

International Pharmaceutical Federation (FIP)

Counseling
Concordance
Communication

Innovative
Education for
Pharmacists



1912 • 2012
100 YEARS OF
ADVANCING
PHARMACY
WORLDWIDE



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Counselling Concordance Communication

Innovative Education for Pharmacists



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Foreword

Patient-centred medication therapy that is based on partnerships in medicine taking has become a “golden standard” in healthcare. This applies also to the pharmacy setting. Medicine users have been recognized as active partners in communication with whom pharmacists are expected to establish a professional relationship based on trust, open communication and mutual decision-making. This has challenged pharmacists to evaluate their communication skills, learn new techniques and reconfigure their service provision to meet the requirement of concordance and patient autonomy. The pharmacist should also have an understanding of his or her role in the collaborative team supporting the medicine user, and the flow of information to the patient from different sources with more and more emphasis placed on electronic information. These have been starting points also to this booklet. But what does patient-centered practice mean? How can pharmacists develop and maintain competencies and skills needed in a new approach to the medicine user?

There is a need for international cooperation in developing new innovations in training concordance-based communications that support adherence. Among the forums for sharing resources are the International Pharmaceutical Students` Federation (IPSF) and the International Pharmaceutical Federation (FIP). IPSF has done important pioneer work by promoting the Patient Counselling Event (PCE) since 1980s. To promote education the patient counselling booklet “Counselling, Concordance and Communication – Innovative Education for Pharmacists” was published as a joint project of FIP and IPSF in 2005. The booklet has provided a useful educational tool to enhance communication skills and learning techniques based on dialogue, respect for patient autonomy, and mutual agreement. However, in current and future pharmacy practice, pharmacists need to have skills to communicate with their customers not only face-to-face, but also via the Internet and email. Additionally, they increasingly need skills to meet special populations (e.g. elderly people and people from different cultures) and skills to support information literacy of their customers.

This new edition builds upon the original concepts presented in the first edition, but is updated to reflect current needs, knowledge and best patient counselling practices where pharmacists can contribute to patient care. Throughout the text the term patient counselling and medication counselling are used synonymously. Similarly, the terms patient, consumer, customer, and medicine user are used interchangeably, to refer an individual who receives or requires health care services, including medicines and pharmacy services.

This booklet is intended to be used as a handbook or guide to the knowledge and skills required in patient counselling in different settings. Additionally, it includes both research-based information and practical tips on providing medicines information services and learning patient counselling skills.

The first part focuses on learning patient counselling skills (Chapters 1-6). Additionally, it provides a theoretical, conceptual and contextual basis for patient counselling. Part II (Chapters 7-11) concerns organizing patient counselling services in different contexts; in community and hospital pharmacy setting, but also via the medicines information centers and services applying technology. Part III (Chapters 12-14) discusses on how to meet the information needs of special

populations. Focus is especially on children, elderly, and ethnic minority people. Part IV concerns national coordination in developing patient counselling services and competences (Chapters 15-16).

This booklet is targeted to a wide range of pharmacy professionals, such as pharmacy students, recent graduates, pharmacy practice professionals, pharmaceutical societies/organisations and key stakeholders involved in the design of pharmacy curricula and continuing education for practitioners. Authors are international experts on patient counselling and education representing both research and practice.

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We would like to express our sincere gratitude to all of the national and international colleagues who have contributed to this booklet. Without their innovative work and commitment, this booklet would not have been possible. We would also like to thank FIP and IPSF for fruitful cooperation and for supporting this project. Our special thanks go to the following esteemed colleagues:

- Dr. Tana Wuliji, the co-editor of the first edition of the booklet in 2005, currently working for USAID Health Care Improvement Project
- Mr. Keith Johnson, Management Sciences for Health, Previously: Director of Drug Information Division, United States Pharmacopeia, Inc.
- Professor Han de Gier, University of Groningen, The Netherlands, Immediate Past President, Pharmacy Information Section, International Pharmaceutical Federation (FIP)
- Professor Patricia Bush, Georgetown University/United States Pharmacopeia, Inc.
- Dr. Alexander Dodoo, President, Pharmacy Information Section, International Pharmaceutical Federation (FIP)
- Ms. Sanne Tofte Rasmussen, President, The International Pharmaceutical Students' Federation (IPSF, 2011-2012)
- IPSF Past Presidents: Mr. John Nguyen (2008-9), Mr. Mohamed Sultan El Sherbiny (2009-10), Mr. Jan Röder (2010-11)
- IPSF Chairpersons for Professional Development: Ms. Ling-yi Tsai (2008-9), Mr. Eric So (2010-12)
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About the Editors

FIP/Pharmacy Information Section

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Marika is a pharmacist with a recent PhD degree in Social Pharmacy. She has received her degrees from the University of Helsinki, Finland where she currently works as a Senior Lecturer at the Division of Social Pharmacy. Her main responsibilities are research and teaching, including undergraduate courses on patient counselling, and medicines information services and sources. Her PhD research, completed in 2010, focused on medicines information sources and services for consumers, particularly medicines information sources applying new information technology. Her most recent research deal with development of consumer medicines information strategy and pharmaceutical policy nationally in Finland and internationally, particularly within European Union (EU). Marika enjoys horses, hiking, nature, and most importantly spending time with her husband and daughter.

Dr. Inka Puumalainen, Finland

Inka is a pharmacist with a PhD degree in Social Pharmacy. She is currently working with continuing education and community pharmacy service development as a Training and Research Manager of the Helsinki University Pharmacy. She graduated from the University of Kuopio, Finland in 1999 (MSc) and 2005 (PhD). She started her career in the Finnish Pharmaceutical Learning Centre where she coordinated courses on patient counselling. Her interest in patient counselling stems from her doctoral thesis that dealt with development of tools to assure quality of patient counselling services. Inka has passion for professional issues and international affairs: as a student, she was actively involved in IPSE. During 2004-2009, she worked as a President of the Finnish Pharmacists' Association. Currently, she is a busy mother of two little daughters. She enjoys travelling and all kinds of sports.



Professor Marja Airaksinen, Finland

Marja is a Vice Dean and a Professor of Social Pharmacy in the Faculty of Pharmacy at the University of Helsinki, Finland. She has been involved in several patient information development programmes nationally and internationally, e.g., in the WHO/EuroPharm Forum,

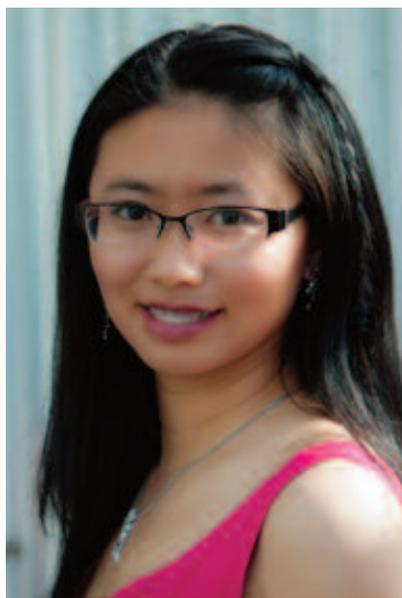


and in the Drug Information Division at the United States Pharmacopeia (USP). During 2000-2008, she served as an Executive Committee Member of the Pharmacy Information Section in the International Pharmaceutical Federation (FIP). Her contributions included edition of the first version of the Counselling, Concordance and Communication Booklet jointly with Dr. Tana Wuliji (at that time the President of IPSF) which was published in 2005. During 2004-2006, she chaired the Council of Europe Expert Group on Safe Medication Practices. She also was involved in the European Commission Pharmaceutical Forum's Working Group on Information to Patients in 2007-2008 as a representative of Finland. Marja's free time is devoted to family and friends, part of the family living abroad.

IPSF

Ms. Shirley S.T. Yeung, Canada

Shirley is a recent pharmacy graduate from the University of British Columbia in Vancouver, Canada. She has been immersed in the IPSF spirit since 2007, when she first attended the 53rd IPSF World Congress in Taipei, Taiwan. Her interest in patient counselling also stemmed from this congress, where she was awarded the winner of the beginner's level Patient Counselling Event. She has then taken roles as coordinators within the Professional Development portfolio. In 2009-10, she was appointed as the Chairperson of Professional Development, which was when the IPSF Executives decided the Patient Counselling Booklet needed to be updated. Besides IPSF work, she practices as an academic detailing pharmacist in Vancouver, providing evidence-informed drug information to healthcare professionals to optimize prescribing. She also loves to travel, swim, and spend time with friends and family.



From the Editors

Globally, pharmacy practice is evolving and the responsibilities of a pharmacist are constantly being pushed beyond its limits. As pharmacists push to move outside of the dispensary and into a more patient-centered role, communication and patient counselling skills are becoming of importance. Pharmacists often serve an advocacy role for the patient on the healthcare team and it is crucial for pharmacists to master communication skills to manage and optimize a patient's pharmacotherapy.

Our goal of this booklet is to provide a guide to patient counselling for pharmacy students and pharmacists around the world. Hopefully it can serve as a motivational tool for pharmacists to embrace the communication skills needed to succeed in a world of new possibilities and opportunities.

From the IPSF President

Patient counselling is one of the areas within the pharmaceutical field where the pharmaceutical profession stand out from other healthcare professions. It is an area that is unique to our profession – an area we excel at. Patient counselling is – and should always be – a dynamic field that keeps on developing and adapting to new knowledge and the requirements of the society. The needs from the patients keep on evolving and the pharmaceutical profession is first in line to adapt to these needs including adding other health professions in the medicine management of a patient.

During our studies we are taught the theoretical part of patient counselling. With a brought knowledge in pharmacology, pharmacotherapy and other relevant areas we get a strong base to secure a high level consultation with the patient and its safety in focus every time. However, it is only through practice, our knowledge and communication skills come to the test and we can develop and excel. As the areas included in the medicine management of a patient keeps expanding, it is important that the curricula taught keeps adjusting to the requirements of the society for us to be as prepared as possible to our professional lives.

Throughout the last couple of years the Professional Development department of the International Pharmaceutical Students' Federation has expanded, giving the possibility for more students and recent graduates to test their skills and knowledge to secure a good pharmaceutical practice – not only at events on international level, but the Patient Counselling Event evaluates the skills of the participants on national and local level as well. Here the national and/or local association conducts the event, often in collaboration with academics, skilled pharmacists and other professional partners. This is an important step for the future of good, innovative practise.

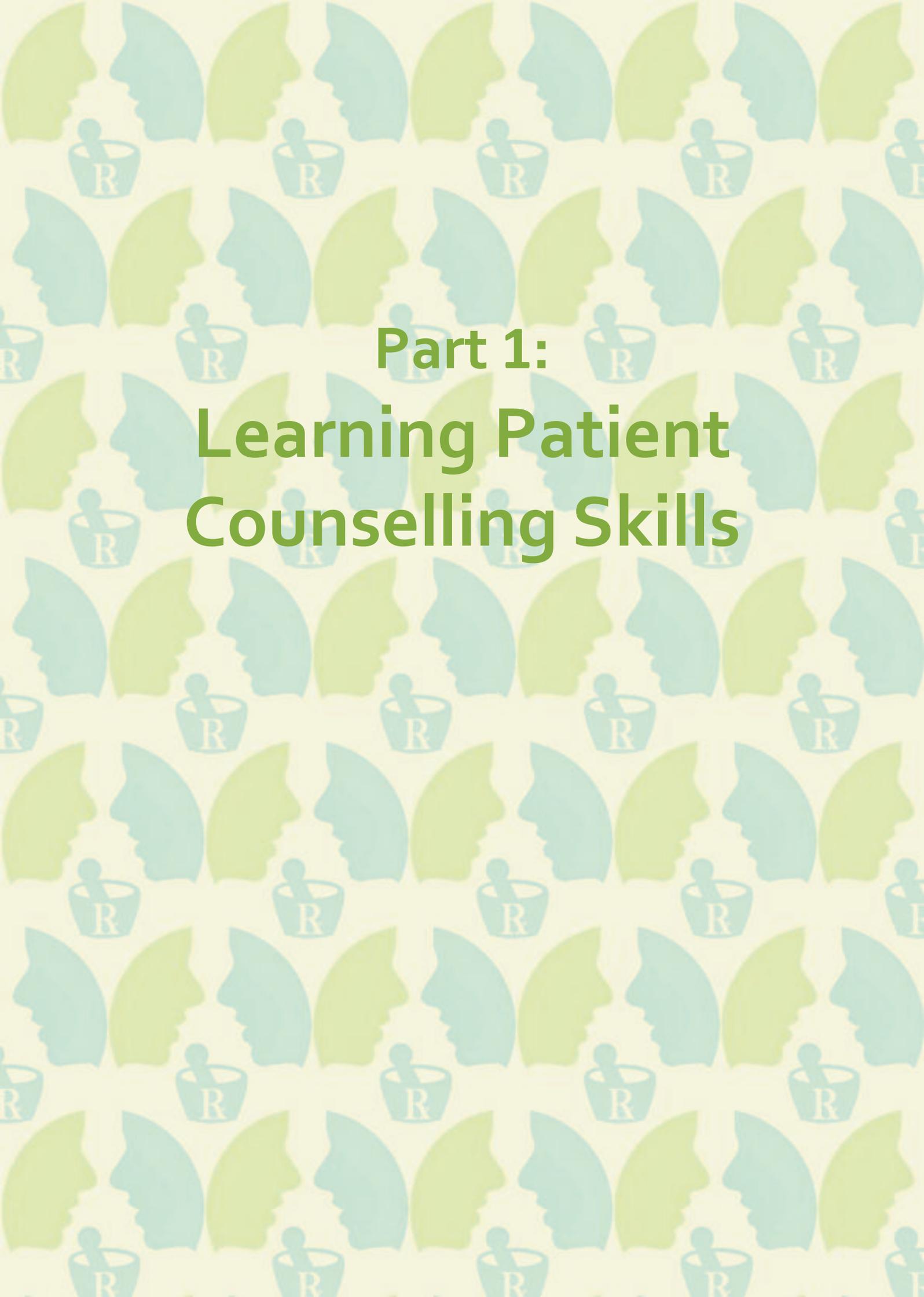
With this booklet there is a solid base for students and recent graduates to take initiative, to develop their skills and to secure strong, skilled practitioners worldwide.

Sanne Tofte Rasmussen
President 2011-12
International Pharmaceutical Students Federation

From the President of FIP Pharmacy Information Section

Patient counselling is at the heart of the professional contract between pharmacists and their patients: without adequate counselling, patients cannot obtain full benefits from medicines or medical interventions. Patient counselling is however poorly undertaken in many countries due to several factors including huge patient load, lack of facilities, lack of time and sometimes even lack of knowledge on patient counselling. The International Pharmaceutical Students Federation (IPSF) deserves special commendation for their commitment to patient counselling and their perseverance in producing such a useful booklet. This 16-chapter Patient Counselling Booklet is an excellent resource for both practicing pharmacists and would-be pharmacists and the Pharmacy Information Section of FIP strongly recommends it to all. This is the second edition of the Booklet and huge efforts have gone into its production. What better way is there to show appreciation for these tireless efforts than to use the booklet, recommend it to colleague pharmacists and pharmacy students, change the life of patients and also provide feedback to the editors? With appropriate patient counselling, pharmacists can improve health outcomes in their patients and improve global health in general. The students have taken the lead – dare we fail them?

Prof. Alex Dodoo
President, Pharmacy Information Section, FIP

The background features a repeating pattern of human profiles in shades of teal and light green, alternating with mortar-and-pestle icons. The profiles are facing right, and the mortar-and-pestles are positioned below them. The text is centered over this pattern.

Part 1: Learning Patient Counselling Skills



Chapter One: The Importance of Patient Counselling – The Students' Perspective

Shirley S. T. Yeung, Canada
IPSF Chairperson of Professional
Development 2009 - 2010

Objectives of the Chapter

This chapter provides student insights in the importance of incorporating teaching communication and patient counselling skills in the basic pharmacy curriculum:

- Communication skills are essential for a career as a pharmacist and they are foundation of the work.
- Communication and patient counselling skills are competencies that can be learned.
- Global discrepancy still remains in the formal pharmacy education and the working life needs of communication skills to assure safe and rational pharmacotherapy in partnership with medicine users.

When it comes to patient counselling, there is a general consensus amongst pharmacy students. Many students recognize the importance of patient counselling as a foundation of communicating about medicines, which is crucial for ensuring appropriate pharmacotherapy. Students also recognize the evolution of the pharmacists' roles and that communication to patients is an important component of medical management. This new consensus also stresses on how important pharmacists are in the healthcare team. Pharmacists are the medication experts and are the healthcare professionals the public can have easy and direct access to resolve their concerns.

Regardless of the pharmacy practice (community, hospital, industry, academia, etc.), students recognize communication skills are essential to fulfil the duties of a pharmacist. However, at a global level, a discrepancy remains in the formal education that students receive. The exposure to patient counselling and communication from schooling greatly varies in different pharmacy schools and countries. The variety in exposure to these competencies can be partly explained by cultural and system differences, which reflect to the public's expectations of a pharmacist and pharmaceutical services.

In some countries, students are exposed to the concept of effective communication within weeks of beginning their formal education. Meanwhile, at the other end of the spectrum, some students do not receive any instruction regarding patient communication until their internships. While some countries have shifted pharmacy towards clinical practice, other countries still relegate pharmacy practice to a mere dispensary role. Regardless of the exposure to formal training on patient communications, many student organizations have hosted their own workshops and patient counselling events. This has been supported by the International Pharmacy Students Federation (IPSF).

Patient counselling and communication skills are not easy skills to learn, but need theoretical understanding of communication and communication techniques. To learn to apply communication techniques to practice in the contexts relevant to pharmacists, practical rehearsals are essential. The more we practice, the easier it will be to meet each individual needs. It is important to remember that every patient is different, each with different needs; therefore, different counselling techniques are required. This makes patient interactions both a fascinating and a challenging part of our professional work.

Communication techniques may be introduced as theoretical knowledge; however, it is extremely difficult to grasp all of these concepts without practice to systematically integrate them in our professional performance. There is no simple trick to excel at patient counselling. It is important to allow oneself time for acquiring these skills and take every opportunity to practice.

