MINOR AILMENT PRESCRIBING BY PHARMACISTS: PART II – PHYSICIAN FEEDBACK

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ABSTRACT
Pharmacists have been granted prescribing privileges for minor ailments in several Canadian provinces. In an ongoing process of evaluation within one province, a random sample of physicians was surveyed for input on select aspects of the program. The objectives were to gauge the activity level involving minor ailments during medical appointments, the public’s ability to self-diagnose their situation, the perceived role and value of pharmacists involving minor ailment care, and the conditions of most and least concern within the program.

In a mail survey, 981 documents were mailed out to family physicians. A questionnaire to meet the needs of the study was not available, so one was created for this purpose.

Data analysis was based on information provided by 289 responders (response rate of 30.1%). Of those responding, 43.4% were female and 56.6% were male. Approximately one-third graduated from medical school in 2001 or later.

Almost two-thirds of responders estimated between 10 to 30% of patient appointments were primarily for minor ailments. These cases do not appear to be a strain on physicians and most would in fact want to see patients about a so-called minor ailment than miss something critical. Physicians indicate that a sizeable portion of those visits see patients mention a self-diagnosis. Most encounters do not turn out to be something more serious. There was not strong support for patients seeing a pharmacist first for a minor ailment. From a list of conditions relevant to pharmacist prescribing, physicians identified Headache/Migraine, Dysmenorrhea, GERD, and Hemorrhoids to be of most concern regarding patient safety, while Cold sores and Athlete’s foot were of least concern.

INTRODUCTION
Minor ailments are a very common part of daily life. Canadian adults experienced an estimated 82 million headaches, 85 million colds/flu, and 46 million episodes of indigestion during one recent year\(^1\). To obtain medical care for any such ailment, a patient would make an appointment, with the physician reimbursed on a fee-for-service basis. Most people do not seek formal care for them, but those that do can impact significantly on a healthcare system\(^2\). As an example, 13 percent of all physician visits in Ontario (circa 1989) were for colds/flu, representing 12.5% of government payments to physicians\(^6\). Regarding system costs, it would also be desirable to see less treatment of minor ailments in emergency rooms\(^10\).
Concern for the costs of such care has given rise to interest in pharmacist-led programs for minor ailments. Pharmacists across the world are at various stages of adding to their scope of practice. In the United Kingdom, they have been able to prescribe since 2003. Pharmacists in more than 40 American states have been granted some form of prescribing authority (although not always specific to minor ailments)\(^{12,13}\). In one of the earliest examples of a program, Florida attempted pharmacist prescribing for minor ailments in the 1980s\(^{14}\).

Most Canadian provinces have adopted (or are currently pursuing) various degrees of prescriptive authority for minor ailments\(^{15}\). When recently adopted in one province, the Minister of Health stated – "We think it makes good sense. It will alleviate waits at doctors’ offices and even emergency rooms."\(^{16}\).

Pharmacists have recently been granted prescribing privileges for minor ailments in Saskatchewan. They now have the option of selecting medicines from a limited formulary, ones traditionally under the sole control of physicians (or prescription-only). The scope of the program encompasses 17 ailments, increased from an initial list of three. An example scenario would be recommending a topical retinoid/antibiotic for a patient with acne. In terms of how events unfold under the program, on listening to a patient describe an apparent minor ailment, a pharmacist would determine that because non-prescription medicines had been tried (and were not effective), a prescription-only agent should next be considered. As of February 2012, this province became the first government to pay for minor ailments prescribing ($18 per case). While prescribing for minor ailments is new, pharmacists were obviously not new to the minor ailment arena. Nevertheless, given the new responsibilities associated with prescribing, pharmacists were mandated to receive additional training for this new service.

Feedback on Canadian programs is starting to materialize\(^{17}\). Reports from Nova Scotia and Saskatchewan have superficially examined patient symptom resolution\(^{18,19}\). In an ongoing process of evaluating the Saskatchewan program, family physicians were contacted for input. The objectives were to gauge the activity level for minor ailments during clinic visits, the frequency of self-diagnosis amongst patients, the perceived role and value of pharmacists during minor ailment care, and the conditions of most and least concern within the scope of the program. A similar survey was carried out with pharmacists to allow for comparisons, and some items not covered by the above objectives were included for that purpose.

