Airing Pain: Programme 38: Can your pharmacy help?

Finding out about the role of the pharmacist and how service users can get the most from them

Paul Evans speaks to Professor David Taylor from the University College London School of Pharmacy about the perceptions and reality of the pharmacist's role and their skills. Pharmacist Emma Hinks talks about how pharmacists can help you with services like the Medicines Use Review (MUR), which looks at how you are getting on with your medicines. We also hear about the increasing emphasis on pharmacists communicating with their service users, working together with other services and recommending non-pharmaceutical forms of treatment.

Paul Evans: Hello, I am Paul Evans and welcome to ***Airing Pain***, the programme brought to you by Pain Concern, the UK charity providing information and support for those of us who live with pain. This edition is supported by the Scottish Government and complements a poster campaign by Pain Concern and Pain Association Scotland to encourage people with pain to ask for advice from their pharmacist and to promote awareness of the information, resources and training available for self-management. So, let's start with the basics: what is a pharmacist? David Taylor is Professor of Pharmaceutical and Public Health Policy at University College London School of Pharmacy.

David Taylor: A pharmacist is a person who today has been through at least 5 years of education about medicines: how to use them, how they should be stored, the people who use medicines. Now, in the past, the pharmacist was the expert on medicines. Today, we like to say that they are the expert on not only medicines but the people and communities who use them. So it's a role which in the past was closely connected with medicine. Up until the beginning of the last century, of course, pharmacists made the medicines in their shop. That changed with the development of the pharmaceutical industry and through the 1950s onwards, there's been such a lot of dispensing that people perhaps lost sight of the fact that pharmacists are healthcare practitioners. But now a lot of that is becoming mechanised and we've got much more emphasis on understanding, that with an aging population, we need to help people use their medicines to best effect. And so the focus is now on pharmacies contributing to clinical care as well as supplying drugs, which is very important to do properly. But supply alone is not enough; it's making sure and helping people to use them to the best effect.

Evans: So, perhaps the common perception of the pharmacist, the chemist, just handing drugs over the counter that the GP has prescribed, is completely wrong?

Taylor: Well, I wouldn't like to say people are completely wrong. People's experience has been – sometimes it's been the counter assistant handing over things and people think it's the pharmacist, and the pharmacist has been in the back of the pharmacy busily dispensing. That probably isn't the best way to use somebody with a lot of education; not only the five years before you qualify, but all the work that's put in afterwards in continuing professional development. I think there's a greater realisation on all sides that the pharmacist should be

playing a more direct role in care, but that's certainly not the fault of the customers. It's understandable if customers got the wrong message in the past, but that's something we are changing now and *hopefully,* there's variation in all professionals: doctors, nurses, pharmacists as well, but *hopefully* now pharmacists should be much more open to listening to the people who come into their stores (I hesitate about the word patient because I prefer to think of us all as normal consumers, whether there's something wrong with us or not) but the people in need of services, service users – pharmacies should be open to listening and helping as much as they can, especially around issues of medicines use. But there are also issues of prevention, lifestyle, and coping with illness, which again one would expect the modern pharmacist to be able to contribute to.

Evans: Now, you're not a pharmacist, you are a professor of pharmaceutical and public health policy. What does that mean?

Taylor: In this context it means that we should understand individual cases of pain within the framework of the wider community, the services available, the sorts of beliefs people have about pain, the range of things that we've got available both in the private sector and in the public sector to help combat it. So it's taking an overview of what the problem is, about what the potential solutions are and making sure, for example with something like back pain, it should be public knowledge that often the last thing you want to do when you have an episode of back pain is to stop moving around. It's important to keep going. Other examples where you've got, say, an acute inflammation, it may do your joint no good to do that. So getting this sort of public understanding because so much of care, of course, is self-care with professional support. So it matters critically that the population, you and me together, have a basic knowledge of health issues. It enables us to behave sensibly, to minimise the distress and maximise what we all want to do, which is age as healthily and as happily as possible.