Reflective feedback is important for learning: always ask for feedback. You need feedback about both your strengths and weaknesses in professional communication. This helps you to construct a picture of your personal communication style and strengthen it. You can use the feedback for setting goals to improve in the next counselling scenarios and see how the interaction unfolds.

It is highly encouraged that students practice by role-playing with each other, pharmacists, and/or standardized actors. Under supervision of a pharmacist, it is reasonable for students to practice counselling with actual patients. This will prevent misinformation to any patients.



Figure 1. A PCE workshop for the students by the Students of Pharmaceutical Sciences, Denmark (Source: IPSF).

One of the methods that was introduced by IPSF in 1980s and is actively promoted by many national and local student organizations is the patient counselling event (PCE). In PCE, students role-play typical scenarios from real-life practice and compete in their patient counselling skills.

Their performance is evaluated by experienced experts. The local winners can participate in a national and/or the international patient counselling event. PCE has encouraged a number of students to motivate each other and themselves to master their patient counselling and communication skills.

Some student organizations have extended PCE to also include workshops where communication experts will discuss patient counselling techniques. Following these workshops, the participants will have the opportunity to showcase their knowledge and communication skills to assess their current performance. This is an excellent opportunity for professional development. It is also a chance to learn from each other and to integrate various techniques that someone else may have used in their counselling scenario. Also, many of these events have been rewarding the top performing students with prizes. Events like this are not only stimulating for the mind, but many students find it a fun way to learn patient counselling and communication skills.



Figure 2. An Indonesian student participating in the PCE while being evaluated by two judges (Source: IPSF).

The learning opportunities and needs for patient counselling and communication do not end when a pharmacy student graduates, instead, school has only provided a foundation for a successful professional performance. As a young pharmacist, every patient encounter should be regarded as an opportunity for professional development, to not only improve the patient's medical therapy but also patient communication. It is through this continuous communication that the pharmacist can fully understand the patient's needs and evaluate the appropriateness of their medical care plan.

In conclusion, students are encouraged to get involved with any professional development opportunity to improve communication and patient counselling skills. Communication with patients is an integral component of every pharmacist's role and thus, important to master. Regard every patient as a learning opportunity to improve. Do not hesitate to ask for feedback as well,

especially when practicing with fellow colleagues. And always remember to use the feedback for future interactions. Self-reflection is an excellent and effective way to assess one's learning. Never be afraid to push beyond your own boundaries when it comes to professional development.

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Chapter Two: Theoretical Basis and Context of Patient Counselling Services by Pharmacists

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Objectives of the Chapter

This chapter provides a conceptual, theoretical, and contextual framework for pharmacists' involvement in communicating about medicines and providing patient counselling services to patients. The following aspects are covered:

- Definitions of the key concepts
- Behavioural aspects influencing patient counselling practices (particularly, the shift from paternalism towards patient autonomy: Empowerment, concordance and partnership in medicine taking)
- Difference between dialogue and monologue and related communication skills
- Different modes and contexts of patient counselling services
- Constitutes of patient counselling quality in the community pharmacy context

Patient-centred drug therapy that is based on partnerships in medicine taking has become a “golden standard” in healthcare. This has also challenged pharmacists to reconfigure their service provision to meet the requirement of concordance and patient autonomy. But what does patient-centred practice mean for pharmacists? How can pharmacists develop competency and skills needed in a new approach to the medicine user? The aim of this chapter is to discuss behavioural aspects influencing pharmacists' patient counselling performance and service provision. Crucial is to understand difference between dialogue and monologue, and to know methods and techniques to involve patients in their care.

The following figure illustrates the context of pharmacists' involvement in communicating about medicines with medicine users (Figure 1). The way we communicate is determined by our understanding of the medicine user's situation: what is the medical condition and how it is treated? Who else are involved in providing care and advice? What kinds of services are available for the medicine user? What drug information sources are available and how they are used? In addition to these factors, our perception of medicine user's role in management of the disease and involvement in decision-making highly influences the way we communicate. Finally, all this action should have a goal: to assure safe use of medications and optimum outcome. Outcome expectations reflect the anticipated consequences of properly conducted counselling interactions (USP 1997). At least the following outcomes have been identified (USP 1997):

1. The patient will recognize why the medication is helpful for maintaining or promoting well-being (applies to prescription and non-prescription medications).
2. The patient will accept the support from the healthcare professional in establishing a working relationship and foundation for continual interaction and consultation.
3. The patient will develop the ability to make more appropriate medication-related decisions concerning adherence to his/her medication regimen.
4. The patient will improve coping strategies to deal with adverse effects and interactions.
5. The patient will become a more informed, efficient, active participant in disease treatment and self-care management.
6. The patient will show motivation toward taking medications to improve his/her health status.

Communication on Medicines

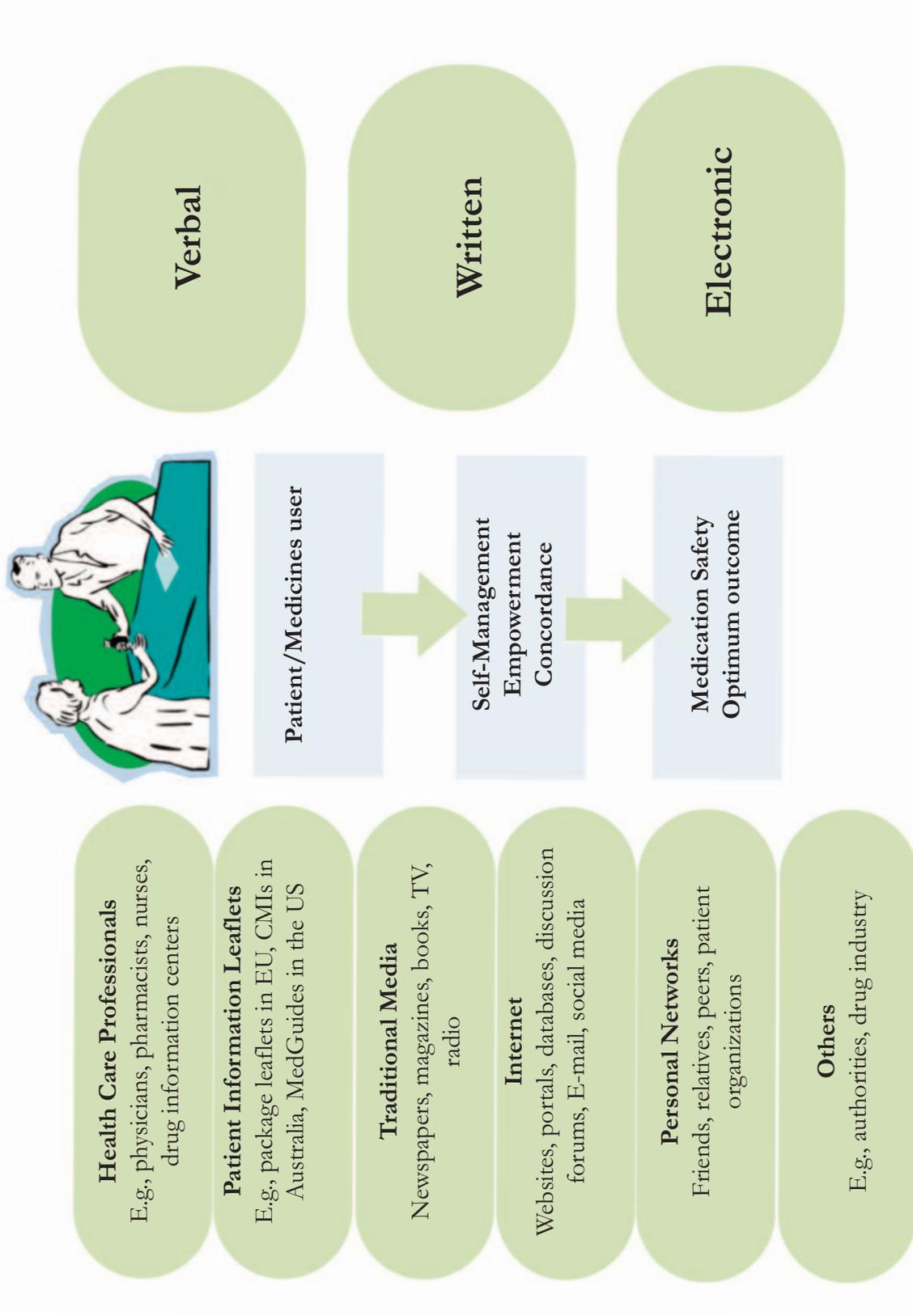


Figure 1. Context of pharmacists' involvement in communicating on medicines with patients and medicine users. Verbal communication refers to face-to-face communication about medicines with professionals. A written mode of information refers to all kinds of written materials designed for patients and medicine users, such as patient information leaflets, books, articles, drug packages and labels. An electronic mode of information refers to all kinds of communication on medicines with the help of information technology, such as Internet, interactive television, data links and mobile communication (Source: TIPPA Project 2004, Pohjanoksa-Mäntylä 2010, modified and updated).

Empowerment and Concordance as Theoretical Approaches to Communicating About Medicines

The recent approach of interaction between health professionals and patients is referred to as concordance. It is based on the notion that the pharmacist and patient interact as equals, thus allowing the formation of a therapeutic alliance between them. In the concordance approach, the role of the pharmacist is to support the patient in constructing knowledge and attitudes towards the use of his/her medication. The patient is perceived as an expert on his or her own disease and medicine use.

The concordance approach has stressed the need for patients to become active participants in health care and to take more responsibility over their own care in terms of self-management (Figure 2). This shift of power is called as empowerment. Concordance and empowerment approaches do not undermine the role of the pharmacist as an expert in medication use, but instead, facilitate a meaningful interaction between pharmacist and patient necessary to promote and support optimal self-management of the disease.

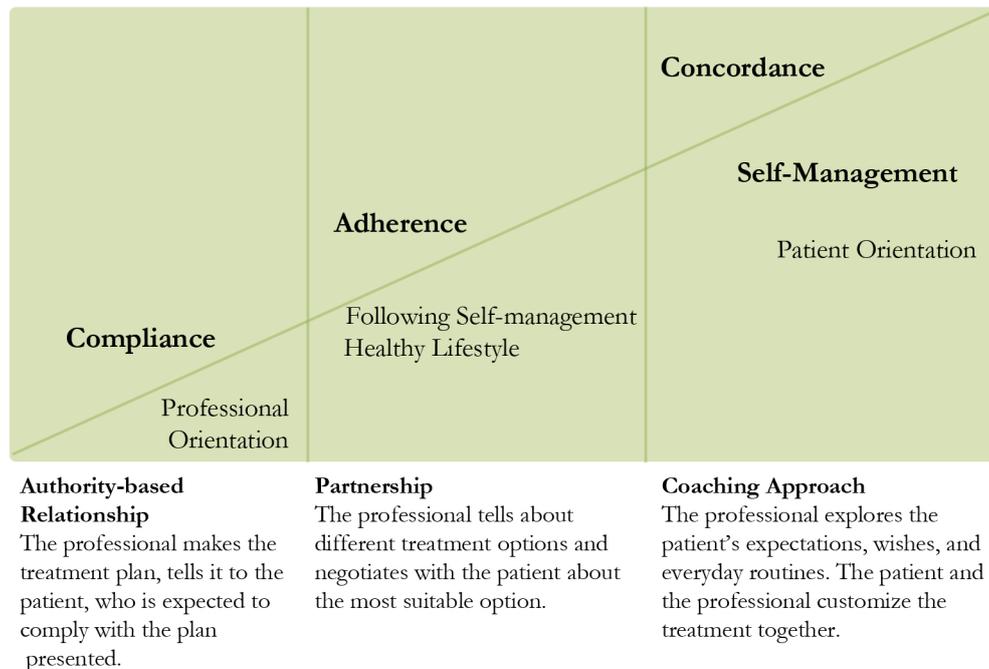


Figure 2. From authority-based professional orientated relationship to patient oriented coaching approach in supporting self-management (Modified from Routasalo et al. 2009).

Medication Counselling Stages: Dialogue vs. Monologue

Different concepts have been applied when referring to the communication between the pharmacist and the medicine user. Such concepts as medication counselling, patient education/counselling, pharmacist-patient communication and advice-giving have been widely used. They can be considered as synonyms on the basis of the ways they have been used in the literature.

Differences merely reflect linguistic differences between countries (e.g., between British and American English) than systematic differences in communication approaches influencing behaviours. A review of 39 studies on patient counselling published in 2006 found that the most applied term was counselling instead of advice-giving or education (Shah and Chaewning 2006). The review conceptualized pharmacist-patient communication as a pharmacist's information provision activity. This conceptualization gives an impression of a one-way action: pharmacist is the provider and the medicine user is the receiver of information. It is a reflection of the traditional paternalistic approach to the patient which has been dominating in health care, and which should be changed towards empowerment respecting patient autonomy.

United States Pharmacopeia (USP) has constructed key definitions related to medication counselling as part of developing The Medication Counselling Behaviour Guideline (USP 1997). Medication counselling is viewed as a continuum of interaction between the healthcare professional and the patient. There are stages in the continuum, starting from limited interaction (i.e., a monologue) to involved interaction (i.e., a dialogue) (Table 1). Major emphasis is placed on empowerment of the patient in these interactions. The interactions are considered to be generic and unrelated to the healthcare professional title who is involved in the communication.



The moment of truth illustrates the actions taken in a pharmacy to interact with customers to add their health and welfare (Source: The University Pharmacy, Finland).

Table 1. Medication counselling stages illustrating the continuum of interaction between the healthcare professional and the patient and the difference between limited interaction (monologue) and involved interaction (dialogue) (USP 1997)

	Medication Information Transfer	Medication Information Exchange	Medication Education	Medication Counselling
Level of information	Basic, brief, non-individualised	Detailed, individualised	Comprehensive, group, or individualised	Detailed discussion and guidance
Spontaneous or planned	Most often spontaneous in response to the medication prescription	Spontaneous or planned	Planned	Planned
Objective of Process	Essential information related to taking prescribe medication as directed (Monologue)	Provider responds to and asks questions related to prescribed medication (Dialogue)	Collaborative learning experience and process regarding prescribed medication (Conversation)	Guidance that assists in fulfilling needs in managing medical condition and prescribed medication (Discussion)
Product to Patient	Focus is on safe and proper use of drug product	Answers and solicits questions about the drug product. Adapts information to the individual, increases knowledge regarding proper and safe use of medication for specific condition	Increases knowledge regarding proper and safe use of medication for specific condition	Enhances problem solving skills and assists with proper management of medical condition and effective use of medication
Nature of Relationship	Passive individual receives instruction given by the health care provider	Questions and answers are actively exchanged between patient and provider	Interactive learning about the implication of the medication is shared between patient and provider	Interactive and collaborative discussion and learning between patient and provider

Definitions of the Terms Used in Table 1 (USP 1997).

Medication information: familiarity, awareness, and comprehension acquired about the medication.

Medication information transfer: a spontaneous activity which focuses on providing brief non-individualized medication information orally, in writing, or audio visually/electronically. The objective of information transfer is to give essential information on taking the medication as directed.

Medication information exchange: a spontaneous or planned activity which focuses on providing medication information and responding to questions of the individual. The information may be given orally, written, or audio visually/electronically to the person. The objective of information exchange is to provide details related to the medications and their use.

Medication education: a planned individual and/or group interactive and collaborative learning experience and process which focus on providing information that increases and influences one's knowledge and skills regarding medication use. The process is individualized in that it accounts for the person's different information needs.

Medication counselling: an approach that focuses on enhancing individual problem-solving skills for the purpose of improving or maintaining quality of health and quality of life. The process emphasizes that the health professional provides and discusses medication information with the appropriate person to achieve this goal. The physical, psychological, socio-cultural, emotional, and intellectual perspective as well as health beliefs and values of the individual must be respected. The health care professional's responsibility is to support the person's efforts to develop medication management skills and to move in the direction of self-responsibility with empathy, sincerity, and patience.

Basic Components of a Medication Counselling Session

A medication counselling session can be divided into four basic components: 1) the introduction of the session; 2) the content of the session; 3) the process followed including the use of different communication techniques; and 4) the conclusion of the session (USP 1997). Table 2 provides an illustration of core counselling items that could be discussed in each phase. More detailed definitions of the core counselling items are presented in Appendix 1. Also the communication instructions given in Chapter 8 for advanced clinical pharmacy practice follow the same principal structure.

Table 2. Illustration of core counselling items that could be discussed in a medication counselling session (USP 1997, Puumalainen 2005). More detailed definitions of the core counselling items are presented in Appendix 1.

Core Counselling Items	Core Communication Items
<p>Introduction of the session (needs assessment for customizing the counselling)</p> <ol style="list-style-type: none"> 1. Conducts appropriate counselling introduction by identifying self and the patient or patient’s agent. 2. Explains the purpose of the counselling session. 3. Reviews patient records prior to counselling. 4. Obtains pertinent initial drug related information (e.g., allergies, other medications, age, etc.) 5. Determines if the patient uses any other medications, including OTCs, herbals/botanicals, and alcohol which could inhibit or interact with the prescribed medication. 6. Determines if the patient has any other medical conditions which could influence the effects of this medication or enhance the likelihood of an adverse reaction. 7. Assesses the patient’s understanding of the reason(s) for the therapy. 8. Assesses any actual and/or potential concerns or problems of importance to the patient. 9. Discusses the name and indication of the medication. 	<p>Communication skills and techniques used in the entire counselling session</p> <ol style="list-style-type: none"> 1. Uses language that the patient is likely to understand. 2. Uses appropriate counselling aids to support counselling. 3. Responds with understanding/empathic responses. 4. Presents facts and concepts in a logical order. 5. Maintains control and direction of the counselling session. 6. Probes for additional information. 7. Uses open-ended questions. 8. Displays effective nonverbal behaviours. <ol style="list-style-type: none"> a. Appropriate eye contact. b. Voice is audible: tone and pace are good. c. Body language, postures, and gestures support the spoken message. d. Distance between the health care professional and the patient is appropriate.
<p>Content of the session (based on the needs assessment in the introduction of the session)</p> <ol style="list-style-type: none"> 10. Explains the dosage regimen, including scheduling and duration of therapy when appropriate. 11. Assists the patient in developing a plan to incorporate the medication regimen into his/her daily routine. 12. Explains how long it will take for the drug to show an effect. 13. Explains in precise terms what to do if the patient misses a dose. 14. Emphasizes the benefits of completing the medication as prescribed. 15. Explores with the patient potential problems in taking the medication as prescribed (e.g., cost, access, etc.) 16. Helps patient generate solutions to potential problems. 17. Discusses significant adverse effects and interactions (drug-drug, drug-food, and drug-disease) and how to prevent or manage those if they do occur. 18. Discusses precautions (activities to avoid, etc.). 19. Provides accurate information. 20. Discusses storage recommendations, ancillary instructions (e.g., shake well, refrigerate, etc.). 	
<p>Conclusion of the session</p> <ol style="list-style-type: none"> 21. Verifies patient’s understanding, via feedback. 22. Summarizes by acknowledging and/or emphasizing key points of information. 23. Provides an opportunity for final concerns and questions. 24. Tells the patient when he/she is due back to a re-fill. 25. Helps the patient to plan follow-up and next steps. 	