**METHODS**

The number of questionnaires deemed necessary for analysis (based on approximately 2150 practitioners) was 328\(^{20,21}\). Assuming a response rate of 33 percent, 981 documents were mailed out.

A mailing list of family physicians was purchased from the Saskatchewan College of Physicians and Surgeons. From the randomly-generated list of names, a one-page Advance Letter was sent in early June 2015 to introduce the concept, outline the goals of the project, and the process to be undertaken. A questionnaire and cover letter followed 10 days later. Documents were returned
to the researcher in a stamped, addressed envelope. No follow-up attempts were made, given that
a tracking system for responses was not utilized. An enticement of a $20 gift card for a popular
restaurant chain was included. Mailing addresses for that purpose were requested with the main
mailing, but were immediately separated from the questionnaire upon receipt.

Sections included in the document were: 1) overview of minor ailment interactions (appointment
frequency, extent of patient self-diagnosis, proportion deemed not minor); 2) physician impressions
of minor ailment dynamics; 3) potential impact of the program (perceived demand for the service,
impact on health care costs and symptom relief); 4) conditions within the program of MOST and
LEAST concern to physicians; and 5) demographics. Response modes varied per section, with
examples being Likert scales and percentage options (from 0 to 100% in 10-point increments).

All items in the questionnaire were created by the author, except for those regarding physician
impressions of the dynamics of minor ailments (Figure 5). These were modified from a report
specific to that topic. The individual items posed to participants were as follows:

1. I often feel frustrated by the amount of work involved in seeing patients for minor ailments.
2. Minor ailment visits help to dilute the more demanding visits, thus balancing my day.
3. I would rather see a patient for a minor ailment than risk missing something of potential importance.
4. People today consult MDs far too early in their illness course.
5. The key to reducing minor ailment visits is to increase patient ability to handle such problems.
6. People should visit a pharmacist about a minor ailment before consulting their MD.

At the start of the questionnaire, a minor ailment was defined as an illness or symptom(s) that is
self-limiting, where the patient can reasonably self-medicate for, and can reasonably be expected
to identify it (or them) by themselves. The survey tool was reviewed by one local pharmacist,
one expert in pharmacist prescribing (UK), and one family physician. Ethics approval was obtained
from the University of Saskatchewan Research Ethics Board.

RESULTS

Of the 981 surveys sent, 13 went undelivered (incorrect address) and seven were removed from the
pool due to receipt by unintended targets (ER physicians, psychiatrists, Nurse Practitioner). With
a denominator of 961, data analysis was based on information provided by 289 responders, for a
response rate of 30.1%. Two surveys were subsequently removed for being incomplete.

Of those responding, 43.4% were female and 56.6% were male. Graduation from medical school
before 1980 accounted for 17.7% of responders, 1981 to 1990 was reflected by 18.4%, 25.1%
graduated between 1991 and 2000, and > 2001 were represented by 38.9%. Regarding patient
load, 45.0% saw 100 or fewer patients in an average week, 101 to 150 patients accounted for 34.0%
of responders, 15.3% fell between 151 to 200 patients, 201 to 300 were seen by 4.3% of physicians,
and 1.4% saw more than 301 patients per average week.
Not every question was answered by all 289 responders, but overall only a very small number of items were left blank. A response of UNSURE, however, was quite common for select questions and these are noted.

**Minor Ailment Landscape for the Physician**

The potential impact minor ailments have on physician workload was ascertained. Almost two-thirds of responders estimated between 10 to 30% of appointments were primarily for such situations (see Figure 1).

**Figure 1: Appointments booked (%) primarily for minor ailments**

![Figure 1: Appointments booked (%) primarily for minor ailments](image)

These visits can start with the patient describing their symptoms (‘I am here because my stomach hurts’) or conversely, by stating a self-diagnosis (‘I think I have Condition X’). Figure 2 depicts how often minor ailment encounters see patients articulate a self-diagnosis at that time. It can be a common occurrence for some; approximately one in five physicians estimated it happens at least 60% of the time.

