The role of communication skills

developing patient-centred practice in community pharmacies

Marja Airaksinen PhD(Pharm)

Professor, Division of Social Pharmacy, University of Helsinki, Finland

Email: marja.airaksinen@helsinki.fi

Patient-centred drug therapy that is based on partnerships in medicine taking has become a "golden standard" in healthcare.[1,2] This has also challenged community pharmacists to reconfigure their service provision to meet the requirement of concordance and patient autonomy. But what does patient-centred practice mean for community pharmacies?

Introduction

How can pharmacists develop competency and skills needed in a new approach to the patient? The aim of this article is to discuss the role of communication skills in this process.

Background information for this paper will be provided from two Finnish national joint programmes. These programmes lasted for a period of 10 years (1993-2003) and were aimed at promoting professional pharmacy services with a special focus on patient information. Both programmes have attempted to implement a dynamic, long-lasting process leading to a permanent change in patient counselling behaviours, including patients' active involvement and two-way communication. Both have also attempted to set up local agreements and guidelines on patient counselling.

The first one, 'Questions to Ask About Your Medicines', QaM Campaign was started by an initiative of the WHO EuroPharm Forum (www.who.dk/europharm) and ran for three years in 1993-1996.[3,4] The QaM was started with a public awareness campaign,[3] followed by a project identifying problems people have with their medicines at home. As the process showed lack of professional competency of pharmacists, the third phase focused on developing tools for pharmacists to improve patient counselling practices. This was intensively continued by the program TIPPA during 2000-2003 that is currently under final evaluation (The abbreviation TIPPA stands for Customised Information for the Benefit of the Patient from the Community Pharmacy). TIPPA was the first massive program in Finland that actively involved all the key stakeholders in pharmacy, including Ministry of Social Affairs and Health and the major third party payer in redesigning community pharmacy services.

Old myths - still dominating the medication counselling behaviour?

Quality communication between the community pharmacist and the patient has been regarded as self-evident among the profession. It is typical to say that "Of course pharmacists interact with patients throughout their practice". The work in pharmacy is regarded as expert work requiring good communication skills. Still, little attention has been paid on developing competency in this field.

Our experiences in Finland show that even though attention was paid, it is hard to achieve a change in counselling behaviours. The following authentic conversation between a pharmacist and a customer was audio-taped during a pseudo customer study conducted annually in 60 Finnish community pharmacies during TIPPA to assess progress in implementation of concordance-based patient counselling behaviours. The total number of pseudo customer visits was 240 per follow up (altogether 960 visits). One of the pseudo customers came to pick up a sympatomimetic inhaler with a new prescription:

Pharmacist: Here is your medicine. Are you familiar with this product?
Customer: No, I am not.
Pharmacist: Did the doctor tell you how to use this medicine?
Customer: No, he didn't.
Pharmacist: Should I then open the package and show you?
Customer: I don't know.
Pharmacist: At least read the leaflet inserted in the package. Are you going to pay by cash?

This typical real-life pharmacist-customer interaction shows the level of competency acquired so far in communication with the patient. This example is derived from Finnish data but it could be derived from any other country. If we read the conversation we can see that the customer is giving the pharmacist a clear indication of his need for information but the pharmacist is not able to communicate accordingly. It seems that the pharmacist has learnt to ask questions but does not know how to make use of the information provided by the customer. This can be seen throughout the discussion: customer indicates that this is a new medication, and the doctor did not indicate how to use it but the pharmacist does not respond to his information. Finally, the pharmacist puts the customer in a difficult situation by asking him to decide whether to show him details about the use of the medicine, the medicine being an inhaled sympatomimetic. This type of behaviour goes against the evidence that laymen trust professionals and want them to decide what information to disclose. The laymen feel they do not know medicines and treatments well enough to take decisions regarding medicine use. This leads to illusion of competence.[5] It means that patients are satisfied with the information provided even though they have not received any as they trust the competency of the expert.

This following audiotaped pseudo customer visit was related to self-medication. The customer asked for two medicines by a brand name, one being a ketoprofen product and the other a ranitidine product. Thus, there was potential for iatrogenic effects.

Customer: Hi, I would like to buy a pack of ketoprofen.
Pharmacist: 8 or 15 tablets?
Customer: The bigger one. And then a pack of ranitidine.
Pharmacist: A tablet to swallow or dissolve in water?
Customer: Ordinary tablets.
Pharmacist: Would you like to have anything else?
Customer: Nothing else.
Pharmacist: It comes to 11 euros and 20 cents.

In this case, the advice of the pharmacist was focused on product facts: which package size - 8 or 15 tablets - and what kind of tablets the customer wants. There is not a word about the symptoms and appropriate choice of the medication, risk assessment, or about instructions on how to use the medicines, or even suggesting a change of the painkiller to a less harmful one for a patient with stomach symptoms.

These two examples show that the value of the pharmacist's advice for the outcome of the therapy is limited. Pharmacists seem to have learnt to ask some questions repetitively without meaning and are unable to fulfil their duty to counsel, but they have not internalised their role as supporter of therapy. The pharmacist is not supporting self-management that is based on understanding the disease and its treatment. If we use this as a criterion for good quality communication, both of these pharmacists failed the test.

In the very best scenarios, pharmacists demonstrated patients inhaling techniques or asked some questions about symptoms when the patient intended to self-medicate, but they rarely showed systematic counselling patterns starting with needs assessment, selection of content accordingly, customising the content by different communication techniques and finally, concluding by assuring understanding. Neither did they show any outcome orientation.