This comprehensive description of the structure and content of a medication counselling session can be used by members of all health professions, for purposes of learning and self improvement (USP 1997). It is a tool that contains items having potential applications to a variety of medication counselling contexts. It is based on inventory of medication counselling instruments used in different health care institutions, schools, and practice settings, primarily in the US. A review of these forms yielded an initial listing of 174 items that were grouped and redundancies were eliminated. The tool has been validated in the community pharmacy context (Puumalainen 2005, Puumalainen et al. 2005a).

The assessment tool (both basic components of a medication counselling session and the core counselling items) can be applied in many ways in developing patient counselling performance (USP 1997, FIP and IPSF 2005, Kansanaho 2005, Puumalainen 2005, Puumalainen et al. 2005a). The key is to use them for educational and service development purposes, not for work-related personnel decisions. They can be used for self-evaluation or peer-evaluation of performance in basic education (see Chapter 6), continuing education and in in-house training (see Chapters 7 and 16).

Use of the medication counselling assessment tool is influenced by the context in which medication counselling occurs (USP 1997). There may be items contained on the form that are inappropriate for specific situations. Furthermore, the comprehensiveness of the items contained on the form may complicate the evaluation process. Consequently, potential users may decide that eliminating particular items would allow for greater efficiency and accuracy in conducting their assessments (see Chapters 3, 6 and 7). There may be also needs to add items to meet some specific needs. The evaluation form presented in the previous version of the PCE Booklet (Appendix 2) and the one currently used by the IPSF in Patient Counselling Events (Appendix 3) provides examples of shortened versions of the medication counselling evaluation assessment tools based on USP Medication Counselling Behaviour Guidelines.

Use of the evaluation form is always affected by the accuracy and efficiency of those individuals functioning as judges (USP 1997). Judges will need to determine in advance if they want to engage in a checklist or rating scale evaluation. The former will tell participants which behaviours they used; the latter will provide a judgement regarding how well they performed these behaviours (see an example of the evaluation form with a rating scale in Appendix 3).

Constitutes of Patient Counselling Quality in Community Pharmacies

When we think about patient counselling quality, we link it with the quality of actual interaction between the pharmacist and the patient or his/her agent. This can be measured e.g., by using the USP assessment tool or its modifications, or by a pseudo-customer method. However, there are more factors influencing the quality of patient counselling than those that can be assessed by observing the communication episode (Figure 3, Puumalainen 2005, Puumalainen et al. 2005b).

The core of the patient counselling quality is the vision and strategy of the pharmacy: it is a strategic issue whether the business idea of the pharmacy includes professional services, such as patient counselling (Figure 3, Puumalainen 2005, Puumalainen et al. 2005b). If these services were not a strategic priority, there would not be adequate resources and support for their provision.



Figure 3. Constitutes of patient counselling quality in the community pharmacy context (Puumalainen 2005, Puumalainen et al. 2005b).

The patient counselling quality management measures should cover three special dimensions, namely 1) understanding customers/medicines users' patient counselling needs, 2) integration of patient counselling with routine dispensing, and 3) assuring patient counselling competency of the personnel and creation of new innovations meeting the needs of the consumers/medicine users (Puumalainen 2005, Puumalainen et al. 2005b).

The Customer dimension consists of indicators that enable to understand the customers' specific information and communication needs in one's pharmacy. These indicators include systematic assessment of customers' drug use patterns and disease profiles, and customer feedback using traditional customer satisfaction questionnaires or pseudo-customer studies.

The goal of the Process dimension is to assure that patient counselling is integrated in the routine dispensing process of prescription and non-prescription medicines. This includes availability of drug information sources (both electronic and manual) during dispensing and selling OTC medications. It should be also assured that pharmacists know how to use drug information sources. The pharmacy premises should permit private patient consultations (Mobach 2009). Pharmacists should create in-house guidelines concerning patient counselling practices. These guidelines are recommended to be shared with other local health care professionals.

Learning and Innovations dimension relates to the competency of the pharmacy personnel. Pharmacists should have adequate skills and knowledge to meet customers' needs. Pharmacists

need to understand the principles of two-way communication and customer-oriented practice. This can be supported by systematic in-house training and continuous professional development (see Chapters 7, 9 and 16). Each pharmacist should have an individual professional development plan. Self-evaluation and peer-evaluation of counselling performance can be used to evaluate existing counselling practices (see Chapter 7).

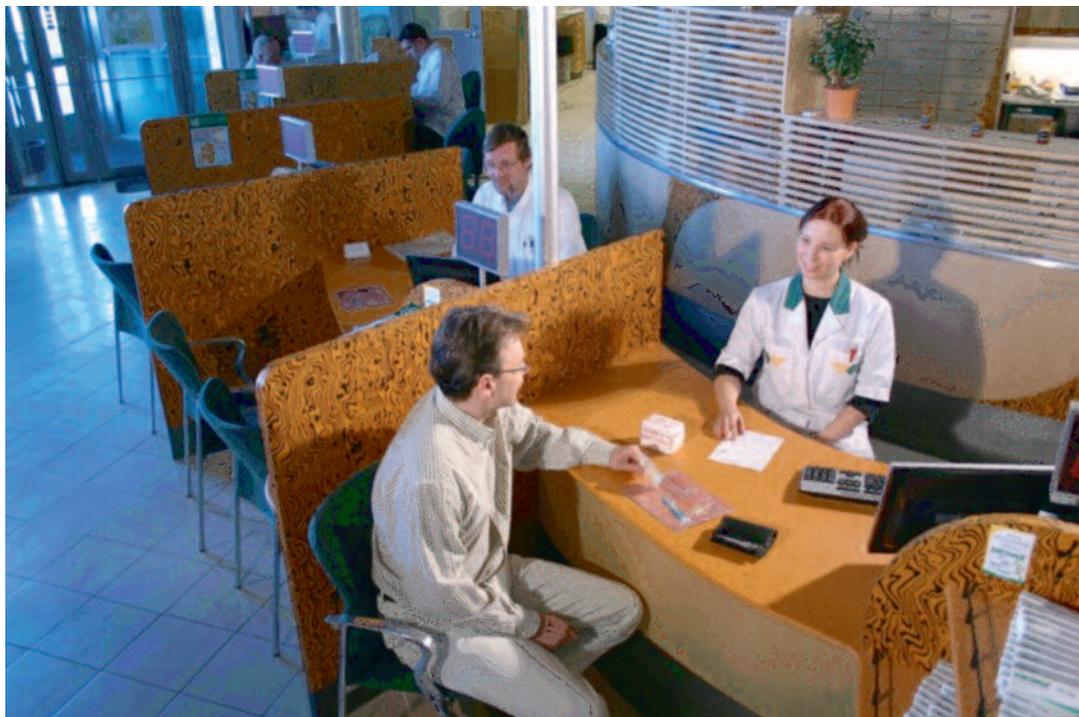


Figure 4. A community pharmacy interior design taking into account constituents of patient counselling quality (Source: The Association of Finnish Pharmacies)

Summary

This chapter has focussed on the assessment tools to measure quality of patient counselling practices. It is important to assess counselling practices in order to gain feedback. This feedback is valuable for both individual pharmacists and the pharmacy as a health care unit providing professional services. Assessment should take place regularly and it should be part of the quality management system of the pharmacy.

Exercise: Read the following two authentic conversations between a pharmacist and a medicine user. They have been derived from a pseudo customer study assessing quality of patient counselling in community pharmacies (Puumalainen et al. 2005c). The data were collected by pseudo-customers by audio-taping. Referring to the content of this Chapter (particularly Tables 1 and 2):

- Were these two interactions based on dialogue/negotiation between the pharmacist and the customer? (Table 1)
- Did the interactions reflect concordance? (Table 1)
- How did the pharmacist make the contact with the customer? (Table 2)
- How did the pharmacist assess the counselling needs of the customer? (Table 2)
- Was the information content appropriate in relation to the customer's situation? (Table 2)
- How did the pharmacist conclude the counselling session? (Table 2)
- What kinds of communication techniques did the pharmacists apply? (Table 2)
- What kind of feedback would you give to these two pharmacists of their performance? (Table 2)
- How would you improve the content and way of communication (-> write a new script)? (Figure 1, Table 2)

Case 1: The customer was picking up a sympathomimetic 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?

Case 2: The customer asked for two OTC-medicines by a brand name: one was a ketoprofen product, and the other was 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.

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References and Recommended Readings

Abdel-Tawab R, Higman James D, Fichtinger A, Clatworthy J, Horne R, Davies G. Development and validation of the Medication-Related Consultation Framework (MRCF). *Patient Education and Counseling* 2011;83:451-457.

Bell JS, Airaksinen MS, Lyles A, Chen TF, Aslani P. Concordance is not synonymous with compliance or adherence. *British Journal of Clinical Pharmacology* 2007;64:710-711.

Concordance, adherence and compliance in medicine taking. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D. December 2005.

Available at: http://www.medslearning.leeds.ac.uk/pages/documents/useful_docs/76-final-report%5B1%5D.pdf

Dickinson P, Wilkie P, Harris M. Taking medicines: concordance is not compliance. *British Medical Journal* 1999;319:78.

FIP, IPSF. Counselling, Concordance and Communication – Innovative Education for Pharmacists. Eds: Wuliji T, Airaksinen M. International Pharmaceutical Federation (FIP) and International Pharmaceutical Students' Federation (IPSF) 2005. Available at: <http://www.fip.org/files/fip/PI/Counselling,%20Concordance,%20and%20Communication%20-%20Innovative%20Education%20for%20Pharmacists.pdf>

Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. *American Journal of Hospital Pharmacy* 1990;47:533-543.

Hämeen-Anttila K. Education before medication: Empowering children as medicine users. Doctoral dissertation. Faculty of Pharmacy, University of Kuopio, Finland, 2006. Available at: <http://www.uku.fi/vaitokset/2006/isbn951-27-0407-2.pdf>

Kansanaho H. Implementation of the principles of patient counselling into practice in Finnish community pharmacies. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, The University of Helsinki, 26/2005. Available at: <http://ethesis.helsinki.fi/julkaisut/far/farma/vk/kansanaho/implemen.pdf>

Kaplan RS, Norton DP. The Balanced Scorecard – translating strategy into action. Harvard Business School Press, Boston, 1996.

Kimberlin CL. Communicating with patients: Skills assessment in US colleges of pharmacy. *American Journal of Pharmaceutical Education* 2006;70(3):Article 67.

Marinker M, Shaw J. Not to be taken as directed: Putting concordance for taking medicines into practice. Editorial. *British Medical Journal* 2003;326:348.

Mobach MP. Counter design influences the privacy of patients in health care. *Social Science & Medicine* 2009;68(6):1000-1005.

National Collaborating Centre for Primary Care. Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence. Full Guideline. January 2009. Available at: http://www.sefap.it/servizi_lineeguida_200902/CG76FullGuidelineApp.pdf

National Institute for Health and Clinical Excellence (NICE). Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. Clinical Guideline 76, 2009. Available at: <http://www.nice.org.uk/nicemedia/pdf/CG76FullGuideline.pdf>

Planas LG, Kimberlin CL, Segal R, Brushwood DB, Hepler CD, Schlenker BR. A Pharmacist model of perceived responsibility for drug therapy outcomes. *Social Science & Medicine* 2005;60(10):2393-2403.

Pohjanoksa-Mäntylä M. Medicines information sources and services for consumers - A special focus on the Internet and people with depression. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, The University of Helsinki, 2010. Available at: <http://urn.fi/URN:ISBN:978-952-10-6128-8>.

- Puspitasari HP, Aslani P, Krass I. A review of counseling practices on prescription medicines in community pharmacies. *Research in Social and Administrative Pharmacy* 2009;5(3):198-210.
- Puumalainen I. Development of instruments to measure the quality of patient counselling. Doctoral dissertation. Faculty of Pharmacy, University of Kuopio, Finland, 2005. Available at: <http://urn.fi/URN:ISBN:951-27-0053-0>
- Puumalainen I, Halonen P, Enlund H, Johnson K, Airaksinen M. Validation of the United States Pharmacopeia (USP) Medication Counselling Behaviour Guidelines. *Pharmacy Education* 2005a;5:87-96.
- Puumalainen II, Kause JM, Airaksinen MS. Quality assurance instrument focusing on patient counseling. *Annals of Pharmacotherapy* 2005b;39 (7-8):1220-1226.
- Puumalainen II, Peura SH, Kansanaho HM, Benrimoj CSI, Airaksinen MSA. Progress in patient counselling practices in Finnish community pharmacies. *International Journal of Pharmacy Practice* 2005c;13(2):149-156.
- Raynor D, Savage I, Knapp P, Henley J. We are the experts: people with asthma talk about their medicine information needs. *Patient Education and Counselling* 2004;8:167-174.
- Routasalo P, Airaksinen M, Mantyranta T, Pitkala K. Supporting a patient's self-management. *Duodecim* 2009;125(21):2351-9 (English summary).
- Royal Pharmaceutical Society of Great Britain. From compliance to concordance: Achieving shared goals in medicine taking, 1997.
- Shah B, Chaewning B. Conceptualizing and measuring pharmacist-patient communication: a review of published studies. *Research in Social and Administrative Pharmacy* 2006;2:153-185.
- Strand LM, Cipolle RJ, Morley PC, Frakes MJ. The impact of pharmaceutical care practice on the practitioner and the patient in the ambulatory practice setting: Twenty-five years of experience. *Current Pharmaceutical Design* 2004;10:3987-4001.
- Subish P, Mukhyaprana P, Ravi S. Patient Counseling by Pharmacist – A Focus on Chronic Illness. *Pakistan Journal of Pharmaceutical Sciences* 2006;19(1):62-65.
- TIPPA Project. Final Report, 2004 (see description of the project in the following references of this chapter: Kansanaho 2005 and Puumalainen 2005).
- USP Medication Counseling Behaviour Guideline. USP DI update volumes I and II. Pp. 664-675, 1739-48. The United States Pharmacopeia Convention Inc, 1997. Also available at: Kansanaho 2005 (Appendix 1): <http://ethesis.helsinki.fi/julkaisut/far/farma/vk/kansanaho/implement.pdf>
- WHO. Adherence to Long-term Therapies – Evidence for Action. World Health Organization 2003. Available at: <http://whqlibdoc.who.int/publications/2003/9241545992.pdf>



Chapter Three: Organizing a Patient Counselling Event (PCE)

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Objectives of the Chapter:

This chapter provides quick step-by-step instructions for any organization to set up a patient counselling event (PCE) by:

- Describing the history, outline and expected learning outcomes of PCE
- Providing practical recommendations for organizing a PCE
- Demonstrating examples of successful events

Patient Counselling Event - A Brief History

Patient counselling event (PCE) is an opportunity where pharmacy students can practice and refine their communication skills against each other. The event was innovated by student organizations in US pharmacy schools in 1980s and supported by the American Pharmacists Association and United States Pharmacopeia (USP). These organizations were also instrumental when the International Pharmaceutical Students' Federation (IPSF) adopted the event in late 1980s.

Patient counselling event (PCE) is an opportunity where pharmacy students can practice and refine their communication skills against each other. The participants are provided a scenario in which they get to discuss medical information with the patient while being mindful of the patient's needs. The competition component is supplemented with a workshop to discuss the components of a counselling session. This is an International Pharmaceutical Students' Federation (IPSF) initiative that was first held at the congress in 1989. And since then, it has been held at every World Congress. To further increase patient counselling to all corners of the world, it is now

hosted at all of the IPSF regional symposiums as well. A variety of PCE styles has been adopted by the various member countries so that they can also host national PCE for their students.

A remarkable outcome of the PCE is development of performance evaluation tools (see Chapter 2). All students participating in PCE role-plays are given feedback on their performance as pharmacists. Invited evaluators, who are experts in communication and pharmacotherapy, need explicit criteria to evaluate student performance. The first evaluation criteria were modified from the criteria used in some US pharmacy schools. In mid-1990s, USP established an expert group to develop criteria that are based on sound evidence and are validated (USP 1997). The expert group conducted an extensive inventory of existing evaluation criteria, and based on it, developed a new evaluation tool called USP Medication Counselling Behaviour Guidelines (see Chapter 2). The simplified version was presented in the first edition of the PCE Booklet in 2005 (FIP and IPSF 2005, Appendix 2 in this edition). It is also recommended by this version of the PCE Booklet to be used as an evaluation tool for patient counselling performance (see Chapter 2, Appendix 2 and 3).

This chapter discusses methods that can be used and practical preparations needed to implement a PCE in your students' association, university department, or professional association. You can also find a useful PCE coordinator's checklist in Appendix 4.

Before the Patient Counselling Event

Organizing a PCE, especially for the first time, can be a lot of work before and during the event. It must be organized within a reasonable student body. The specific format of the event should be determined first. Also, it is important to dedicate a coordinator to this event who would be responsible for ironing out all the details. The coordinator is recommended to have a small group of assistants or volunteers that can provide help throughout the preparation as well as on the actual event date.