**Figure 2: Minor ailment encounters (%) where patients state a self-diagnosis**

![Figure 2: Minor ailment encounters (%) where patients state a self-diagnosis](image)

This, of course, is no indication as to how accurate patients might be with those assertions. That aspect was addressed in subsequent questions (Figures 3 and 4). Physicians have more faith in
the public’s ability to recognize symptoms they have seen before, rather than those involving first occurrences. Further to the public’s ability to assess symptoms, regarding appointments purportedly booked for a minor ailment, the bulk of responders felt between 10 and 30% end up being more serious than what patients anticipated when making the appointment. One physician added there may actually be ‘a higher percentage of self-diagnosed “major” problems that turn out to be minor’. [Respondent 131]

Figure 3a & b: The public’s ability to self-diagnose minor ailments

Figure 4: Appointments for minor ailments (%) eventually deemed more serious
The next series of questions attempted to gauge physician impressions of other dynamics relative to minor ailments (Figure 5). The feedback indicates appointments for minor ailments are not overly burdensome to physicians (they help balance out visits with heavier needs) and that many physicians would prefer to see patients for a so-called minor ailment rather than miss something critical.

**Figure 5a-f: General impressions of the minor ailment care process**

- **a: Frustrated by minor ailment workload**
  - Number of times selected
  - Strongly disagree, Mostly disagree, Somewhat disagree, Undecided, Somewhat agree, Mostly agree, Strongly agree

- **b: Minor ailment cases balance my day**
  - Number of times selected
  - Strongly disagree, Mostly disagree, Somewhat disagree, Undecided, Somewhat agree, Mostly agree, Strongly agree

- **c: Importance of seeing minor ailments to prevent risk**
  - Number of times selected
  - Strongly disagree, Mostly disagree, Somewhat disagree, Undecided, Somewhat agree, Mostly agree, Strongly agree

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Impressions of a pharmacy service.

The Saskatchewan minor ailment program includes 17 conditions:

- Acne
- Allergic rhinitis
- Athlete’s foot
- Canker sores
- Cold sores
- Diaper rash (fungal)
- Dysmenorrhea
- Eczema
- Folliculitis
- Gastro-esophageal reflux disease (GERD)
- Headache/Migraine
- Hemorrhoids
- Impetigo
- Muscle sprain
- Ringworm
- Tinea cruris
- Thrush (oral)

From this list, physicians were asked to identify conditions that gave them MOST concern for...
patient safety relative to pharmacist prescribing. Up to five conditions were allowed. One hundred seventy-seven responders chose the maximum five conditions, suggesting that if more spaces were provided, more conditions would have been selected. For the remaining responders, 10 physicians selected NO conditions (that is, they had no concerns with the list), eight responders chose one condition, 16 picked two conditions, 38 selected three conditions, and 38 identified four conditions of most concern to them. Specific conditions are depicted in Figure 6, with Headache/Migraine, Dysmenorrhea, GERD, and Hemorrhoids garnering the most attention.

**Figure 6: Conditions of MOST concern to physicians**

Responders were also asked what conditions gave the LEAST concern (if any) for patient safety relative to pharmacist prescribing. Again, up to five conditions were allowed. Twenty-five physicians indicated they had concern for the entire list (that is, none of least concern). The remaining physicians narrowed the field down. Nine physicians chose one condition, eight chose two conditions of least concern, 20 chose three conditions, 31 felt four were of least concern, and 194 listed the maximum five conditions. The tally of specific conditions is identified in Figure 7. Cold sores were one area of low concern.

**Figure 7: Conditions of LEAST concern to physicians**

Physician perspective on public demand for this new service was gauged (see Figure 8). The majority was undecided as to what the demand level might be. Of those making an estimate, more felt consumer demand would be low.
Figure 8: Public demand for pharmacist prescribing for minor ailments

Whether pharmacist prescribing for minor ailments will reduce health care costs is depicted in Figure 9a. Based on the feedback, 150 responders were either unsure or agreed (somewhat, mostly, or strongly) that it would save dollars. Conversely, 135 responders disagreed (somewhat, mostly, or strongly) that the program would help save resources. Those disagreeing were then asked to provide reasons for that position (Figure 9b). The options provided to responders were: 1. Physician care will be needed to fix pharmacist oversight; 2. It will lead to pharmacists and physicians billing the government for the same ailment; 3. Minor ailments that are often mild are now needlessly treated; and 4. OTHER. Forty-one selected a single reason from the list, with the rest choosing multiple reasons.

