness of community pharmacy-based interventions to reduce risk behaviours and risk factors for coronary heart disease. J Public Health Med 2003; 25: 144-153.
11. Cooper R, Anderson C, Avery A, Bissell P, Guillaume L , Hutchinson A, James V, J. Lymn J , Macintosh A, Murphy E, Ratcliffe J, Read S, Ward P, Nurse and Pharmacist Supplementary Prescribing in the UK - a Thematic Review of the Literature. Health Policy 2008; 85(3): 277-292.
12. Ryan K, Bissell P, Anderson. C, Traulsen. J M, Sleath B. Teaching social sciences to undergraduate pharmacy students: An international survey. Pharmacy Education. 2007; 7(1): 1- 9.
13. Johnson C A, Wertheimer A I. Behavioural pharmacy. American Journal of Pharmacy Education. 1979; 43: 257-261.
14. Leufkens H. G, Schaefer M., & Harris M. F. Global survey of teaching pharmacy administration in colleges of pharmacy. American Journal of Pharmaceutical Education. 1993; 57: 74-76.
15. Manasse H R, & Rucker T D. Pharmacy administration and its relationship to education, research and practice. Journal of Social and Administrative Pharmacy. 1984; 2(3):127-135.
16. Harding G, & Taylor K. Defining Social Pharmacy. International Journal of Pharmacy Practice 1993; 2: 62-63.
17. Mount, J. What is Pharmacy Practice Research?. International Journal of Pharmacy Practice, 1994; 3:1-2.
18. Ryan, K, Bissell, P. What is Pharmacy Practice? What is Social Pharmacy? What is the Difference Between the Two?, Paper presented at the 13th International Social Pharmacy Workshop, Exploring Theoretical and Cultural Perspectives, Malta,2004.
19. Study Commission on Pharmacy. Pharmacists for the future. Ann Arbor, MI: Health Administration Press, 1975.
20. AACP, CAPE Final DRAFT Supplemental Educational Outcomes, 2004, (2006 update) http://www.aacp.org/site/page.asp?TRACKID=&VID=1&CID=1374&DID=7881 (accessed 27/08/2008).
21. Nuffield Committee of Inquiry into Pharmacy. Pharmacy: A report to the Nuffield foundation. London: Nuffield Foundation, 1986.
22. Report of Working Party on Social and Behavioural Science. London: Royal Pharmaceutical Society of Great Britain, 1989.
23. http://www.pci.nic.in/Pharm.D.(Revised)A.doc (accessed 27/8/08)
24. Murphy E, Dingwall R, Greatbatch D, Parker S, Watson P. Qualitative research methods in health technology assessment: a review of the literature Health Technology Assessment 1998; 2(16):102-106.

25. Pope C, Mays N. Qualitative Research in Healthcare. 3rd ed Blackwell Publishing, Oxford 2006.
26. Creswell J Creswell, John W Plano Clark, Vicki L Designing and Conducting Mixed Methods Research Sage , CA , 2006.
27. Bissell P, Anderson C Supplying emergency contraception via community pharmacies in the UK: reflections on the experience of providers and users. Soc Sci Med 2003; 57: 2367-2378.
28. Bissell P, Savage I, Anderson C. A qualitative study of pharmacists' perspectives on the supply of emergency hormonal contraception via patient group direction in the UK. Contraception 2006; 73: 265-270.
29. Anderson C, Bissell P Using semi covert research to evaluate an emergency hormonal contraception service. Pharm World Sci 2004; 26:102-106.
30. Edmunds J, Calnan, M. The reprofessionalisa-tion of community pharmacy? An exploration of attitudes to extended roles for community pharmacists by pharmacists and general practitioners in the UK. Social Science & Medicine, 2001; 53: 943-955.