The Date

Pick a date for the event. If this is to be organized locally at a school, then try to pick a date that would be suitable for everyone. Do not pick a date that is near or during exams because this could lead to a lower participation rate. Another common date of choice is during a local association's congress or conference. This way, students from varying schools and areas can all participate at this event and may increase the participation rate as well.

A popular format of this event is to have it locally at multiple schools and then the winner of each school will go on to participate in a national competition amongst others. Obviously, this would require clear communication between the local and national organizational committees. There are many positive experiences of organizing the final round of the event in cooperation with national organizations and as a part of national conferences.

The Venue

After finding a suitable date for the event, an appropriate venue would be required. Patient counselling events can be done as closed door events or open door events. The latter involves an audience and the contestants will demonstrate his or her skills to others. Generally, open door

events would be reserved for the final round of a competition, where there are a few participants. This is because it would not be time effective to ask the audience to watch a large group. Closed door event, as it is simplest, will require a room, where the participant can counsel the actor (standardized patient) while the judges can adjudicate them at the same time. The more rooms available, the more simultaneous counselling sessions can occur and the more participants can take part in the time frame. An open door event will require a venue that can accommodate for an audience (Figure 1).



Figure 1. A German pharmacy student participating in an open round of PCE (Source: IPSF).

In general, PCE is a popular event and do try to accommodate for as many people as possible. A stage will be needed for the participant and the actor. The judges can sit in the front row of the audience. Some may feel this would be a rather intimidating situation to counsel on stage and arrangements can be made. Depending on the venue and the audio-visual settings, it may be possible to have the participant counsel the actor in another room, either behind the stage or somewhere just away from the audience and have that broadcasted to the main viewing area for the audience. However, this would require more technical set up and is not possible under every circumstance. In either situation, a holding or waiting area should be available to the participants. The participant does not need to be there for the entire time, but at least immediately before their session.

Each counselling session should be around seven to ten minutes long, maximum. Therefore, the allotted amount of time for each participant should be fifteen minutes. Time switching from one participant to the next must be taken into account and there should always be a few minutes at the end where the judges can provide some immediate feedback. Consider what would be a feasible amount of time for the overall event. For example, a 3 hour event would easily

accommodate for 12 participants provided one room is available, but if more than one room is available, then the number of participants can be easily increased.

Preparation of Scenarios

Depending on the group of students, multiple levels of varying difficulty of cases with qualification rounds may be necessary.

The Judges

After the physical logistics have been organized and planned, decisions must be made to determine who will be involved as a judge. Typically only one judge is required for the event; however, if it is possible to invite more pharmacists to be a part of the jury, it would be ideal. Pharmacists of varying backgrounds would be helpful as they can provide different point-of-views and opinions. One of the judges is also recommended to have expertise in communication skills. As there is more than one way to counsel patients, it is great if the participants get different ideas and feedbacks to incorporate into their own counselling sessions.

When inviting the judges, it would be important to know what their practice is, if it is in the community, hospital, or other areas. It is reasonable to ask them for their CVs/resume, especially if you are not familiar with the judges. When inviting the judges, send them a formal invitation letter. This way, they would have a better understanding about the event and this is more professional. The judges would also serve as consultants throughout the process. For example, when developing the cases, the judges can always be asked for their input to see if there is anything that can be changed and improved. The judges serve as an excellent resource.

Evaluation Criteria for Patient Counselling Performance

There are a number of evaluation tools that can be used. A general one that has been used within IPSF events can be found in Appendix 2 and 3. Different kinds of tools can be modified from the USP Medication Counselling Behaviour Guidelines (Chapter 2). There are two aspects that need to be taken into account when making the modifications: 1) which items to include and why; 2) what kind of evaluation scale to apply if any (e.g., a 5-point evaluation scale ranging from poor to excellent performance).

The PCE participants can be introduced to the evaluation form before the role-plays so they know what aspects of their performance will be evaluated. This will reinforce learning. It is also important that the judges will personally discuss their ratings with the participants so that the participants can make use of the feedback in their skills development.

The Patient Cases (scenarios)

Meanwhile, the cases that will be used for the competition must be prepared. There are so many topics to choose from in pharmacy. Consider a difficulty level suitable for the participants. If multiple levels are decided, then it would be ideal to have an easier level and a harder level. Think about how many years of schooling or how much experience the students would have. For example, if most of the students would be in the lower levels, then consider choosing a topic that would be covered in the lower levels. Varying difficulty of PCE levels can be based on, e.g., the type of products chosen, and over-the-counter product versus a prescription item. Also, in a more beginner level, consider a simpler scenario and the focus will be on developing

communication skills. If the event will have participants from different countries, scenarios need to be designed to be understandable and relevant from the international perspective (e.g., selection of condition and its treatment, use of brand/generic drug names).

The scenarios should be educational and fun at the same time. The point of the PCE is not to fool or trick the participants, but rather to empower the students to continuously develop their communication skills to meet their patient care needs.

A Sample Case

A woman in her thirties enters the pharmacy asking for the best allergy relief medication that can be used for itchy skin, sneezing and watery eyes.

The key to helping this woman is to ask her if she is the one experiencing these symptoms. Upon questioning, one will discover that it is actually her eight year old daughter who was just stung by a bee. Knowing that this will be for a child, it will be important to find a medication that is available in a liquid formulation, making it easy for the mother to administer it to her child.

Keep in mind that the participants would also be given resources to refer to in preparation for the counselling session. With that, consider what resources to be used. Choose a reference that is either commonly used and it should be a drug reference that contains the basics like drug dose, common adverse effects, monitoring points, and interactions. It is also recommended that the participants have package inserts or patient information leaflets available. The cases and the judging criteria should be developed at the same time as well. As mentioned previously, feel free to work together with the judging panel to for input and feedback on the cases and the judging criteria.

The Patient

There are a lot of options in terms of who gets to role play as a patient in a PCE. The use of real patients is not recommended as the participant may provide incorrect information. Otherwise, options for patients include standardized patients, practicing pharmacists, or other students.

Standardized patients (SP) are professionally trained to act and will respond the same way to the participants. However, SPs are generally paid and this must be taken into account when planning for the event. The use of practicing pharmacists is a reasonable choice as not only can they be the patient, they can also be the judge for the event. Also, pharmacists generally know how a typical patient will react and can provide the appropriate response. Pharmacy students may also be as patients and this actually provides good insight for the student to understand it is like to be counselled as a patient. This actually serves as a good learning tool and a useful method for both the participant and the actor to learn and develop their counselling skills. However, as students, they may not know how to respond to certain comments or remarks and may lead to inter-participant variation.

Recognition

Determine whether or not there will be a prize given to the winner of the event. This may require sponsorship, so take account of it early during budgeting. At the least, the participants should receive a participation certificate and this will need to be designed ahead of time.

The Actual Event

Preparation Phase

The participants will always get preparation time prior to actual counselling session. This information can be presented immediately before the competition or even earlier, like 24 hours prior to the event. Keywords, like drug names, disease states, a prescription, should be given to each participant so they can prepare for the counselling session. If the preparation material was to be given a day in advance of the event, then this information can either be emailed out to all the participants or even ask the participants to gather together and the information is presented to them. If the preparation material is given immediately before the event, then ensure the participants arrive knowing exactly what time to arrive for this. In general, the amount of preparation time should be no longer than 15 minutes. For a challenging event, the preparation time can be eliminated but this would be a more advanced variation of the event and may not be suitable in many situations.

Participants will need to arrive at least 5 minutes before their actual counselling session. Ensure all the participants are clear as to what time they should present themselves and where they should be meeting. There should be a holding area for the participants to wait just prior to the event and this could be where the participant prepares for the counselling session. Paper, writing utensils, references, and calculator should be available for all participants here. Use a timer to ensure all the participants receive the same amount of time for the preparation time. This would be a place where a volunteer can help out with greeting the participants, the timing and smooth transition from one participant to the next.

The Actual Competition

After the preparation time, ensure the participant knows where to go for the counselling session. There should be a helper here that informs the participant when to go in and also be responsible for timing of the counselling session. Reminders should be given either by knocks on the door or a bell when there is two minutes left in the session, this way, the participant would have an idea as to how much time there is left. After the counselling session, there should be approximately two to three minutes to allow the judges to provide some immediate feedback. Then the process continues until all the participants have had their chance to counsel.

Figure 2. Polish pharmacy student counselling on the appropriate use of a nebulizer during a PCE (Source: IPSF).



After the Event

Gather all the feedback forms from the jury and also ask to see what their overall thoughts were. Ensure the participants receive the feedback form as well and ask to see if there is any feedback from the participants. Feedback is critical for the participant as this phase allows them to learn more about their current counselling skills and also help them further develop these skills.

It is always a good idea to reflect on the overall event. Also ask the volunteers who were part of it to see if they felt the event ran smoothly. This way, future events can be improved and more participants can benefit from this experience.

Consider developing a portfolio for this event within the school and/or local organization. This can be passed from one PCE coordinator to the next with each subsequent event. The portfolio can contain past cases and this would help new coordinators with ideas for patient scenarios. There should also be a list of contact information with past judges, who have indicated they would be interested in assisting with future events. With a portfolio, this will ensure smooth events time after time.

Summary

Organizing PCE for the first time can be a daunting task; however, with some guidance and help from peers, it can be a fun experience. It is important to be diligent and have a plan to follow, but also be ready to be flexible. Always be prepared with lots of extra time as there are lots of opportunities for last minute changes. Lastly, share the experience with others and this can help optimize future events to ensure the best possible learning experience for the participants. Also share the experience with your pharmacy school teachers to promote teaching communication skills in basic education.



Chapter Four: How to Develop Communication Skills Using Drama Techniques

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Objectives of the Chapter

Learning communication and patient counselling skills requires a mixture of various pedagogic methods which can help in constructing understanding of medicine user's needs and in rehearsing own skills and scripts. Role-plays and socio-drama are particularly useful in this respect. The aim of this chapter is to give an overview of various drama techniques that can be applied in pharmacy education. This chapter provides

- Ideas to show how drama can improve communication skills and how such skills can be taught
- Practical examples how to use role-playing in basic pharmacy education and continuing education.

When you think of drama, you may remember the last play you went to see in town, which made you laugh or cry. Or maybe you think about your own performance at school as an angel in a play. But have you ever thought about drama as a useful skill to enhance your professional performance?

Good communication skills are essential to advance pharmaceutical care. In order to improve communication with patients it is important to place yourself in their shoes. Drama provides an opportunity to make this happen! In this chapter, ideas are explored to show how drama can improve communication skills and how such skills can be taught.

Drama and Pharmacy

Drama and medicine may seem to have nothing in common, but when searching the literature for a link between drama and medicine, the results show that there is some expertise in using drama techniques in different settings. For example, in public health care programmes and in monitoring health care, trained actors play mystery patients and evaluate the quality of care. There is also increasing experience in using drama to train health professionals and pharmacists in communication skills. This is quite often done through the use of *role play*. Such methods can also be called *simulation* or *behaviour rehearsal* or communication rehearsal or socio-drama depending on the chosen approach. This chapter provides an overview on how to use role-playing in basic academic education and continuing education.

Through drama you:

- Learn to put yourself in the shoes of a patient.
- Learn to improvise and feel more confident in different situations.
- Learn to understand communication skills in your own performance.
- Can experiment with different communication techniques in various scenarios.
- Learn to develop your own communication style.
- Learn "applied pharmacotherapy" (to determine the critical issues to be discussed with the patient).
- Learn to modify the message by using different techniques and ways to communicate.
- Develop listening skills to understand the needs of the patient.
- Train to present the information according to the needs of the customer.
- Understand principles of two-way communication.
- Become aware of your own attitudes to the patient (e.g. paternalistic or concordant).
- Learn to understand myths and beliefs behind your own performance.
- Gain feedback and self-assessment skills.

Role Playing

The classic role play scenario is as the follows:

The classroom is a pharmacy setting (Figure 1). The pharmacist is played by the learner, who can be a pharmacy school student or a practising pharmacist in continuing education or an in-house training session. The patient is a professional actor, a teacher, or one of the training participants. Cases can be prepared beforehand by the one playing the pharmacist role or they can be directly presented by the participant acting as patient. The exercises are videotaped. The remaining training participants provide feedback, using structured forms or open questions (e.g., Chapters 2-3, and Appendices 1-3 can be used to develop feedback forms). The teacher acts as the moderator in the discussion.

Theatre Sports

If you are looking for an innovative approach to training communication skills or way to break the ice with a group before practicing real role plays, then you can consider using drama techniques like those used in theatre sports. This type of improvisation theatre uses an element of competition, as in sports. This approach was developed to reduce stress in nervous players. These techniques help actors gain the confidence to face unknown situations as well as the courage to discuss any given matter. These techniques also prove to be useful in improving patient interaction in a pharmacy setting and developing confidence in yourself so that you will be able to interact

with the patient in any circumstance. As theatre sports exercises were developed to reduce barriers and enable everyone to participate in a scene, they are very suitable for use in communication training.

Several improvisation games have been developed over the years. A useful list is available in English at www.learnimprov.com. Different games can be used to train different aspects of communication. In an educational setting, the competition element may be left out. Public interaction through scene intervention tailors the setting to the audience and makes livelier discussion. However, the session's moderator will also need to have good improvisation skills.

We will now examine some exercises that have been adapted for training communication skills in pharmacy.

You can start with an eye contact game that demonstrates the importance of eye contact in interactions. Ask the participants (maximum 20-25) to form a circle. Then ask each of them to select one peer from the other side of the circle to whom they start staring at intensely. Ask them to go on staring as long as the person they are staring at reacts to their behaviour and starts approaching them. Encourage the pair to go on staring as long for as they meet. Then ask them to shake hands. After completing this, ask each participant to find another person to stare at and repeat the rehearsal. The rehearsal can be repeated several times. It helps pharmacists to learn how they can effectively establish and use eye contact.

Game 1: The Emotional Quadrant in the Pharmacy

The moderator asks the group to make a list of communication techniques (listening, empathy etc.) and emotions (fear, anger etc.).

Materials: Flip chart or white board

The pharmacist-actor chooses a communication technique for feedback and the audience chooses the emotion of a patient, and a scenario (or the moderator decides on a "good medicine" for a patient presenting with a headache). Then the pharmacist and the customer role play the scenario with the given parameters.

Try this again with the same situation but other communication techniques, as well as varied patients. Hint for the feedback discussion: What is the effect of using that technique in that particular patient? Discuss the effect of using different techniques in various situations/emotions.

Game 2: Gabbish Talk

The moderator selects the patient and pharmacist. The group is asked for a situation, patient character and/or emotion, without the pharmacist knowing what they are. Patient and pharmacist speak in a non-existent language (or their own if not understood by others). Only one or two words decided by the group may be used in English or in another language they both know, but avoiding keywords which will reveal the situation too quickly. The pharmacist and the patient role play the scenario with the given conditions.

Hint for the feedback discussion: How do you communicate with a language barrier? This game is a good opportunity to discuss the importance of non-verbal communication and it is also a starting point for discussing cross-cultural communication. What kind of techniques can be used to make yourself understandable communicating to a patient with a different language?

Game 3: Rewind the Video

The group chooses the patient's problem, question, character and emotion. A new pharmacist and patient are selected. They begin the counselling interaction in the scenario. The moderator demonstrates the game by stopping the scenario by clapping his/her hands in a crucial part of the interaction (e.g. inadequate questioning, good explanation, paternalistic expression etc). Another pharmacist and patient take over from this point (new pharmacist and patient) and repeat the last two sentences before continuing with the scenario. The group can then clap their hands to stop the scenario and continue the game in this way.

Hint for the feedback discussion: Why has the scenario been stopped? What are the important aspects of the interaction?



Figure 1. A role-play rehearsal on serving OTC-customers in a teaching lab where both the pharmacist's and customer's role are performed by students. The lab is designed to simulate actual customer service environment in a typical community pharmacy (both for dispensing prescription medicines and selling OTC-medicines) (Source: Kirsikka Mattila, University of Helsinki, Finland).

Summary

The techniques presented in this chapter illustrate the variety of ways to rehearse communication skills. We encourage you to use your creativity and imagination to develop new versions of these techniques. It is also useful to refer to literature related to socio-drama as a pedagogic method in order to have a deeper understanding of its role in developing patient counselling skills.

References and Recommended Readings

Boesen KP, Herrier RN, Apgar DA, Jackowski RM. Improvisational exercises to improve pharmacy students' professional communication skills. *American Journal of Pharmaceutical Education* 2009;73(2):Article 35.

Elliott L, Gruer L. Theatre in AIDS education - a controlled study. *AIDS Care* 1996; 8(3):321-340.

Madan AK, Caruso BA, Lopes JE, Gracely EJ. Comparison of simulated patient and didactic methods of teaching HIV risk assessment to medical residents. *American Journal of Preventive Medicine* 1998;15(2):114-119.

Madden JM, Quick JD, Degnan RD, Kafle KK. Undercover care seekers: simulated clients in the study of health provider behaviour in developing countries. *Social Science & Medicine* 1997; 45(10):1465-1482.

Maurizi A. Humour and the theatre promote discussion. *World Health Forum* 1994;15(2):181-182.

Mesquita AR, Lyra DP, Brito GC, Balisa-Rocha BJ, Aquir PM, Neto AC. Developing communication skills in pharmacy: A systematic review of the use of simulated patient method. *Patient Education and Counselling* 2010; 78:143-148.

Rao D. Skills development using role-play in a first-year pharmacy practice course. *American Journal of Pharmaceutical Education* 2011;75(5):Article 84.

Rickles NM, Tieu P, Myers L, Galal S, Chung V. The impact of a standardized patient program on student learning of communication skills. *American Journal of Pharmaceutical Education* 2009;73(1):Article 4.

Seguin A, Rancourt C. The theatre: an effective tool for health promotion. *World Health Forum* 1996;17(1):64-69.

Taverner D, Dodding CJ, White JM. Comparison of methods for teaching clinical skills in assessing and managing drug-seeking patients. *Medical Education* 2000;34: 285-291.