Evans: You co-produced the University College London paper *Talking About Pain*. Now, the headline is 'Eight less pain questions to discuss with your pharmacist'.

Taylor: Yes, that was part of a wider study we did about relieving persistent pain and improving health outcomes related to pain, because we now realise that pain should be seen as something very important itself, not just as a symptom of other conditions that we take more seriously. So this research was done in University College London and with colleagues in the NHS, and, for example, Dr Roger Knaggs of Nottingham University. The talking about pain instrument was something for pharmacists to use when talking to their customers about their experience of pain: so how long the pain has gone on for, did it start at a particular point, how did it start, how severe is it, what does it feel like, is it stabbing or tingling? All those sorts of questions which should help a health professional to understand the problem they are dealing with. That's not to say that there are magic cures sometimes, but it can mean that we use medicines to better effect. Even very simple things, like people are told to take a medicine three times a day, at mealtimes. Now, if you happen to have tea very early, say, 5 or 6 o'clock in the evening, and you don't have a breakfast till 9 o'clock the next morning, it's not going to be very surprising if you wake up with pain in the night because three times a day actually means once every eight hours. Something as simple as that can make a big difference to people. So many of the simple things we could do, for example, some sorts of painkillers will make you constipated. Have people been helped to

ensure that doesn't happen to them? Other issues about if a painkiller is working, some people don't convert the medicines to the active ingredients in their body as well as others. That should be found out about. And sometimes a particular sort of medicine may work in ordinary pain but in chronic special pain cases, so-called neuropathic pain cases, they may not work. Differentiating and making sure we've got horses for courses is what good pharmacy care is about.

Evans: David Taylor, Professor of Pharmaceutical and Public Health Policy at University College London School of Pharmacy.

Now, devising policy is one thing, but how does that policy affect you and me? Emma Hinks is a pharmacist working at Prince Charles Hospital in Merthyr Tydfil. And she's community pharmacy facilitator for Cwm Taf Health Board in South Wales.

Emma Hinks: Through the last couple of years the pharmacy contract that pharmacies have with the National Health Service to provide services has changed considerably and a lot of new services have been introduced for pharmacies to deliver. Probably the most commonly known is the Medicines Use Review (MUR) Service, which is where pharmacists sit down with a patient and goes through the patient's medical condition and also the medicines they use to control their condition and to look at ways to maximise that therapy.

Evans: So how would I get a medicines use review?

Hinks: You can request one at the pharmacy, you can self-refer or the pharmacist may feel that you would benefit from one, so they may offer you the service, as well.

Evans: But how could I possibly benefit from one, because my doctor does that.

Hinks: What the medicines use review isn't, it isn't a clinical review of your medical conditions, so it doesn't look at test results and about the clinical decisions around your therapy. It's very much more about how you use your medicines and what you understand about your medicines, to try to maximise the benefit that they give you. Lots of patients tend to find that they don't like to ask questions; sometimes they might be feeling like they are underusing medicines, they might be overusing them, if they're not thinking that they are controlling their symptoms. And what the medicines use review is, it's an opportunity to sit down with a pharmacist and go through all of those sorts of questions or concerns that patients may have about the tablets they are taking.

Evans: But certainly there is an attitude, that if a doctor has given you a tablet, then it must be correct.

Hinks: Yes. And again, this isn't about questioning whether it's the correct tablet for you. It's around, are you using it in the most appropriate way to get the maximum benefit from it? Lots of patients find that, if they take multiple medicines, some need to be taken before food, some need to be taken after food, some it doesn't matter when you take it, and it's about formalising a process around what each tablet does, why they do it, and what's the best way to take it. And that way you can help patients manage their conditions better, and also you can make sure that the NHS is using their resources properly because by taking medicines

properly, then what we're doing in turn is managing patients' conditions more effectively and then we're reducing any waste in the system as well.