These scripts reflect that old traditions still dominate pharmacist-customer interaction. Pharmacists seem to still have the attitude of selling medicines instead of selling treatments and this is influencing their behaviour. Pharmacists should instruct patients about the use of their medicines and provide medicine-related services which they believe will benefit their patients. Their relationship is paternalistic and asymmetrical, i.e. the pharmacist is 'in control'. They have a drug-centred way of thinking and the transfer of information is monologue-based. Assessment of symptoms is missing most often, reducing evidence-based decision-making for the treatment resulting in decreased value for the patient.

The communication behaviour of the pharmacists seems to be determined by beliefs and myths that are transferred from one generation of practitioners to another.[6] Pharmacists believe that customers do not want information, especially when they pick up refills, customers are passive, we should not disturb them by transferring facts about medicines. Pharmacists also believe that it is not possible to learn communication skills. They feel it is like an inherited feature: some pharmacists are good communicators by nature and some are not.

Where do these myths and beliefs originate? According to our experience in Finland, it is because most of the practitioners lack training in communication and patient counselling skills.[6,7] The systematic training of patient counselling skills started in the mid-1990's among basic students, and in 2000 among practitioners along with TIPPA. The data collected during TIPPA shows that practitioners lack the understanding of principles of two-way communication and the role of the patient in self-managed treatment. This negatively influenced their performance even though feedback from them showed that they were motivated to make a change.

Teaching practitioners a new approach to communication with the patient

It is crucial to teach practitioners a new approach to communication with the patient.[6,7] The patient is an active medicine user, an active partner in communication with whom pharmacists are expected to establish a professional relationship based on trust, open communication and mutual decision-making. These principles are also mentioned as prerequisites for performing pharmaceutical care services, e.g., by the FIP statements.[8,9,10] The pharmacist should also have an understanding of his role in the multidisciplinary team supporting the patient and the flow of information to the patient from different sources with an emphasis placed on electronic information.

How can new patient-centered scripts be developed? According to our

experience in Finland and experiences in other countries, an extensive learning process is needed at the pharmacy level that involves individual pharmacists to develop personal competency; the whole working society needs to change the communication culture; pharmacy owners need to incorporate professional services into the vision and business strategy of the pharmacy; local consumers need to be encouraged to take an active role in self-management; and other healthcare providers need to agree on the new roles in multidisciplinary teams. [7,11,12]

According to our experiences, practitioners need practical guidelines and resources based on concordance in acquiring a new practice. They also need to learn how to process in-house guidelines, i.e., some kind of protocols or standard operating procedures to reconstruct their communication patterns and produce repetitive quality. These mutual decisions within the working society of what to tell to the patient about the treatment can be taken at the general level. However, more and more pharmacies have been processing treatment-based guidelines for the patient groups who visit the pharmacy most often. Processing in-house guidelines was promoted by the Association of Finnish Pharmacies in 2002 with detailed instructions for implementing the switch of emergency hormonal contraception (EHC) to self-medication. The switch was historical in that the authorities obliged pharmacists to take increased responsibility of the proper use of EHC medicines than in previous switches with other OTCs, although duty to counsel has been covering OTCs as well as prescription medicines since 1983 in Finland. This indicates that authorities are increasingly recognising the pharmacist's competency and ability to work for health policy goals.

Long-term development plans are needed in pharmacies

Pharmacists require systematic and planned training, or even coaching to make use of new tools. [7,11,12] To make this happen in Finland, each pharmacy has been encouraged to develop a long-term action plan that takes into account local conditions by applying principles of strategic planning. The recommended period for this action plan has been set at two years to make a permanent change. Pharmacies have also been encouraged to incorporate patient-counselling-specific feedback measures into their quality management systems.

For the development plan, current practices need to be evaluated in a wider perspective than the customer-pharmacist interaction in order to implement good quality patient information. The three key dimensions crucial in this respect are (1) understanding the needs of the customers; (2) modifying service processes, including resources and facilities to integrate counselling, and (3) developing competency of the personnel.

Developing training courses on communication skills

During TIPPA, we have realised the urgent need to train practitioners in counselling skills. The basic students need to be taught principles of patient-oriented counselling to adapt that approach from the very beginning. Practitioners need to be supported to change their routines and adapt new behaviour patterns.

The effective learning process needs to focus on principles of two-way communication, patient-orientation and concordance, self-evaluation and personal development, collective learning, strategic planning and quality assurance.

The learning process needs to be systematic and horizontally designed, that is, based on constructive and experimental learning. [13] It needs to be started with an introduction to medication counselling as a process e.g., by using the USP Guidelines or some other instrument to facilitate detailed analysis of performance. It is also important to integrate theory and practice.

The learning methods should consist of a mixture of labs, lectures, seminars, group-work, self-study and role-plays. We have found role-plays and socio-drama especially useful. They help in processing a picture of patient needs and in rehearsing own skills and scripts. Learning can be intensified by using real patients as standardised patients.

International cooperation is needed

Internationally, there are still challenges to overcome in organising training in communication skills. The availability of courses, especially long-term courses that will involve the entire working society is limited. There is also a lack of training materials, as well as competent tutors and teachers. There is a need for international cooperation in developing training. Initiatives have already been taken to establish a forum for sharing resources. This will be discussed in the 13th International Social Pharmacy Workshop in Malta in July 2004. The conference will gather together more than 100 researchers and teachers in Social Pharmacy all over the world. Also the FIP Pharmacy Information Section will be organizing a two-day pre-congress training related to Medicines Information to Support Concordance in New Orleans in September 3-4, 2004. The deadline for registration is August 15 (preliminary program available on the Internet: www.fip.org).

The Malta College of Pharmacy Practice would like to congratulate the Antibiotic Team at St Luke's Hospital on their recent excellent publication of the Antimicrobial Prescribing Guidelines.

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