Wong YY, Shahabudin SH. An adaptation of the simulated patient methodology to study preventive health advice by doctors. *Medical Teacher* 1996;18 (2): 111-115.

This chapter was based on the work done by Lidewij Sekhuis, a pharmacy student, who performed a literature study and interviews to explore this theme. The drama techniques were tested at the 12th International Social Pharmacy Workshop in Sydney 2002 by Evelyn Schaafsma (e.s.schaafsma@farm.rug.nl) and Marja Airaksinen (marja.airaksinen@helsinki.fi) as moderators during the workshop.



Chapter Five: How to Develop a Patient Counselling Course

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Objectives of the Chapter

This chapter provides a guide for the development of a course on patient counselling at both undergraduate and postgraduate levels for pharmacists. The strategies recommended are aimed at the individual pharmacy student or practicing pharmacist, and not at a pharmacy organisational level.

In developing a course, several elements must be considered, including the needs of the target audience, learning outcomes, course content, teaching methods, learning resources, participant assessment, course evaluation and quality assurance. The course must be developed with an emphasis on a student-centred approach to teaching and learning. This approach encourages the student¹ to take responsibility for their own learning, as well as a deep and active approach to learning. Although the emphasis is on the student, student collaboration with peers and mentors is also recognised as an important aspect of this approach.

Several factors should be considered prior to developing the course:

- the amount of educational material to be included;
- the cost of developing the course;
- the ability to design a course which is reproducible and practical;
- the time involved in delivering the course;

¹ For the purposes of this chapter, the term “student” is used to refer to the pharmacy undergraduate student or practicing pharmacist undertaking a course on patient counselling.

- easy access by all pharmacists to the course (for a course aimed at practicing pharmacists); and
- an effective mode of delivery, which is likely to have an impact on the patient counselling skills of participants at the undergraduate or postgraduate level.

A Needs Analysis Process

A needs analysis process (Hawe et al. 1990) may be conducted as the first step in course development, to identify the gaps in the knowledge, skills and behaviours of the target audience (undergraduate pharmacy students or practicing pharmacists) in relation to patient counselling. This needs analysis can include assessing normative needs, that is, what experts in the field believe to be the gaps; expressed needs, or what the course developers infer to be the target audience's needs from the information provided by the target audience; comparative needs, or when the needs of the target audience are assessed by comparing their knowledge, skills and behaviour to those of another group; and/or felt needs, that is, what the target audience have stated to be their needs.

Hawe et al. (1990) have schematically illustrated the processes of needs assessment, programme development and evaluation, which are recommended for development of a course on patient counselling (Figure 1).

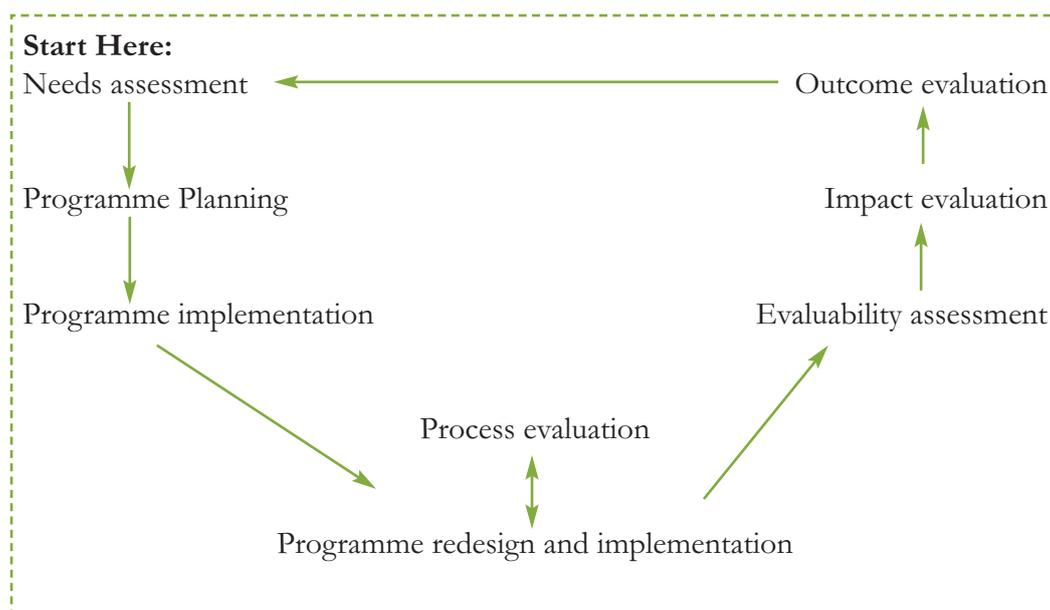


Figure 1. Course planning and evaluation cycle (adapted from Hawe et al. 1990)

Learning Outcomes

Learning outcomes define what the students should know or be able to do by the end of the course. They relate to the knowledge, skills and behaviours that students will gain from the course. The learning outcomes should be aligned with the course learning objectives, and should be explicit and clearly communicated to the students at the beginning of the course. It is imperative that students are aware of the course expectations, and the skills and knowledge that they are likely to gain from the course.

Example of a learning outcome:

Demonstrate effective verbal communication skills in a range of pharmacy related settings and situations.

Learning objectives convey the goals of the course, minimising student confusion and uncertainty about the content of the course. Good objectives are created with three components which correspond to good teaching: the objectives

- describe what the student will be doing, such as demonstrating a skill or explaining a theory;
- describe the learning conditions; and
- indicate how the student will be assessed.

Example of a learning objective:

To provide students with the effective verbal communication skills required to counsel patients in a range of pharmacy related settings and situations.

Additionally, the learning outcomes should be aligned with the teaching methods as well as the course assessments. This will ensure that appropriate teaching methods are used to address the course objectives and provide the students with the knowledge and skills set out in the learning outcomes.

Assessments play an important role in effective learning. Linking assessments with learning outcomes ensures that students are aware of whether they have met the intended outcomes of the course through their performance in the course assessments.

Teaching Methods

Teaching approaches which are intellectually challenging, encourage reflection by the 'learners', discussion of the topic, performance of role plays, and have a feedback mechanism incorporated, are the more appropriate forms of teaching techniques (Brookfield 1990, Apps 1991, Heimlich and Norland 1994, Jarvis 1995). Traditional didactic teaching methods, such as lectures or seminars do not possess all of the above attributes, even though they are the most effective method of providing information to a large group in a limited period of time. Group collaborative teaching methods, such as workshops, which respect the 'learners' prior knowledge and experience with regards to the topic (Jarvis 1995), give them more control over the content, process and evaluation of their teaching and learning (Brookfield 1993, Tennant and Pogson 1995, Cranton 1996).

“Adults learn best when they do not have to rely on memorising, but can learn through activity at their own pace with material that seems relevant to their daily lives and uses their own experience” (Rogers (1979) cited in Brookfield (1983)). Workshops have been identified as a new learning forum (Bonk and Kim 1998) which can provide the desirable teaching environment and characteristics described above. Furthermore, workshops can provide a learning community, which is social and allows learning through interaction with others (Kahn (1993) cited in Bonk and Kim (1998)).

The educational course should not only provide information about the new behaviour to be attained, but should also provide opportunities for the participants to observe and practise the behaviour (Gaffney and Rowling 1990). Individuals learn from experience (Jarvis 1983, Jarvis 1987). A workshop can provide these opportunities through the use of videos and role plays, as well as provision of feedback by peers.

Thus, the course should be structured to include a combination of short didactic sessions (e.g., lectures), observation of video-taped or live rehearsed role plays of good communication and counselling scenarios, and experiential learning through role plays with pseudo-patients or actual patients in authentic pharmacy settings. At an undergraduate level, the course may consist of a series of lectures followed or interspersed by a series of tutorials or workshops, as well as experiential learning at pharmacy sites. While at the postgraduate level the emphasis may be more on experiential learning. In both cases, the students can self-reflect on their performance as well as seek feedback from their peers.

Course Content

The learning objectives and outcomes determine the content of the course, as well as the teaching methods. The content should address the needs of the target population. Additionally, activities may be included, such as icebreakers, at the start of tutorials or workshops, which aid the flow of the sessions. It is important that students are comfortable in communicating with each other and the teacher, especially in a course on patient counselling, which is likely to include a number of role plays where feedback is sought from peers.

A course on patient counselling aims to provide the students with the knowledge and skills required to counsel patients about their disease and therapy. The course sets out to change student behaviour to provide counselling to patients. Thus, it is important that the course is underpinned by one or more theoretical models of behaviour change. There are many theories and theoretical models developed to understand and predict individual behaviour. However, it is beyond the scope of this chapter to discuss the various models and how they can be used to develop a course on patient counselling. The majority of the models aim to provide knowledge and skills, to change the students' attitudes about the behaviour, to motivate the students to perform the behaviour, and to provide them with the skills and resources required to be able to conduct the behaviour.

Egger et al. (1990) suggested the following features to be considered when designing a programme aimed at changing behaviour:

- The change in behaviour is desired by the individuals if it is perceived to prevent or avoid undesirable outcomes.
- This change in behaviour occurs as a result of information provided to the individuals.
- There is peer support for the change in behaviour.
- Specific activities are conducted in order for the behaviour change to occur.
- Any barriers to the behaviour change are overcome.
- The change is appropriate for the group of individuals.
- There is no peer pressure against the change in behaviour.

Poor counselling (Herrier 1994) and communication skills (Rantucci 1991) have been cited as barriers to patient counselling. Pharmacists, until recently, have not been receiving training in communication and counselling skills (Smith et al. 1990). “The development of adequate interpersonal skills is now a goal of educational and training programs in health professions” (Montagne 1987). A high standard and level of communication skills are required by pharmacists to counsel, educate, and motivate consumers about their medications (Mays 1994).

Thus, some possible topic areas for the course on patient counselling may include:

- the rationale for providing disease and medicine information to patients;
- the rationale for educating patients about their disease and therapy;
- patients’ need and desire for information about their disease and therapy;
- the positive and negative impacts of patient counselling on patients’ attitudes and behaviours;
- good verbal communication skills (Dickson et al. 1989, Kimberlin 1989, Gardner et al. 1991, Pfizer 1993, Tindall et al. 1994, Foster et al. 1995, Rantucci 1997), with specific emphasis on:
 - the use of open ended questions to determine the patient’s needs and elicit information from the patient and determine what the patient already knows and understands about their disease and therapy,
 - provision of information to fill in the gaps in the knowledge of the patients,
 - verification of the patient’s understanding of the information provided.
- patient counselling skills (Kimberlin 1989, Ranelli 1990, Gardner et al. 1991, Raynor 1992, Pfizer 1993, Tindall et al. 1994, Currie et al. 1997, Rantucci 1997);
- the use of written information as part of the verbal counselling process; and
- the integration of patient counselling services in everyday pharmacy practice activities and pharmaceutical services provided.

The course should commence with a review of the learning objectives and outcomes as well as the teacher and student expectations. It should finish with a review of the course content with referral back to the learning outcomes, so that the students can reflect on what they have gained from the course.

People learn through observing others (Kehoe and Katz 1998). Videotaped role plays have been reported to be an “optimal observational strategy, since they capture both verbal and non-verbal communication behaviours” (Inui and Carter 1985). Therefore, videotaped role plays of pharmacists’ communication and verbal counselling skills should be included in the course.

An experiential training method should also be employed in the course (Egger et al. 1990) to promote an opportunity for the participants to practise what they had learned in the course, by performing role plays. The experiential training method is an approach that has a direct impact on the subjects in changing their behaviour. Thus the students should be provided with the opportunity to practise their communication and counselling skills through performing peer reviewed role plays. In addition to self-assessment, direct feedback should be given during the course. Again, allowing the participants to learn through observing others (Kehoe and Katz 1998). The experiential learning experience should also extend to include observations and provision of feedback on patient counselling skills in authentic pharmacy situations.

Learning Resources

The resources included in the course may range from reference texts and videotapes, to role plays with real patients. Participants should also be provided with patient counselling guidelines and checklists that can be referred to during practice.

An important resource can also be the use of a facilitator who can observe and provide feedback on the patient counselling behaviour of an undergraduate pharmacy student or a pharmacist in a pharmacy setting. This gives the student the opportunity to implement the information and receive immediate feedback, a process which can lead to sustained behaviour change (De Almeida Neto et al. 1999).

Participant (student) Assessment

The primary aim of assessment is to improve the student's knowledge and skills. The assessment tasks should be aligned with the course objectives and learning outcomes, and should measure what the course has set out to achieve. Some skills and knowledge are easy to quantify and assess, while others may be harder to do so. It is important that the assessment focuses on skills and knowledge that are easier to measure. The assessments should be clearly transparent, with the criteria explicitly stated; and feedback provided following the assessment. In this way, the assessment becomes an important teaching tool.

There are three forms of assessment: teacher, peer and self assessments, depending on who conducts the assessment. Practical assessments are recommended for evaluating skills and behaviours such as patient counselling. These practical assessments can take the form of observations of the student's patient counselling skills when counselling patients or pseudo-patients in authentic pharmacy settings, using set criteria. The use of pseudo-patients allows a greater degree of consistency and control over the counselling scenarios, aiding assessments by ensuring standardisation of the assessment process.

Some assessment criteria for patient counselling skills can include the following:

- the type of information provided (verbal and written);
- the amount and appropriateness of the information provided
- the organisation of the patient counselling session;
- the verbal communication skills and techniques demonstrated, such as establishing rapport, the use of open-ended questions, and verification of patient's understanding;
- the non-verbal communication skills, such as eye contact, tone and interpersonal distance;
- the degree of two-way interaction with the patient; and
- the use of written information as a counselling tool.

Course Evaluation and Quality Assurance

The last step in course development consists of evaluation, which can take the form of process, impact, and outcome evaluations. All forms of course evaluation are necessary in the quality assurance process to ensure that an effective course has been developed. The evaluations may be conducted by the teacher and/or students. Additionally, course evaluations may constitute

evaluating the outcome of the course on student knowledge, skills, and behaviour. Although it is always gratifying to receive positive feedback or observe positive impacts of the course, the quality assurance process should primarily focus on the negative results and identify problems that can be improved. This process is essential in improving the course quality.

The first step in the quality assurance process is to determine the process goals, and next, to develop or use appropriate tools to address them. For example, if one of the goals is to determine what students value as the best elements of the course, then the students can be surveyed about the best elements of the course. The final step is to interpret the data obtained from the evaluation step and use the data to further improve the course. For example, if the students felt that role plays with pseudo-patients were more helpful in gaining patient counselling skills than role plays with each other, the course developers should increase the number of role plays with pseudo-patients.

Some examples of quality assurance methods and tools include:

- evaluation of the teaching of the staff;
- quantitative and qualitative surveys of students;
- immediate impact on student skills and knowledge; and
- impact on student performance during practice.

Summary

This chapter has provided an overview of developing a course on patient counselling, focusing on the elements to be considered when developing such a course. The chapter has provided information on needs analysis, learning outcomes, course content, teaching methods, learning resources, participant assessment, course evaluation and quality assurance.

It is important to note that course development is a dynamic process, with quality assurance playing an important role in ensuring that the course developers are continuously monitoring the course and ensuring that the course is of a high quality and meets the needs of the target audience - pharmacy students and practicing pharmacists.

References and Recommended Readings

Apps JW. *Mastering the teaching of adults*. Malabar, FL, Krieger, 1991.

Bonk CJ, Kim KA. Extending sociocultural theory to adult learning. *Adult learning and development: perspectives from educational psychology*. Eds. Smith MC, Pourchot T. Mahwah, NJ, L. Erlbaum Associates, 1998.

Brookfield S. Supporting adult learners in the community: the individual mode. *Adult learners, adult education and the community*. p. 149-172. Milton Keynes, Open University Press, 1983.

Brookfield S. Self-directed learning, political clarity, and the critical practice of adult education. *Health Education Quarterly* 1993;43(4): 227-242.

Brookfield SD. *The skilful teacher: on technique, trust, and responsiveness in the classroom*. San Fransisco, Jossey-Bass, 1990.

- Cranton P. Professional development as a transformative learning. San Fransisco, Jossey-Bass, 1996.
- Currie JD, Chrischilles EA, Kuehl AK, Buser RA. Effect of a training program on community pharmacists' detection of and intervention in drug-related problems. *Journal of the American Pharmaceutical Association* 1997;NS37(2): 182-191.
- De Almeida Neto AC, Benrimoj SI, et al. Achieving change in practice behaviour. Unpublished data, 1999.
- Dickson DA, Hargies O, Marrow NC. Communication skills training for health professionals - an instructor's handbook. London, Chapman and Hall, 1989.
- Egger GR, Spark, et al. Focus on groups. *Health promotion strategies and methods*. Sydney, McGraw-Hill Book Company: 50-63, 1990.
- Egger GR, Spark, Lawson J. Health and human behaviour. *Health promotion strategies and methods*. Sydney, McGraw-Hill Book Company: 15-29, 1990.
- Foster SL, Smith EB, Seybold MR. Advanced counselling techniques: integrating assessment and intervention. *American Pharmacy* 1995;NS35(10): 40-48.
- Gaffney D, Rowling L. Report on the evaluation of the Straight Talking project. Sydney, Health Education Unit, University of Sydney, 1990.
- Gardner M, Boyce RW, Herrier RN. Pharmacist-patient consultation program - an interactive approach to verify patient understanding. New York, Pfizer-Roerig, 1991.
- Hawe P, Degeling D, Hall J. Needs assessment. *Evaluating health promotion - a health worker's guide*. p. 16-40. Sydney, MacLennan & Petty, 1990.
- Hawe P, Degeling D, Hall J. Process evaluation. *Evaluating health promotion - a health worker's guide*. p. 59-85. Sydney, MacLennan & Petty, 1990.
- Heimlich JE, Norland E. Developing teaching styles in adult education. San Fransisco, Jossey-Bass, 1994.
- Herrier R. Why aren't more pharmacists counselling? *American Pharmacy* 1994;NS34(11): 22-23.
- www.itl.usyd.edu.au/Tutoring/study/aims/objective4.htm accessed 23 March 2004.
- Inui TS, Carter WB. Problems and prospects for health services research on provider-patient communication. *Medical Care* 1985;23(5): 521-538.
- Jarvis P. Adults learning - some theoretical perspectives. *Adult and continuing education - theory and practice*. p. 90-111. London, Croom Helm, 1983.
- Jarvis P. Experiencing the social situation. *Adult learning in the social context*. p. 63-85. London, Croom Helm, 1987.
- Jarvis P. *Adult and continuing education*. New York, Routledge, 1995.
- Kahn TM. *A learning agenda: putting people first*. Palo Alto, CA, Institute for Research on Learning, 1993.
- Kehoe WA, Katz RC. Health behaviours and pharmacotherapy. *Annals of Pharmacotherapy* 1998;32:1076-1086.
- Kimberlin CL. Communications. *Pharmacy Practice - Social and Behavioural Aspects*. p. 159-177. Eds. Wertheimer AI, and Smith MC. Baltimore, Williams & Wilkins, 1989.