Evans: My personal experience is that I take several repeat prescription drugs. I called in to my pharmacist last Friday and there was a big green and orange sticker on them and the pharmacist said, 'Can I have a word with you about this?' And I thought, 'Well, what's going on here, what have they found?' She sat me down and talked about the things: 'Do you have any problems with them?' 'No, I'm absolutely fine, they're doing well, they're bringing my blood pressure down; everything seems to be fine.' And she said, 'Any other health issues?' And I said 'Ooh, I've had a cough since October.' She immediately looked up at me, recognised the problem, said: 'I heard you coughing' and immediately pointed to one of the drugs I was taking. It's a very well-known side effect of that.

Hinks: Absolutely. Yes, I take that tablet too. And that's what MURs are about really: it's about identifying medicines related issues that you may think are trivial or you may not attribute to something in particular but can be something which can affect you taking your tablets. Some people who get coughs when they're taking the medication will stop taking the medication, or they will think, 'This is the only option for me, and if I don't take this then I won't be able to do anything else,' and that is certainly not the case. There are lots of different medicines that work in different ways, so if you get problems with one, you can look at recommending a change to something else. That would be what anyone would do: identify the problem and then refer that on to the GP for the GP to look at how is best to resolve that issue going forward for the patient.

Evans: But, you see, I'm absolutely staggered by this, that the pharmacist knew immediately, *you* knew immediately what I was taking without me telling you, but it had been missed.

Hinks: I think what the MUR service does quite nicely is it sits alongside the GP reviews. So, GPs do a fantastic job and pharmacists do a fantastic job, but working together on things they can perhaps start identifying things that perhaps one or the other might not have picked up on in the past. And that's what the MUR service is all about – it's about identifying the medicine related problems, referring those on to the GP for the GP to look at how those medication-related problems can be resolved to ensure that the patients get the best treatment that we can give them.

Evans: I had my flu jab last year in my local pharmacy and I was asking the pharmacist who did it and had been on a training to push needles into me, how she was finding this new role in her job, and she said, 'I love speaking to people and just sitting down and talking to them. We should be doing more of that.'

Taylor: Sitting down and talking, communicating: that is fundamentally important. So, in the past we had very rigid boxes and put nurses in the caring box, pharmacists in the drug management box and doctors in the pure diagnostics box, etc. And, of course, [there was] a huge social hierarchy around those divisions. Now I think we can blur the roles between professionals and consumers, overlap more, try to be more effective, to use our collective knowledge to best effect.

Evans: Many people won't understand different forms of pain relief. Some you can buy straight over the counter, or from high street shops, like paracetamol. What are the differences between these things? Are there things we ought to know?

Taylor: Certainly, if your pharmacist is desperately busy, then he or she might not have time to explain but normally they explain to people the difference between, say, opiates – morphine-based drugs – which we tend to think of as for more severe pain, and for example the normal non-steroidal anti-inflammatories that you can buy over the counter, like aspirin. The key thing to know there is that those over the counter medicines are normally provided for short-term pain relief. So something that's happened to you, you've had a blow for example and there's pain in the arm or pain in your teeth, then you may need short-term relief for that. But for long-term relief it's much better to have coordinated proper medical and pharmaceutical care. So not, for example, topping up medically prescribed drugs with privately purchased drugs, which you don't tell anyone about. It's a very good idea to avoid that and to be open with the pharmacist and if you have problems communicating with the doctor, ask the pharmacist to help you do so effectively.

Evans: Many people who take medication for chronic pain complain that the side effects can be worse than the original condition itself. Can you help on that?

Taylor: All healthcare professionals, doctors, pharmacists should be able to listen very seriously when people tell them that and do the best they can to help. Sometimes, we have a difficult situation in that the control of pain is not perfect and we may have to pay through suffering some side effects. So, don't necessarily expect perfection but normally therapy can be improved and, as necessary, specialists in pain like Dr Knaggs, who I've mentioned recently, who worked with us on developing our talking about pain instrument, will have experienced the problems before. The key is communicating: if you don't tell people, then you won't get the benefit of their knowledge.