Figure 9 a&b: Impact of minor ailment prescribing on healthcare costs
The last two items on the questionnaire assessed perceptions of clinical outcomes subsequent to pharmacist care. Figure 10a shows the percent of patients likely to attain satisfactory symptom relief within a reasonable timeframe following pharmacist assistance. For this, 125 responders were unsure. Of the remainder, approximately two-thirds felt the success rate would fall between 50 and 80 percent. On the other side of this equation, approximately one in five doctors felt that 70% (or more) of patients seeing pharmacists would need medical care soon after the original consultation (Figure 10b).

**Figure 10 a&b: Clinical outcomes as a result of minor ailment care from pharmacists**

![Graph](image)

**Comments section**

Just over 100 responders provided comments at the end of the questionnaire, a very large number relative to the total number of documents received. A cross-section of the general themes uncovered is as follows.

A full spectrum of feedback was seen, from negative to positive:

*A most ill-advised project. I have had nothing but near disasters following pharmacists prescribing.* [Respondent 028]

*I think it is a good service.* [Respondent 101]

The vast majority were negative, however. First and foremost, comments focused on the pharmacist skill level:
I would prefer a person with more medical training such as a nurse practitioner to see these patients. As far as I am aware, pharmacists have zero clinical training for examinations of patients. Have the pharmacists taken a course in dermatology? [Respondent 142]

These minor ailments can be very easy to diagnose, but can also be very easy to miss by even an experienced physician. [Respondent 212]

I don’t really understand the purpose of this whole process. Some of your ‘minor’ ailments require detailed examination, such as migraine or dysmenorrhea. How will a pharmacist get this training? [Respondent 077]

I have had several instances of mismanaged or delayed care because of pharmacist prescribing. Also, I would question any diagnosis made without an exam. [Respondent 023]

Another key block of comments expressed dismay over the ethical issue of pharmacists diagnosing, then prescribing, a medicine:

It is a conflict of interest for the seller of the treatment to be making a diagnosis and prescribing a treatment. [Respondent 041]

It is a little frustrating that after years of the College of Physicians and Surgeons being so adamant about no association between pharmacies and physicians, so as not to result in ‘unnecessary’ prescribing, pharmacists themselves can now prescribe!! Also, previously where a pharmacist would use product A or B for a minor ailment, are they possibly going to be pushed in the direction of product C, as this will result in the pharmacist being able to bill for a consult? And product C costing more? [Respondent 099]

Several noted the complex dynamics of minor ailments within the full scope of patient care:

Visits to the family doctor for minor ailments serve other purposes than just diagnosis and treatment of the presenting complaint. It also provides an opportunity to establish and monitor trust, check other concurrent conditions such as hypertension, diabetes, etc. I am, however, very supportive of team-based care. [Respondent 050]

The majority of patients seeking such service will be old, with chronic disease, and already on multiple meds. Medication interactions and side effects will become very difficult to manage. [ Respondent 076]

Frustration over incursion into the domain of the physician was evident:

Pharmacists should not be allowed to prescribe prescription drugs!!! Go to medical school if you want to prescribe drugs. [Respondent 089]

Lastly, a minority of feedback identified a need to know more about pharmacist training:

My UNSURE answers are not due to negative thinking or disagreement with pharmacists prescribing. It simply indicates my lack of education in this area. The pharmacists I know best would be educated and cautious prescribers. [Respondent 070]
Some of the UNSURE responses are because I do not know what level of training pharmacists have to undertake prior to treating minor ailments and also because there is likely a wide range of quality of care and experience of community pharmacists at present. [Respondent 064]

DISCUSSION

The impetus for minor ailment prescribing is a perceived need for less expensive, yet effective care. But, there is significant concern whether pharmacist-directed care will be of an appropriate standard24-27. To gather perspectives on that, as well as other information, a survey of physicians was undertaken. It should be noted that the ideal method for assessing pharmacist-directed care would assess more outcome-based measures. Nevertheless, the views/perceptions of physicians should be considered vital to the full evaluation of such a scheme.

This project was contentious from the start. The value of even doing a survey was questioned:

The thing that bothers me about this survey is that I am sceptical the results will have any impact on policy. Instead, this survey will be used to pay lip-service, that consultation was done with family physicians, implying support for the policy which may not be true. [Respondent 265]

It is clear this program is of significant concern to the medical community, evident in the sheer number of comments added at the end of the questionnaire. While a full spectrum of feedback was seen, the vast majority were negative. Physicians had concerns about the pharmacist skill level, the ethics of pharmacists diagnosing then prescribing a medicine, and perceptions that pharmacists were practicing medicine. Overall, the ferocity of some of the comments was quite unexpected.