Mays N. Health services research in pharmacy: a critical personal review. HSR and pharmacy - a critique. Proceedings of a conference held at the King's Fund Centre, London, on 12th December 1994. Ed. Hibbert D. London, Pharmacy Practice Research Resource Centre, 1994.

Montagne M. Research and evaluation in health communication. *American Journal of Pharmaceutical Education* 1987;51: 172-177.

Pfizer. Pharmacist-patient consultation program PPCP, Unit 2: How to counsel patients in challenging situations. New York, National Healthcare Operations, 1993.

Ranelli PL. Rediscovering the act of interviewing by pharmacists. *Journal of Clinical Pharmacy and Therapeutics* 1990;15: 377-380.

Rantucci M. Patient counselling - How to make it happen in your pharmacy. *Australian Pharmacist* 1991;10(4): 163-167.

Rantucci MJ. *Pharmacists talking with patients*. Baltimore, Williams & Wilkins, 1997.

Raynor DK. Patient compliance: the pharmacist's role. *International Journal of Pharmacy Practice* 1992;1: 126-135.

Rogers J. *Adults learning*. Milton Keynes, Open University Press, 1979.

Smith FJ, Salkind MR, Jolly BC. Community pharmacy: a method of assessing quality of care. *Social Science & Medicine* 1990;31(5): 603-607.

Tennant M, Pogson P. *Learning and change in the adult years: a developmental perspective*. San Fransisco, Jossey-Bass, 1995.

Tindall WN, Beardsley RS, Kimberlin CL. *Communication skills in pharmacy practice: a practical guide for students and practitioners*. Philadelphia, Lea & Feberger, 1994.



Chapter Six: Organizing a Patient Counselling Course: Experiences from the University of Helsinki, Finland

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Objectives of the Chapter

This chapter provides an example of organizing a patient counselling course for undergraduate pharmacy students at the university. Both pedagogical and practical issues are discussed that should be taken into account in course development to assure quality of learning in terms of:

- Learning objectives
- Contents
- Teaching methods and course design
- Evaluation of learning outcomes
- Program development and evaluation

Patient education and counselling are among the most important tasks of pharmacists in the contemporary pharmacy practice. Although pharmacists are encouraged to reflect and to develop their expertise through lifelong learning, the basis for these skills is constructed in the undergraduate education in the universities. This chapter provides an example of organizing patient counselling course at the university.

In the University of Helsinki, the patient counselling course has been included in the pharmacy curriculum since 1995. The course is obligatory to all pharmacy students (both B.Sc. and M.Sc.), and it is part of the second year studies. In order to better meet the learning objectives, the course has evolved to become a long-term module integrating teaching of pharmacotherapy

and patient counselling skills at the university, and learning during the obligatory internship of six months (Figure 1). These two integrated courses make altogether 7 credits out of the total 180 credits required for a BSc degree in Pharmacy (one credit point equals to 27 hours of student work). The patient counselling and communication part of the module makes four credit points. Students earn 30 credit points from the obligatory internship (minimum 3 months of the internship needs to be done in a community pharmacy, the other 3 months can be done in a hospital pharmacy).

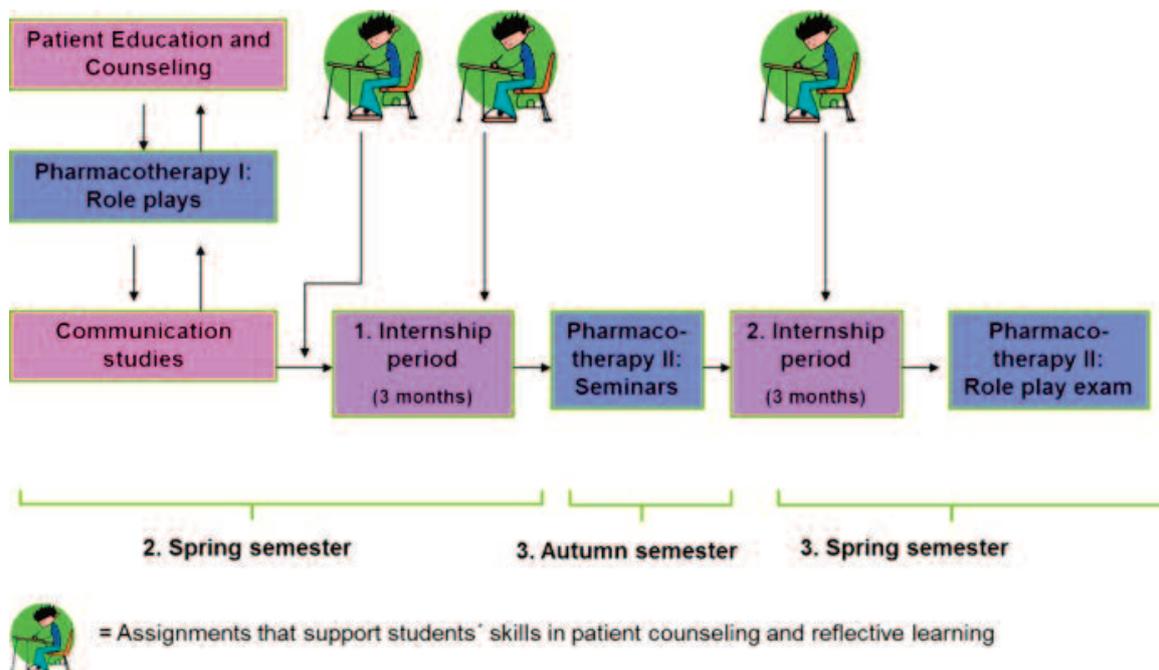


Figure 1. Integration of patient counselling course into the pharmacy curriculum.

Learning Objectives of the Patient Councillng Course

The patient counselling training at the University of Helsinki has three major goals: to provide students with adequate 1) pharmacotherapeutic knowledge; and 2) skills required in communicating with patients about their diseases and treatments; and 3) to develop students' understanding of reflectivity so that they can learn to assess their communication skills and counselling performance. Through reflectivity, students are encouraged to life-long learning and development of their professional competence (Figure 2). At the end of the course students should:

- Understand the importance of counselling and communication skills in a community pharmacy setting;
- Know the principles of concordance and dialogue-based patient counselling process and have the ability to apply that knowledge into different types of customer/patient interactions in a pharmacy setting. This includes customers purchasing over-the-counter and prescription medicines. Of these customers, many have special needs in communication, such as the elderly, adolescents, and people with hearing and vision impairment.
- Know and have skills to use the most important evidence-based information sources available in community pharmacies to support counselling.
- Have competence to assess their peers' counselling performance and give them feedback.



Figure 2. The major goals of the patient counselling training at the University of Helsinki: The long-term module during the 2nd and 3rd years of studies integrates teaching of pharmacotherapy, communication skills, and principles of self-assessment and feedback to prepare for lifelong learning and competence development.

Theoretical Basis of the Course

Empowerment and concordance are applied as the theoretical framework for teaching patient counselling and communication skills to the students. Thus, students are systematically introduced to apply principles of concordance in their communication, and to learn to see patients as active participants in health care, also in medicine taking (See Chapter 2). Emphasis is on collaborative decision making and patient involvement in their care (Horne et al. 2005, National Institute for Health and Clinical Excellence 2009, Routasalo et al. 2009).

Although other patient counselling guidelines and models are recognized, teaching is based on the USP Medication Counselling Behaviour Guidelines (USP 1997, Puumalainen et al. 2005a and 2005b). This is because the USP Guidelines provides a tool to understand a patient counselling session as a process with 4 basic components as described in Chapter 2: the introduction and needs assessment; the content; the conclusion; and the use of different communication techniques throughout the session. These components have proved to be useful in analysing the counselling performance with the students. The same applies to description of core counselling items (Appendix 1).

The USP Guidelines also helps students to understand the continuum from limited interaction (monologue) to involved interaction (discussion). Students are encouraged to learn such counselling and communication techniques that are needed in establishing a dialogue and mutual agreement with the customers. This means that the USP Guidelines is not used as a strict checklist which needs to be followed step-by-step, but merely a tool to guide reflective learning towards interactive, customized communication about medications (See Chapter 2, Salmond and Young

2011). The USP Guidelines can be applied to any kinds of medications, both those prescribed and taken as over-the-counter medicines. The students are also introduced to the idea that the Guidelines can be easily modified to different educational purposes and to evaluating the practice in various community and hospital settings (see Chapters 3 and 7).

From the pedagogic perspective, the patient counselling course is based on the constructive alignment, a pedagogical model established by Biggs (1999). Following this model, the course is designed so that the learning activities and assessment of learning outcomes are aligned with the intended learning outcomes. Instead of focusing only on the substance, memorizing and rote learning (surface learning), students are encouraged to integrate and synthesize information with prior knowledge and to apply knowledge to practical problems and simulated real life situations (deep learning).

Course Design, Content and Teaching Methods

Previous studies show that student-centered, constructive approach to teaching is more effective than traditional behavioristic approach in enhancing students' learning (See Chapter 5). Particularly, acquiring practical skills, such as communication skills, requires students' active involvement: they cannot learn just sitting in the lecture hall and listening to the instructor (Leung et al. 2009). Thus, the teaching methods of our course are designed to consist of a mixture of methods:

- 1) A preliminary exam is designed to assure that students know basic concepts, theories and communication techniques before entering to the role-play period of the teaching. The exam is based on the handbook on patient counselling (Hakkarainen and Airaksinen 2001);
- 2) An introductory lecture (2 hours) is designed to discuss learning objectives and student expectations, as well as to describe the outline of the learning process (Appendix 5);
- 3) A series of interactive lectures (34 hours) is integrated with the role-play sessions and is designed to deepen students' understanding of applying different communication strategies with different kinds of pharmacy customers and medicines users (Appendix 5);
- 4) Role-play sessions with other students performing as simulated patients (4x4 hours per student) are designed to be a platform for putting theory into practice. Students can rehearse their patient counselling skills and receive feedback on their performance. They are given the scenarios beforehand in the beginning of the course so that they can search for pharmacotherapeutic information and design their communication strategies before the role-plays (Mesquita et al. 2010). Each student will receive a videotaped copy of their performance for a more detailed self-evaluation of their strengths and weaknesses in communication.
- 5) Reflective assignments at the end of the course are designed to reinforce understanding of own communication skills and their development needs, and constructing understanding of crucial issues to be discussed with medicine users having different health problems (two written reports that are graded by the instructors).
- 6) Experiential learning on patient counselling skills is designed to continue during the internship periods in the pharmacy (Figure 1). In addition to self-reflective assignments, the preceptors at the internship site are instructed to give feedback (Hyvärinen et al. 2008).

The lecture series consists of three main themes: 1) the theoretical basis of patient counselling and communication in a community pharmacy setting; 2) meeting the needs of different types of customers; and 3) the development of counselling services at the organizational level (Appendix 5).

In role-play sessions, students act both as pharmacists and customers in a classroom that simulates community pharmacy setting (Figure 3, Chapter 3: Figure 1). Students are prepared to perform in any of the scenarios designed for the session (about 10 scenarios per session). The assessment of students' counselling performance is based on self-assessment and feedback from peers and instructors specialized in pharmacotherapy and communications. In each session there are two instructors who moderate discussion and give feedback to the students. Peer feedback is facilitated by feedback cards derived from the USP Guidelines. The feedback cards focus on different aspects of communication and counselling process: 1) Making contact; 2) Assessing customer needs; 3) Asking questions; 4) Relevance of the topics discussed to the customer; 5) Listening; 6) Clarity of counselling; and 7) Summary and review. The role play rehearsals are videotaped so that each student can later analyse one's own performance and write a self-assessment report based on the material.



Figure 3. Communication skills teaching lab simulating a community pharmacy context. The lab has videotaping equipment which has been made invisible to the students to minimize the effect of videotaping on their rehearsal (Source: Kalle Aaltonen).

Student Assessment

As previously described (See Chapter 5), the assessment should be aligned with the course objectives and measure what the course has set to achieve. Referring to our course, assessment is based on a preliminary exam that covers communication theory and principles of patient counselling in a community pharmacy context. Additionally, students' performance is continuously assessed in role-play rehearsals and related self-reflective assignments.

The grading is based on two reflective assignments at the end of the course. First, students conduct a detailed self-evaluation of their patient counselling performance by analyzing the videotaped role-play sessions. The USP Guidelines is recommended to be used as a tool in the analysis to evaluate the structure and content of the session in relation to the patient's condition. The other assignment is for developing a patient counselling guide (a checklist) for a selected condition. The checklist needs to be evidence-based and focused on the key issues to be discussed with the patient concerning his/her medication. Each group of 2-3 students prepare one guide and all the different guides (about 60) are shared through e-learning environment (Moodle) after the instructor has checked appropriateness of their pharmacological and clinical content.

Program Development and Evaluation

The course has been continuously developed and refined based on the feedback and experiences from instructors, practitioners, students, as well as ongoing research in the field. All developments are done with an emphasis on a student-centered approach. As a part of the annual course evaluation in 2007, a core content analysis was conducted among second year students in order to find out what they prioritise as a core content of the teaching module on patient counselling. A questionnaire was given to every student during the last obligatory session of Patient counselling course (n=180; response rate 76%). The students were asked to list five core topics under categories: 1) must know; 2) should know; and 3) nice to know. They were also asked about the most important topics they had learned during the course (open questions without given alternatives).

The most often mentioned topics in the “Must know” list were:

- Principles in patient education and counselling
- Different patient cases and how to counsel these patients
- Question asking techniques
- Skills in self-assessment of performance

Under the “Should know” category the students listed:

- Giving feedback
- Medicines information sources
- Customized counselling
- Medication counselling on prescription and non-prescription medicines

In the “Nice to know” category students prioritized:

- Communication theories
- Counselling practices in different countries
- Consumer medicines information sources
- Guidelines and laws related to counselling

Students’ perceptions were mostly in line with the instructors’ perceptions. The results of the core content analysis have been taken into account in formulating the content and teaching methods of the course. It was found that the core content analysis by students is a useful tool for instructors when they want to customize their teaching and to assess how the students’ learning objectives are met.

Conclusions

Based on the feedback, Patient Counselling course has been perceived as an important part of the undergraduate pharmacy curriculum. The course has been well received by the students and instructors. Particularly, the role-play sessions are highly valued by the students. Additionally, situated learning on site in community pharmacies during the internships is found to support learning. It also improves students’ understanding of the importance of patient counselling and communication skills in their work as pharmacists. A core content analysis by students can be recommended for a systematic tool in course evaluation and development.

References and Recommended Readings

Biggs J. What the Student Does: teaching for enhanced learning. Higher Education Research & Development 1999;18(1).

Hakkarainen T, Airaksinen M. Take the Entire Course – A Patient Counselling Handbook (Kuuri loppuun – lääkeneuvonnan opas). Pharmacy Students' Organization Fortis, Kuopio, 2001 (in Finnish).

Horne R, Weinman J, Barber N, Elliot R, Morgan M. Concordance, adherence and compliance in medicine taking. Report for the National Coordinating Centre for NHS Service Delivery and Organizing R & D (NCCSDO), 2005.

Hyvärinen M-L, Tanskanen P, Katajavuori N, Isotalus R. Feedback in patient counselling training – Pharmacy students' opinions. Patient Education and Counselling 2008; 70: 363-369.

Kansanaho H. Implementation of the principles of patient counselling into practice in Finnish community pharmacies. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, University of Helsinki, 26/2005.

Available at: <http://ethesis.helsinki.fi/julkaisut/far/farma/vk/kansanaho/implemen.pdf>

Kimberlin CL. Communicating with patients: Skills assessment in US colleges of pharmacy. American Journal of Pharmaceutical Education 2006;70(3):Article 67.

Leung F-H, Martin D, Batty H. A Theory-based Curriculum Design for Remediation of residents' communication skills. Medical Teacher 2009; 31: e555-e559.

National Institute for Health and Clinical Excellence (NICE). Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. Clinical Guideline 76, 2009. Available at: <http://www.nice.org.uk/nicemedia/pdf/CG76FullGuideline.pdf>

Mesquita AR, Lyra DP, Brito GC, Balisa-Rocha BJ, Aquir PM, Neto AC. Developing communication skills in pharmacy: A systematic review of the use of simulated patient method. Patient Education and Counselling 2010; 78:143-148.

Puumalainen I, Halonen P, Enlund H, Johnson K, Airaksinen M. Validation of the United States Pharmacopeia (USP) Medication Counselling Behaviour Guidelines. Pharmacy Education 2005a;5:87-96.