Evans: High street pharmacies are commercial operations. Could there be a conflict of interest between pharmacies promoting self-management – things like cognitive behavioural therapy (CBT), relaxation – as opposed to selling drugs?

Taylor: I think there's always a potential for conflict of interest, wherever you work, whether you're a GP, paid by particular incentive schemes. The great majority of pharmacists I know are deeply ethical and concerned people. What they know about most is medicines and I think if there's a bias there [it's that] their training may historically have been focused on drugs rather than on people. But modern pharmacy training is about being aware of the value of psychological therapies, the values of CBT in pain and being able to signpost where this is necessary if pharmacists themselves can't directly provide the treatment. So, of course it's true, there's conflict of interest everywhere, even in journalism, dare I say it, but as you know, good people try to overcome that and do the best job they can.

Evans: Professor David Taylor. Emma Hinks, community pharmacy facilitator for Cwm Taf health board once again.

Hinks: What community pharmacists can also offer are a range of additional services. Now we offer smoking cessation services through the community pharmacy, there are minor

ailment services in development and being run within community pharmacies, so they offer a sort of wide range of services. But also onward referral to other services when they can't help.

Evans: But, moving away from that, tablet counter…

Hinks: Absolutely, from the traditional service, which everybody sort of associates with community pharmacy. I think one of the other key things that they can refer you into – do you know much about the Expert Patient Programme?

Evans: Well, I've done the Expert Patient Programme, and I know that many people who listen to ***Airing Pain*** have done it as well.

Hinks: Yes, we've worked with the local Expert Patient Programme team to try and develop links between community pharmacy and the service. So we're looking at how community pharmacies can refer patients into those services, because I know patients with many chronic conditions find that a really helpful and supportive environment in which to learn skills to help them cope with their conditions.

Evans: Of course, the thing about the Expert Patient Programme is that it is not run by health professionals.

Hinks: That's right, yes. It's run by volunteer staff who are usually patients who have suffered with a chronic condition themselves and, therefore, it's very much about supporting lifestyle changes and things you can do to self-care. So supporting management of a condition by managing certain aspects yourself.

Evans: And I seem to remember that one session was devoted to how to use your pharmacist.

Hinks: That's right, yes, and it's around building links again with this Medication Use Review, and things like that, so encouraging patients to speak to pharmacists when they've got medicines related concerns.

Evans: You're based at Prince Charles Hospital in Merthyr Tydfil, which is part of the Cwm Taf health board. In previous generations, this has been one of the heaviest industrial areas and one of the poorest areas in the UK. Pharmacists in this area health board have started visiting people in their homes.

Hinks: We've already talked about the Medicines Use Review service, and it's been running since 2006. One of the things that we've picked up, as we've gained from experience of commissioning the service, is that the patients who access it find it very useful, they learn from it. The pharmacists delivering it enjoy speaking to patients about their medicines, they enjoy having protected time where they can sit down and build a relationship with patients, but what we found was that there were a number of patients that weren't able to access that service because they're housebound. So what we've done locally is we've introduced a service whereby pharmacists can go out and visit those patients at home, so that we can ensure that all patients have access to a service which is of value and demonstrates some really good outcomes.

Evans: We've talked a little bit about GPs and over the counter pharmacists. Another issue people might have is when they've been in hospital, and they're looked after with the pharmacists in the hospital, they're given a pile of drugs. What happens when they leave?