Regarding the main components of the questionnaire, a few reports suggest physicians may be somewhat frustrated with the workload associated with minor ailments22,28. They have accounted for approximately 10 to 20% of physician activity in various locales29-31. Approximately two-thirds of American physicians felt between five and 25% of office visits are for minor ailments that could be self-managed by the patient31. In the current survey, Saskatchewan physicians gave similar estimates for patient load, with almost two-thirds claiming between 10 to 30% of appointments being primarily for minor situations. Refuting a notion that such visits may be a strain on physician well-being, it appears Saskatchewan physicians have not grown weary of appointments involving minor ailments.

There was not strong support for such patients seeing a pharmacist first. Given that physicians will know the patient’s full history better than other healthcare providers, and can physically examine the patient, this may be ideal care. While minor ailments do not require medical attention by actual definition8,32, research has also found they can be far more complex than trivial, inappropriate, or unnecessary consultations that waste the time of the physician23.

If pharmacists should not be a port of first call for minor ailments, it does tend to run contrary to some health systems (primarily in the UK) encouraging patients to consider this very option33-38. It also raises the question as to where pharmacists are perceived by physicians to fit, as patients themselves at times consider pharmacies a logical place to start the care process39-42.
If patients should seek medical care first, one might speculate on the increase in minor ailments likely to be seen by physicians and whether there is current capacity for that. Or, the answer could simply be adding more physicians to meet this demand, rather than routing minor ailments to other healthcare providers. As a starting point for gauging such numbers, in work done in Canada (circa 1996), it was estimated that approximately 15.3 million minor ailment consults took place in pharmacies in a year. Scaling those numbers roughly down to the pharmacies operating in Saskatchewan would mean about 550,000 cases per year potentially needing to choose another care option.

It must be noted that the public, for better or worse, tends to self-medicate minor ailments before seeing any healthcare provider. Thus, many of those 550,000 cases might simply opt to solely self-medicate instead. Early American work found that an over-the-counter drug (OTC) was used within the first four hours in nearly half the incidents of acute minor illnesses. For patients with respiratory tract infections, 55.4% self-medicated before medical consultation and 21.5% did so after consultation. This will of course vary with the nature of the illness. In the USA again, of those reporting a symptom of interest, the percentages using an OTC for treatment were 81% for headaches, followed by coughs/colds/flu/sore throat (72%), skin problems (68%) and heartburn (66%). Menopausal symptoms were the least likely to be treated with an OTC (19%).

When care is sought, physicians and pharmacists are key sources, although online symptom-checkers are gaining prominence. Physicians are seen as a first choice by many. Researchers found that of 1521 people seeking help from physicians for a minor ailment, only 38% opted for pharmacist care when offered the option. In other reports, it is the pharmacist who would first be approached. UK mothers have noted they would consult with pharmacists if their children had coughs, colds, aches, and pains, but turn to their physician for childhood fever, sickness, diarrhea, and rashes. In other British work, those visiting a pharmacy felt their symptoms were not serious enough to consult a physician, while those visiting a GP felt their symptoms were not serious enough for the emergency department. Many Canadians in another report stated they don’t like to bother physicians for minor ailments.

Whether pharmacist prescribing would reduce health care costs identified uncertainty amongst responders, but a full spectrum of opinion was again seen. Overall, most disagreed the program would save money, largely due to the impact of double-billing for the same ailment and/or inappropriate prescribing by pharmacists. Several physicians were unsure what pharmacists received as payment for minor ailments, making decisions on potential cost-savings challenging:

_Difficult to answer this survey without knowing the critical variable, which is how much does the pharmacist charge for this service? I believe they bill more than a physician, am I correct? [Respondent 236]_

_I fear that many patients will also see doctors about the same symptoms ... but the service may prove helpful over time. [Respondent 092]_

The feedback on the conditions garnering the most and least physician concern is quite new to the minor ailment realm. A report in the UK asked physicians to rate a list of conditions that could be first dealt with by pharmacists. Most physicians felt that colds, mouth ulcers, and muscle aches/
pains could be, while hemorrhoids and cystitis were least suitable for that path.