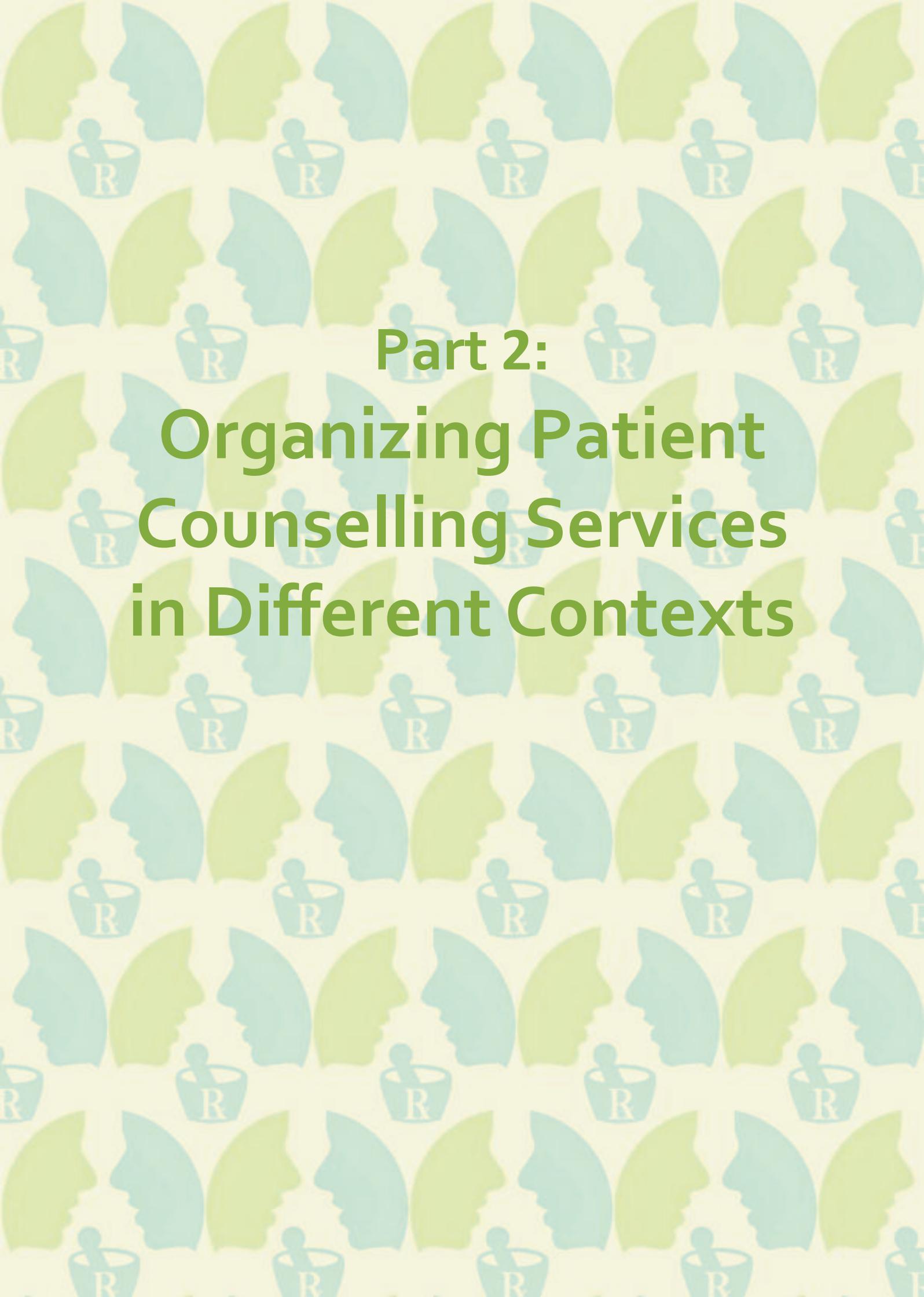
Puumalainen I, Kansanaho H, Varunki M, Ahonen R, Airaksinen M. Usefulness of the USP Medication Counselling Behavior Guidelines. Pharmacy World & Science 2005b;27(6):465-468.

Routasalo P, Airaksinen M, Mantyranta T, Pitkala K. Supporting a patient's self-management. Duodecim 2009;125(21):2351-9 (English summary).

Salmon P, Young B. Creativity in Clinical Communication: From Communication Skills to Skilled Communication. Medical Education 2011; 45: 217-226.

USP Medication Counseling Behaviour Guideline. USP DI update volumes I and II. Pp. 664-75, 1739-48. The United States Pharmacopeia Convention Inc, 1997.

Also available at: Kansanaho 2005 (Appendix 1): <http://ethesis.helsinki.fi/julkaisut/far/farma/vk/kansanaho/implemen.pdf>

The background features a repeating pattern of stylized human profiles in shades of teal and light green, alternating with mortar-and-pestle icons. The profiles are facing right, and the mortar-and-pestles are positioned below them. The text is centered over this pattern.

Part 2:
**Organizing Patient
Counselling Services
in Different Contexts**



Chapter Seven: Organizing Patient Counselling Services in Community Pharmacies

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Objectives of the Chapter

This chapter provides an example of a systematic, long-term development of patient counselling services in an ordinary community pharmacy. The chapter also demonstrates how USP Medication Counselling Behaviour Guidelines can be applied as a development tool at the organizational level. Furthermore, this project illustrates potential for cooperation between academia and community pharmacies which benefits them both in professional development.

In the Mikkeli Otso Pharmacy patient counselling has been an important part of pharmacists' work. Concordance-based medication counselling challenges community pharmacists to encounter their customers as active partners negotiating about self-management of their treatment. To succeed, communication skills and ability to customize the counselling to the customer needs are required.

The Mikkeli Otso Pharmacy is a privately owned Finnish community pharmacy with an annual prescription volume of 130,000 prescriptions. The staff consists of 14 full-time pharmacists and 6 technicians. To implement concordance-based medication counselling practices we conducted a systematic service development project in 2008. We applied USP Medication Counselling Behaviour Guidelines as a learning tool. The Guidelines describe medication counselling as a 4-stage process (Figure 1). This tool was selected, because it is a validated instrument suitable for promoting two-way communication and customer-oriented medication counselling (see Chapter 2).

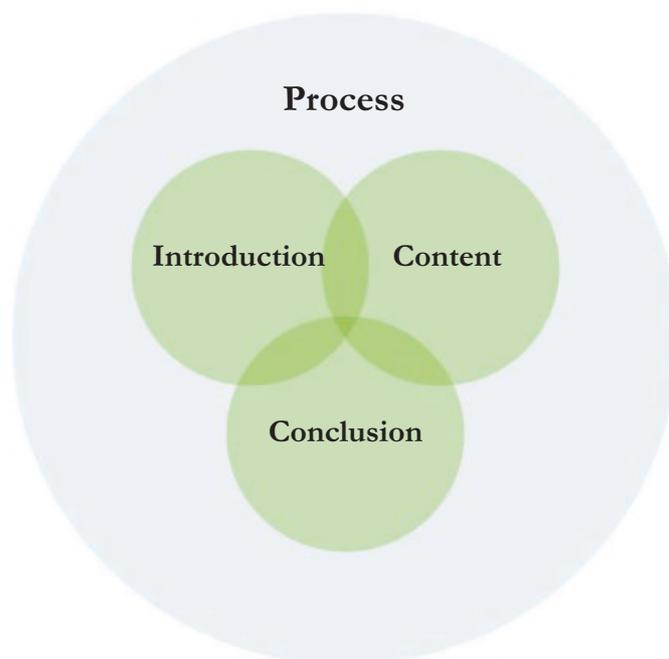


Figure 1. Mikkeli Otso Pharmacy's illustration of the components of a medication counselling session according to the USP Medication Counselling Behaviour Guidelines: Introduction, Content, Process and Conclusion.

Objectives

The aims of the project were:

- To apply new tools to promote concordance and two-way communication with pharmacy customers.
- To assess practical usefulness of the USP Medication Counselling Behaviour Guidelines in developing medication counselling skills of community pharmacists by self-evaluation.
- To assess perceived long-term impact of the training on performance of the pharmacy practitioners.

Outline of the Development Project

The outline of the development project is presented in Figure 2. The process was led by the chief pharmacists of the pharmacy. The project was conducted step-by-step and it was mainly based on reflective in-house training and self-evaluation of patient counselling practices. The self-evaluation occurred at the individual pharmacist's level and at the organizational level. In the

first phase, pharmacists were introduced the principles of concordance and how it reflects to communication with medicine users. The pharmacists were also familiarized with the idea of analyzing a medication counselling session component by component (Figure 1). When the pharmacists had acquired this basic theoretical knowledge they were given a self-evaluation assignment. It applied a modified and simplified version of the assessment tool presented in the USP Medication Counselling Behaviour Guidelines. The summarized results of these self-assessments comprised the core materials for the in-house training sessions and other activities of the project. All the trainings and activities were designed to be interactive and constructive.

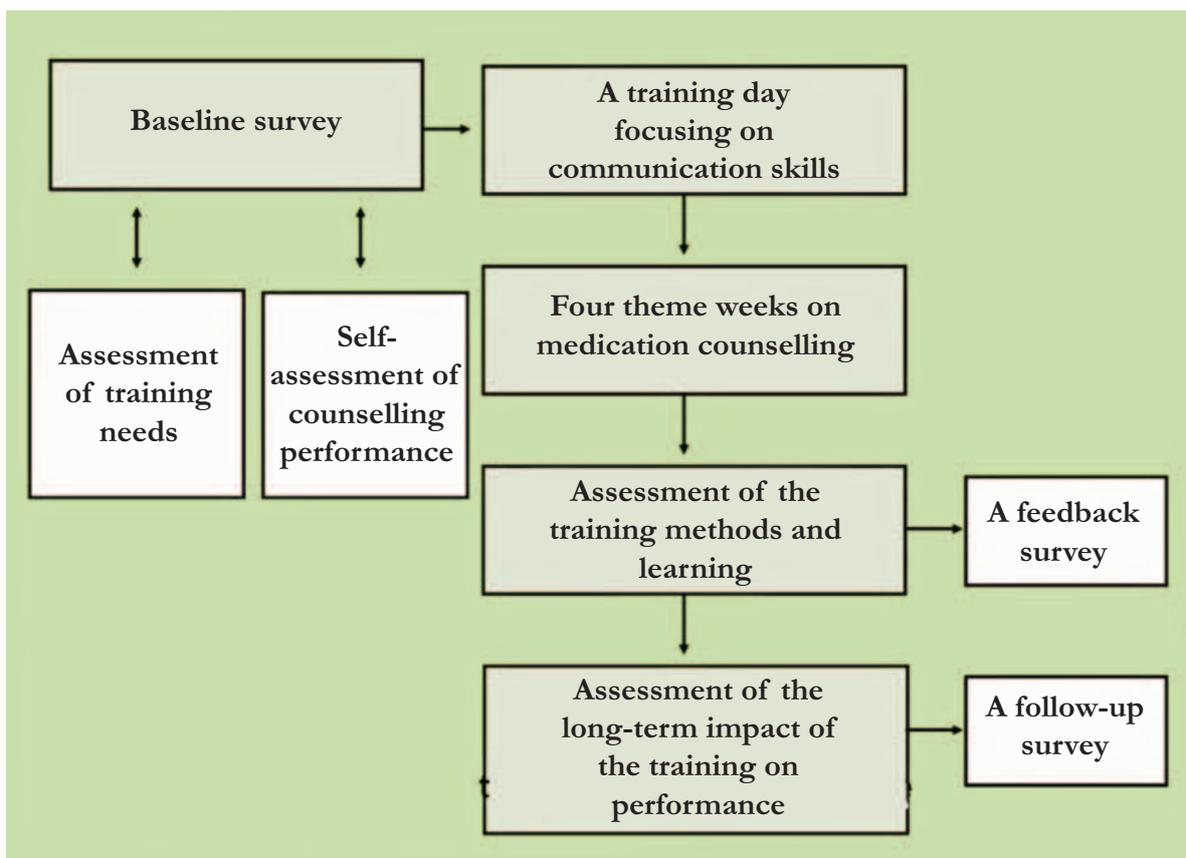


Figure 2. Outline of the pharmacy-based medication counselling development project in the Mikkeli Otso Pharmacy.

Baseline survey

At baseline, a questionnaire was designed to assess pharmacists' attitudes towards medication counselling, as well as their opinion of the main therapy groups in which they required more education. They were also asked to provide their ideas for improving medication counselling practices in their workplace.

The in-house training day

During the in-house training day, the pharmacists were introduced to the USP Medication Counselling Behaviour Guidelines and to the principles of customer-oriented counselling. Before the training day, the pharmacists self-assessed their counselling skills and practices.

The theme weeks

Implementation of the new medication counselling principles was supported by four theme weeks when the counselling practices were trained with real customers (Figure 3). The pharmacists self-assessed their performance with ten prescription customers every week by using the assessment form. After each week, an in-house meeting was arranged where the counselling experiences were discussed.

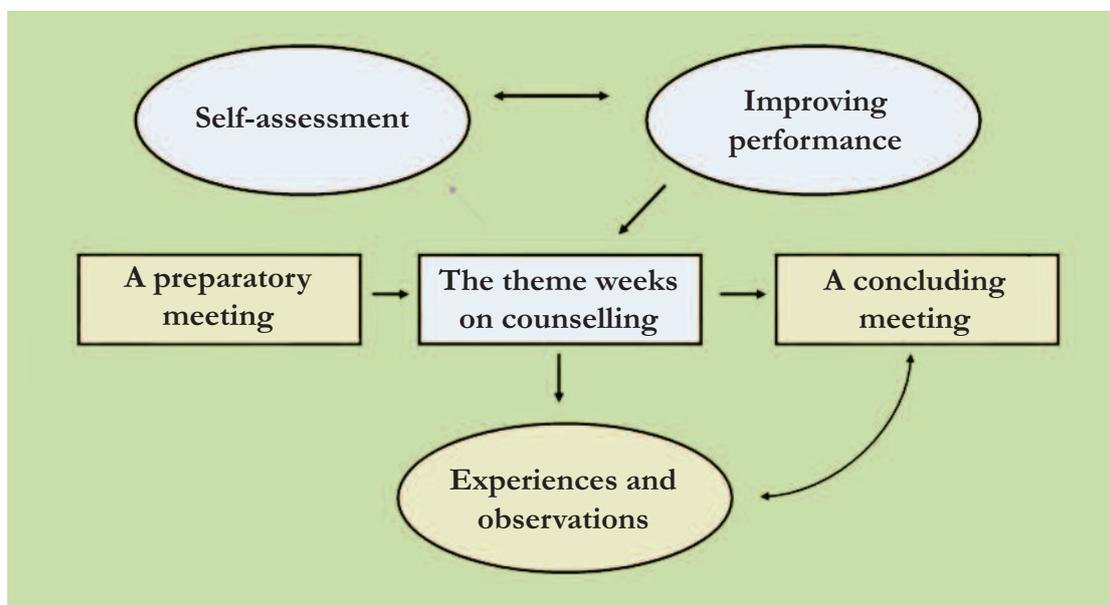


Figure 3. The process of using theme weeks in implementing new medication counselling practices.

The feedback survey

At the end of the development project, pharmacists were asked to assess both their learning during the project and the usefulness of the USP Guidelines to develop the counselling practices.

The follow-up survey

After eight months from the end of the four-week project (Figure 3), a follow-up survey was conducted to assess long-term impact of the training on the medication counselling performance.

Results: Feedback on the in-house training

Pharmacists found medication counselling an essential part of their work and were interested in developing their counselling skills. A regular in-house training on different diseases and their medical treatment, as well as on communication skills was considered important.

Results: The theme weeks

The pharmacists participated in the project very actively. The encouragement to two-way interactive communication during the theme weeks proved the pharmacists the importance of listening and asking open-ended questions during the counselling session.

“Instead of saying: ‘Did the doctor tell you about the medicine?’ I asked: ‘WHAT did the doctor tell you about the medicine?’ In this way, it was easier to get the customer to participate in the conversation.”

"I asked a customer who was buying hydrocortisone cream to tell how she had used the cream. She answered: 'Often and for several years.' I also asked her about the intervals in using the cream, and she exclaimed: 'Intervals, what intervals!' So, we talked a bit more..."

The project feedback

All pharmacists (n=13) considered the step-by-step-approach to learning new counselling practices useful. Many respondents (9 out of 13) thought that the components of a medication counselling process (Figure 1) were easier to adopt by focusing on one theme at a time (e.g., by focusing on creating the contact and assessing customer's needs during the first week, then focusing on evaluating relevance of the counselling content during the second week, and so on).

Open-ended questions were found to be useful in identifying patient needs. The self-assessment of performance turned out to be an appropriate method in developing own counselling skills even though almost all (11 out of 13) perceived it difficult. Accordingly, peer assessment was suggested to be applied in the future by few respondents (3 out of 13).

The follow-up survey

After eight months from the end of the four-week project (Figure 3), every pharmacist (n=11) felt that the project had improved their medication counselling skills. Almost every respondent (10 out of 11) thought that the principles learned during the project were still influencing their counselling practice.

As a long-term impact of the development project on practice, several pharmacists (8 out of 11) told they involve customers more actively in the communication process as medicine users and partners. While motivating and supporting customers with their therapies, the pharmacists (9 out of 11) had started to experience their professional role more significant than before.

Below are some quotations of responses to the follow-up survey question: How do the principles learned during the development project influence your current medication counselling?

"I try to involve the customer in the communication process as a more active partner."

"I try to pay more attention to the way how I ask."

"By listening to customers, it is easier to recognize the possible problems in their treatments."

Conclusions

The USP Medication Counselling Behaviour Guidelines proved to be a useful instrument for learning the principles of patient counselling in a community pharmacy. It seems to be possible to achieve long-term influences on performance from the pharmacists' viewpoint. Open-ended questions and concentration on listening are essential tools in identifying the patient needs. The self-assessment of performance turned out to be appropriate in developing counselling skills.

Practical Implications

By focusing on concordant-style counselling we have been able to maintain our position as one of the biggest pharmacies in Mikkeli even though all the other pharmacies have moved into shopping centers where the natural flow of customers is larger. Today the flow of customers in Otso Pharmacy is four times greater than ten years ago when we started.

Many patients willingly want to do business in Otso Pharmacy. Customers continuously thank us for our customer-oriented medication counselling. While visiting and giving short presentations in local patient associations and retirement clubs, our customer-centered services and interactive way of communication are often mentioned and appreciated. This approach also confirms pharmacists' role in patient care and keeps the work meaningful. Some pharmacists have specialized in asthmatic, cardiac, and diabetes diseases. These specialized community pharmacists train the other staff pharmacists, assist in solving complicated treatment problems and cooperate with other local health care units involved in patient care.