Hinks: Traditionally, that I think has always been something that we recognise has been a gap, maybe in the transfer of patients back from hospital to their GP and moving forward in their care. What the Welsh Government did back in 2011 was again introduce a new community pharmacy service called a Discharge Medicines Review Service, which aims to bridge that gap, to support patients in that transfer of care. And what the service is designed to do is to make sure that both the patient and the GP have the same information about the medicines following the discharge from hospital. And the review helps to ensure that patients continue to take the medicines they were prescribed in hospital once they come home. It's a two part service – the first part is very much around checking that the medicines are the same when they come out of hospital, and again there's a follow-up appointment a month later which is very similar to a MUR and that looks at how you're getting on with those medicines, so since you've been discharged, have you had any problems with them, is there anything that you're concerned about, is there anything that you've forgot to ask when you were discharged, when you had the opportunity to speak to the pharmacist, and again it's just a chance to reinforce information and to chat through any problems you've got. It also involves the pharmacists working with your local GP to make sure that that list of medicines is right for you.

Evans: I just want to talk about how important a pharmacist can be in the community. You won a Royal Pharmaceutical Society award for something you did with a long forgotten disease (I thought): tuberculosis (TB).

Hinks: Yes, we did a screening programme in a local community within Cwm Taf, where they identified some patients with latent tuberculosis, which is quite easily treated with antibiotics but what you tend to find is that patients have problems taking that medication. It is quite strong and it can cause side effects and from the research that was available it showed that whilst patients should take it for three months, lots of patients dropped out of treatment because of the problems they were getting. So what we introduced was a service whereby the community pharmacists monitored those patients, and they picked up the medication every fortnight and the pharmacist went through any problems they were getting with their medication. And we found that the success rate and the completion rate amongst those patients was much higher than in previously documented reported completion levels.

Evans: So it's the pharmacist. The community pharmacist is able to do not just the collection of data but to be the person to talk to and to encourage the patient.

Hinks: That's right. I mean, they worked very closely with the hospital consultant and the TB specialist nurse, who were obviously involved in the care of those patients and what they did, they were like the first point of contact. So if there was an issue that the patient was concerned about they would come and chat to the pharmacist. If the pharmacist could resolve it they would. If the pharmacist felt that they needed to be referred back into clinic then they would telephone the clinic and get that patient seen as quickly as possible. So it

was very much a multidisciplinary approach to it with different professionals working together in a different way to improve patient outcomes.

Evans: Now, we're in Cwm Taf health board, which is Merthyr Tydfil, the Rhondda Valleys, the old industrial centre of South Wales – mining, steel, iron, heavily populated. Each area health board will have its own policy. How would someone with chronic pain find out what their local pharmacists will do?

Hinks: The easiest way for a patient to find out what services are available to them locally is to visit their local pharmacist. That pharmacist will obviously know which services they provide themselves and will also know which services the pharmacies around them provide. And each health board has also got its own individual website, so if you visit your local health board website there will be information there about community pharmacy services.

Evans: Now I just need to remind you of our usual words of caution: that whilst we believe the information and opinions on ***Airing Pain*** are accurate and sound, based on the best judgements available, you should always consult your health professional on any matter related to your health and well-being. He or she is the only person who knows you and your circumstances, and therefore the appropriate action to take on your behalf. In this edition of ***Airing Pain*** we're looking at the role of the community pharmacist, and how he or she could help those of us living with pain.

So how should we approach a conversation with our pharmacist? Here is David Taylor again.

Taylor: Well, I think that if you're not used to speaking to your pharmacist about clinical issues, there may be a degree of uncertainty. I think the best thing to do is to choose a time when the pharmacist clearly is not dealing with a host of other issues in front of them, and to say, 'I've had a long standing problem with pain, or a member of my family has. I'd really like to talk to you about it, and about the value of medicines and how to use them properly. Do you have time to talk to me now?' To be open about it. Now some pharmacists may feel that they're uncertain in that area – we don't all have the same areas of expertise, and when you think of the range of things which can happen to our bodies that's not surprising. But I think if one is open and asks for support, most pharmacists would be only too delighted to spend some time, share some time, going through the problems. Remember that the important thing to do often is to go in with it in your mind what you want to say – if there's a side effect or a fear you've had that you've never told people about before. Some people don't talk about their pain because they fear it might be an indication of, for example cancer, which I happen to have had, but nowadays people can get better from cancer. So often most pains aren't due to cancer but that's a quite common thing – people don't talk about them because they fear it's something horrible and they don't want to find out. Now, getting over those things, being clear that you want to communicate to a health professional, is important.