The Figures tend to be mirror images of each other, with a high score on one receiving a lower score on the other. However, the data could be confounded by the maximum number of conditions allowed for selection. Otherwise, cold sores were an area of low concern, which is the condition pharmacists most commonly prescribe for under the current program. On the opposite side of the spectrum, Headache/migraine, dysmenorrhea, GERD, and hemorrhoids were highly worrisome to physicians. Many pointed to the fact that no physical exam would be performed:

*My major concern is quality of care. To me, someone presenting with a headache is a long visit with detailed history, neuro exam, etc. If someone presents with hemorrhoids or jock itch, I examine them. I doubt pharmacists are doing rectals.* [Respondent 079]

This concern is justified, as all can be indicative of serious issues. Further, physicians were very clear on their stance that pharmacists are not trained in diagnosis.

Physicians may question whether pharmacists share the same concern – that something serious can present as something minor. It is highly probable that pharmacists are cognizant of the risks inherent in managing minor ailments, given their long history of involvement. To further allay the concerns of physicians, pharmacists in Canada tend to be a cautious group. When recently asked whether three agents (simvastatin, omeprazole, fluticasone) with OTC status elsewhere in the world should be deregulated in Canada, many chose *‘the condition and/or the drug is too complex to manage without physician care’* as reasons not to do so.

Prescribing protocols in Saskatchewan (developed in collaboration with physicians) are in place for each condition and would appear to address some of the concerns. According to the various guidelines, pharmacists are only allowed to provide care for mild or simple cases. Physician care is also eventually needed for chronic conditions such as acne and allergic rhinitis.

Specifically in reference to one high-concern topic, Canadians can currently select OTC products for hemorrhoids, thus requiring no professional intervention of any sort. It is up to the patient to decide on the appropriateness of such a decision. This was the reasoning behind the current survey’s questions about the public’s ability to assess minor ailments. As one example identifying a need for concern, many patients with anorectal complaints will attribute them to haemorrhoids. While being the cause of some situations, as many as one half will have another problem. If at some point a pharmacist is asked for assistance for a suspected case, guidelines require them to ask about current symptoms, whether they appear to be consistent with hemorrhoids or something more serious, and whether a physician has previously diagnosed the case. During this questioning, if symptoms have been present for more than seven days despite treatment, referral to a physician is required.

Regarding another condition of high concern, patients currently can obtain ibuprofen without prescription for dysmenorrhea. If a patient does ask for pharmacist assistance, physician referral is required for red flag symptoms such as 1) new onset of pain with bleeding (in an otherwise pain-free history), 2) persistent bleeding between periods, 3) patient reports palpable abdominal or pelvic lump, 4) pain occurs outside first 3 days of menses, 5) changes in severity or pattern of the
pain and menstrual fluid, 6) previous trial of proven therapy has failed, and 7) co-morbidities such as GI disorders, renal or hepatic disease (if NSAID therapy is considered). These queries are in addition to other extensive questioning during the consult.

**Limitations**

For conditions of most and least concern to physicians, limiting responders to five items may have constrained the full spectrums of either list. In particular, the list of most concern must be viewed with caution, in that it may present a far narrower spectrum than actual reality.

Those with strong opinions might have been most apt to respond to this survey and overall, it is unknown to what extent the sample represents the population of Saskatchewan family physicians.

Physicians were found to have more faith in the public’s ability to recognize symptoms they have seen before, rather than those involving first occurrences. The questions pertaining to such ability would be condition-dependent, since some patients might be able to assess common cold symptoms reasonably well, while skin or ophthalmic conditions could easily tax their skill level. The author was aware of this problem when crafting the questions. The only perceived way around the issue would have been to list a wide range of minor ailments, then ask for input on each one relative to potential patient ability. This would have dramatically increased the commitment required of responders.

**CONCLUSION**

Pharmacist prescribing for minor ailments has been a contentious issue for many physicians in this province since inception of the program. This survey attempted to quantify and qualify some of that concern, relative to potential symptom relief, cost savings, and conditions perceived to be beyond the scope of pharmacist-based care. Responders indicated the importance of minor ailments within their own practice, and were largely unsupportive of patients seeing a pharmacist first for these. The value of pharmacist involvement from the perspective of cost-savings and clinical improvement was questioned. The breadth of conditions covered by the program was alarming to physicians, mainly due to the lack of a physical exam needed for some. It can be concluded that much work has to be done to better explain to physicians the checks and balances in place for the program.

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