Remember, when you've communicated to one health professional it's often easier to communicate to the next, so sometimes talking to the pharmacists helps you then go and talk to the doctor, helps you talk to your nursing support. Becoming skilled at communication, respecting others, never talking down too much to others who you think may not know as much, or up too much to people you think are hugely informed and sometimes they're not,

just being clear and getting across the key messages that have been worrying you, I would say is the key advice.

Evans: Because the consultation is a two way process, isn't it? It's not just you looking at me, if you are a doctor looking at me and saying, 'This is what's wrong with you'. It has to be me gathering my thoughts and saying, 'I am depressed, or I hurt. This is what is on my mind; this is what is worrying me.'

Taylor: Absolutely Paul. I think you're completely right that it's that ability and responsibility to communicate on both sides. Doctors aren't psychic, neither are pharmacists, neither are nurses – they won't know unless you've told them. At the same time they've got to be capable of expressing themselves clearly when the time comes. But for the consumer to say, 'Well, I've tried that, it didn't work, it hasn't worked for me,' but to do it in that spirit of good faith, and mutually working towards an agreed aim, but *not* being passive and *not* accepting quietly inadequate care, perhaps out of politeness to the doctor. I'm sure that isn't what most members of the medical profession want, I'm sure it isn't what most pharmacists and nurses want. They want people to be able to say clearly their needs when a problem hasn't been resolved. So it may be difficult, it may be that you feel like you're being a bore, but if you're hurting, if you're in chronic pain and it hasn't been resolved, then keeping on telling people and pushing for better services, whilst at the same time not being unrealistic and not being unreasonable.

Evans: It's the 21st century where we are now. Where do you think the role of the pharmacist will lead?

Taylor: I think, probably, as with all professions, as computers get smarter at doing basic jobs like providing information (we'll probably be able to talk to them soon), like for example the electronic transmission and prescriptions and then going into dispensing machines, the pharmacist's role will become more clinical. I'm reasonably sure that it will be more similar to what we thought of in the past as the general practitioner role. And there will be big opportunities and roles for general practitioners as care gets more complex in the community, and as our populations age, that they support complex cases and we allow this gradual cascading down of authority, power and tasks, ultimately to the consumer. So for example when somebody has got a diagnosis of type 2 diabetes, which can involve pain problems of course, they are more enabled to understand their condition, to eat properly, to exercise properly, to safeguard themselves. So gradually all the time in society we're trying to move that point of authority closer to the consumer, and that's not to deprive them of the care they had in the past, but to acknowledge the fact of consumer sovereignty; that most good health is down to the efforts of individuals and their families. And what professionals can do is help, but as soon as they just try and take total power, that often is more disabling than it's worth.

Evans: David Taylor, Professor of Pharmaceutical and Public Health Policy at University College London School of Pharmacy. Don't forget that you can still download all previous editions of ***Airing Pain*** from *www.painconcern.org.uk*, and you can obtain CD copies directly from Pain Concern. If you would like to put a question to our panel of experts, or just make a comment about these programmes, then please do so via our blog, message board, email,

Facebook, Twitter or pen and paper. All the contact details are at our website. Once again, it's *www.painconcern.org.uk*.

Now, do check the websites of your local health board to find out what community pharmacy services are available in your area, because:

Hinks: Community pharmacists are a great gateway for accessing a wide range of services. If a patient has a medicines-related problem, then the community pharmacist is probably the first place to go. You can see them without an appointment, you can chat through any concerns you have, and they can then refer you on to any other health professional they feel necessary.

Evans: So, we should use our pharmacists?

Hinks: Yes. Look at what services they can provide and use those services to help patients gain the best from their treatments.

Contributors

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