As a conclusion, we can say that changes in medication counselling culture in a community pharmacy can be achieved even by minor practical actions. These can be carried out in an individual pharmacy without big investments, e.g., in external consulting. One of the key factors to success is the commitment and support of the management and the pharmacy owner.

To keep up the professional talents we need to:

- organize regularly in-house training days which are planned to create desired competences
- underline in custom service training the importance of pharmacist's attitude. Pharmacists should learn to make a dialogue, ask open-ended questions and listen to the customer/medicine user. They should stop supposing on behalf of the patients without assessing their situation and medicine taking behaviours.
- establish multi-professional collaboration with the local health care professionals, make agreements on the each ones responsibilities in patient care (particularly with nurses and physicians), participate in common trainings, and have regular meetings with them.

References and Recommended Readings

FIP, IPSF. Counselling, Concordance and Communication – Innovative Education for Pharmacists. Eds: Wuliji T, Airaksinen M. International Pharmaceutical Federation (FIP) and International Pharmaceutical Students' Federation (IPSF) 2005. Available at: <http://www.fip.org/files/fip/PI/Counselling,%20Concordance,%20and%20Communication%20-%20Innovative%20Education%20for%20Pharmacists.pdf>

Hakkarainen T, Airaksinen M. Take the Entire Course – A Patient Counselling Handbook (Kuuri loppuun – lääkenneuvonnan opas). Pharmacy Students' Organization Fortis, Kuopio, 2001 (in Finnish).

Kansanaho H. Implementation of the principles of patient counselling into practice in Finnish community pharmacies. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, University of Helsinki, 26/2005. Available at: <http://ethesis.helsinki.fi/julkaisut/far/farma/vk/kansanaho/implemen.pdf>

Puumalainen I. Development of instruments to measure the quality of patient counselling. Doctoral dissertation. Faculty of Pharmacy, University of Kuopio, Finland, 2005. Available at: <http://urn.fi/URN:ISBN:951-27-0053-0>

TIPPA Project. Final Report, 2004 (see description of the project in the following references of this chapter: Kansanaho 2005 and Puumalainen 2005).

TIPPA Project. Make TIPPA an everyday practice! Quality management handbook on patient counselling services with practical measures and instruments (Tippa tavaksi! Lääkeneuvonnan laatuopas ja mittaristo, in Finnish). Eds. Puumalainen I, Kause J, Airaksinen M. The Association of Finnish Pharmacies, 2002.

USP Medication Counseling Behaviour Guideline. USP DI update volumes I and II. Pp. 664-75, 1739-48. The United States Pharmacopeia Convention Inc. 1997.

Also available at: Kansanaho 2005 (Appendix 1): <http://ethesis.helsinki.fi/julkaisut/far/farma/vk/kansanaho/implen.pdf>

Westerling A. Information Technology Development Needs in Community Pharmacies: A Strategic Approach. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, The University of Helsinki, 2011. Available at: <https://helda.helsinki.fi/handle/10138/28196>

This chapter is based on a presentation at the FIP Congress in Basel in 2008 (Community Pharmacy Section).

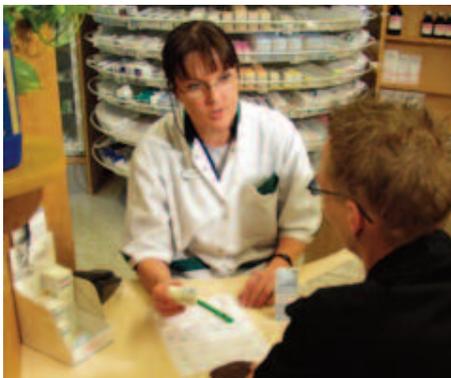


Figure 4. Pharmacist's dispensing station in a Finnish community pharmacy assuring privacy and having internet access to electronic dispensing record, evidence-based information databases and the drug-drug interaction screening system (Westerling 2011). Source: The Association of Finnish Pharmacies



Chapter Eight: Pharmacy Patient Care Practice: Focus on Communications in the Theoretical Framework of Pharmaceutical Care

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Objectives of the Chapter

This chapter provides a succinct overview of core skills and knowledge needed for effective patient centered communication in an advanced clinical pharmacy practice. Strong communication skills facilitate the gathering and assessment of accurate medication histories. This chapter will help you understand how to:

1. Use a patient care practice framework to guide your patient interactions. Elements include:

- a. how to open and develop a relationship with a patient
- b. how to complete an integrated assessment, care plan, and education session with a patient
- c. how to close a patient-interaction and plan for follow-up

2. Select and integrate communication techniques as appropriate for each individual situation. Examples include: active listening, empathetic responding, probes, summarizing, questioning, and non-verbal communication skills.

3. Foster curiosity to understand and appreciate your patients' unique life experience.

The Pharmacy Patient Care Practice Framework evolved from concepts arising from Patient-Centered Care (Mead and Bower 2000), Pharmaceutical Care (Cipolle et al. 2004), Shared Decision Making (Makoul and Clayman 2006), and the Calgary-Cambridge Communication Model (Kurtz et al. 2003). Elements of each were combined and situated within the patient-pharmacist context (Figure 1).

This framework was not designed to prescribe how pharmacists should practice or communicate with patients. It is a resource to explore how effective patient-pharmacist communication comes from an understanding of the individual pharmacist, pharmacy profession, and patient. Pharmacists should use their own experience to guide them in deciding how to incorporate elements of this framework into their patient care practice.

This framework recognizes that both patients and pharmacists are not blank slates when they communicate. They bring perspectives, knowledge, and experiences that shape and create the shared interaction. Pharmacists are able to select their practice philosophy which may include a belief in shared decision making, patient centred care, pharmaceutical care, or many others.

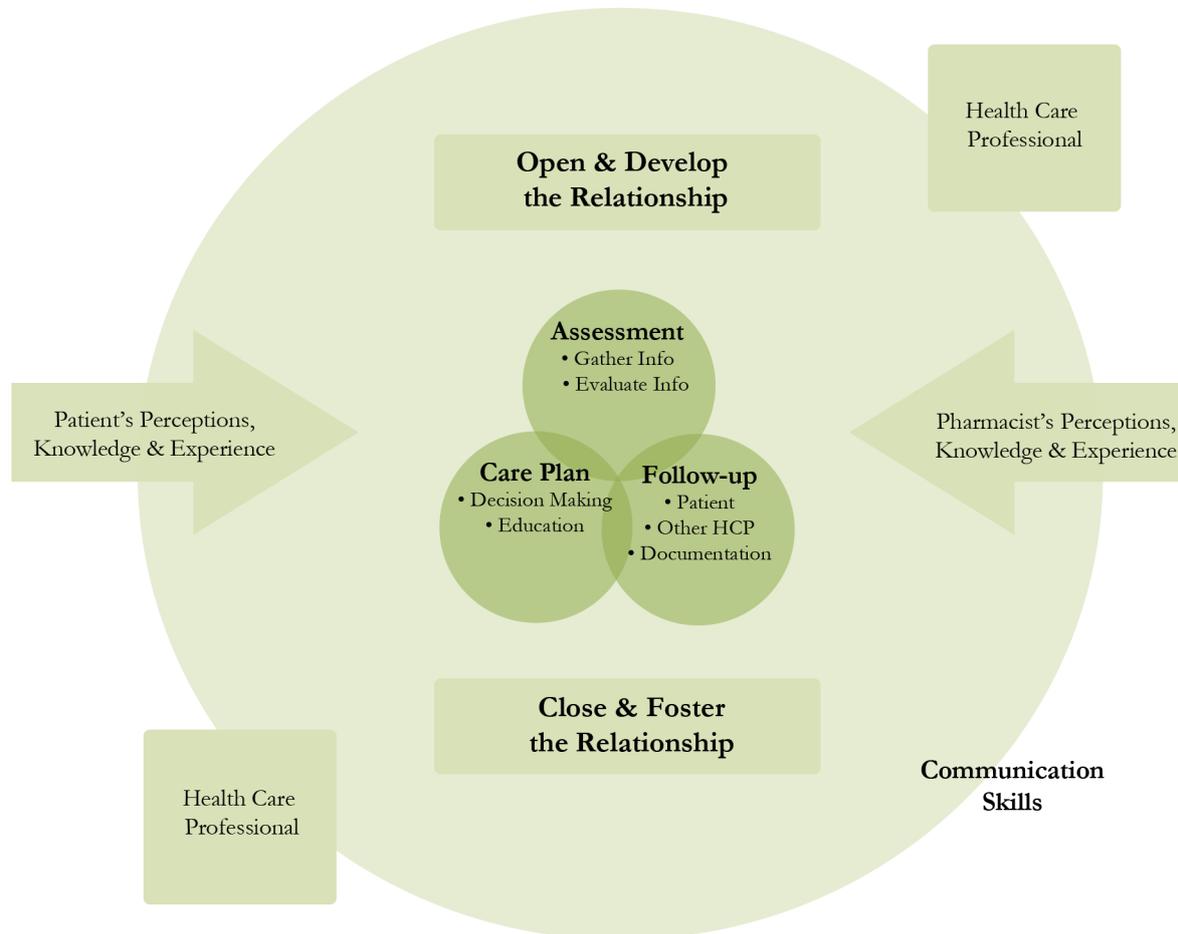


Figure 1. The Pharmacy Patient Care Practice Framework

Open and Foster the Relationship

The patient-pharmacist relationship has been recognized as part of pharmaceutical care since its inception (Hepler and Strand 1990). The term therapeutic alliance is often used to describe this relationship where intimate knowledge is shared within professional boundaries (Cipolle et al. 2004). Pharmacists may realize several benefits to establishing relationships with patients. First, pharmacists may experience the professional benefit of understanding and connecting with their patients. Second, patients may have an increased willingness to share details of their medical histories allowing the pharmacist to better optimize medication therapy. Third, patients who perceive their health care provider as caring are less likely to sue for malpractice (Hojat 2007).

The skills required to start patient relationships draw on a practical knowledge of social interactions. First, pharmacists should take care to identify themselves and their role. Many patients cannot distinguish pharmacists from technicians in community pharmacies and from other health care providers in hospitals. Pharmacists should introduce themselves at each new interaction until the patient knows the pharmacist by name. When possible, use a patient's name to display recognition of the individual. As appropriate, take a moment for personal conversation (i.e., small talk) to demonstrate genuine interest and concern for the individual; although this should not be the focus of the time together.

As the pharmacist moves from pleasantries to the primary focus on the interview, explain the purpose and the time required. Patients may not be accustomed to answering questions from a pharmacist and may have already provided a medication history to another health care professional. An introduction may shape patients' expectations.

"I would like to take 10 minutes to ask you a few questions to make sure you get the most from the medication. As a pharmacist, I will focus on details of your medicines and how they are working for you. Is this a good time?"

In the next three sections, this chapter discusses the three core activities in pharmaceutical care: assessment, care plan, and follow-up. In practice these activities may occur simultaneously despite their sequential presentation in this chapter. Figure 1 uses overlapping circles to represent the integrated nature of assessment, care plan, and follow-up.

Assessment

Assessment consists of both gathering and evaluating patient information to optimize an individual's medication therapy. While this section will focus on gathering information from a patient, pharmacists should consider multiple data sources such as patient charts, pharmacy profiles, electronic health records, other health care providers, and care givers. If feasible, pharmacists should review these sources first to use patient time effectively.

Assessment: Gather Patient Agenda

The patient's agenda is their list of concerns, problems, or questions. Soliciting the patient's agenda at the start of an interview demonstrates a willingness to listen and focus on the patient's needs. It may also prevent the patient from mentioning an important clinical issue at the end of an interview.

The process is straightforward. Pharmacists can ask patients what questions they have and probe until they have a complete list. Pharmacists should avoid "jumping" to answer the first patient response. Solicit a complete list from the patient, by asking "what else?" until no further new issues arise. Active listening should be demonstrated by facing the patient, keeping eye contact, and suspending other thoughts to genuinely listen to what the patient has to share.

Pharmacists are not required to answer patient's questions immediately. Often, it is best to complete the patient assessment and then provide a potentially more accurate and comprehensive answer. Once the patient has identified his/her concerns, pharmacists should summarize the patient's agenda and suggest their own items. Subsequently, the patient and pharmacist may jointly identify items to cover in the current visit and plan how other items may be addressed in future.

Box 1: Agenda Setting

Pharmacist: Before I get started asking you about your medications, what questions or concerns would you like to discuss?

Mr Smith: Well, I am worried that the heart meds are getting a bit expensive.

Pharmacist: Yes, they can be expensive. We can look at that. What else?

Mr Smith: I am not sure the heartburn pills are doing their job. I still get the burning sometimes.

Pharmacist: Thank you for telling me, that is important. What else?

Mr Smith: Hmm. My blood pressure is still high. The doctor says if it is still high at the next visit in six months I may have to take another pill. I don't want that.

Pharmacist: You sound frustrated.

Mr Smith: You bet, it never seems to end.

Pharmacist: It does seem like that at times. I would like to help you with that today. [Pause] What else would you like to discuss?

Mr Smith: That's all.

Pharmacist: Thanks. Today, we only have 15 minutes. I need to gather a full list of the medicines you are taking. I would like to address the heartburn right away. Then when you are in again next week, we can finalize you blood pressure options including costs. Is that all right with you?

Mr Smith: Seems reasonable to me.

The interview starts....

Assessment: Gather Medical History

The pharmacists' focus is medication; still an understanding of a medical history will allow you to check for untreated conditions, disease-drug interactions, and unnecessary medications. Pharmacists tailor their assessment to gather pertinent information for each situation. In community practice, it may suffice to ask "What medical conditions do you have?" for a refill prescription. During a medication review, there may be more time for an in-depth review. One technique is a head to toe history, a health care professional asks about medical conditions starting with the head, neck, chest, and continuing down the body to feet. A second method is a review of systems whereby a health care professional systematically explore medical conditions based on systems (e.g., respiratory, gastrointestinal, circulatory).

Patients may choose to share both joyful and tragic history. The pharmacists can share recognition of these feelings through empathetic techniques (Coulehan et al. 2001). In response to a person's feelings, pharmacists can identify the patient's feeling and communicate their recognition. Pharmacists can communicate their recognition by 1) reflecting the content "Sounds like you think you have appendicitis and that you might need to go into the hospital", 2) identifying and calibrating the emotion "Sounds like you were frightened when you found that lump" or 3) legitimizing the emotion: "A lot of people feel angry about getting diabetes".

After communication recognition, it may be helpful to request and accept correction. A pharmacist may simply ask, “Is that right?” The patient and pharmacist may wish to explore this emotion and the surrounding situation. Other times it is appropriate to move to the next topic.

Pharmacists can use empathic responding without feeling strong empathic feelings and vice versa. The skills of empathic responding will help pharmacists connect with their patients. Empathic responding does not require the pharmacist to agree with a patient and will not “cure” the patient. It may start them working through a problem which may require the support of other health care professionals.

Assessment: Gather Medication History

A medication history involves two main tasks: gathering a list of all medications and exploring the patients’ use and understanding of each medication. To gather a list of medications, pharmacists may start with a broad question, such as “Tell me what medications you are using.” Follow-up with specific probes to uncover if they are using: non-prescription medications, herbals, alternative medications, vitamins, patches, creams, inhalers, drops, liquids, and injectable medicines. It can be helpful to ask about recent changes to medications. Ask each probe separately as responding to a list is a cumbersome task. The medication and medical history may be taken simultaneously. For example, pharmacists may ask about any conditions involving the head and then medications for that condition. In addition, pharmacists may use a medication list from another source as a starting point, by updating it with the patient.

The second task in a medication history is to explore the patient’s use and understanding of each medication. This may be combined with gathering the list of medications if desired. The three prime questions (3PQs) is an efficient method to gather the required information about each medication by asking about patients’ understanding of medication’s purpose, directions, and monitoring. This patient-focused technique has been widely promoted in USA pharmacy schools and has appeared in the Canadian pharmacy practice literature (Janke 1997, Anonymous 2002). For each medication, pharmacists can ask questions (Figure 2) to assess what the patient was told or knows about new medications or how the patient has been using existing medications (i.e., refills).

Purpose

“What is this medication for?”

It is important that patients understand why they are taking the medication. This information may also help you tailor the information you provide to patients.

Directions

New: *“What were you told about how to take your inhaler?”*

Refill: *“How do you take this medicine?”* or *“How you fit this medicine into your day?”*

This question is useful for assessing if the patient understands the medications (for new medications) and to assess how patients are taking medication at refills.

Monitoring

New: *“How can you tell if it is working?”*

Refill: *“How is your blood pressure?”* or *“What have you noticed since starting this pill?”*

You should ask about two key areas of monitoring: Benefits and Side Effects.

New prescriptions: This question will assess patients’ understanding of and help you to monitor medication benefits and side effects.

Figure 2. Assessment of Medication Use: Three Prime Questions (Anonymous 2002).

Assessment: Evaluate your Information

Pharmacists should continually assess the amount and appropriateness of the patient information they have gathered. Cipolle et al. (2004) suggest that an assessment should allow a pharmacist answer the following questions:

1. Is each medication indicated?
2. Is each medication effective?
3. Is each medication safe?
4. Is the patient able to/willing to use each medication?
5. Does the patient have an untreated condition?

These questions were presented to help pharmacists establish if they have sufficient patient information. If pharmacists answer “not sure” to any of these questions they require more information from the patient, other sources of patient information, or reference materials. If pharmacists answer “no” to any questions, they have identified a drug-related problem. Additional information on the clinical decision making process is available in Cipolle et al. (2004, a new edition in 2012).

Care Plan

In the context of patient and pharmacist communication, this chapter will focus on the process of creating a care plan and patient providing education to effectively implement this plan.

Care Plan: Shared Decision Making

Shared decision making refers to the process in which the pharmacist and the patient explore options together and choose the most appropriate treatment plan. Pharmacists not only help patients make decisions about whether to start a medication, but also what time to take medications, how to combine medications, how to manage side effects and which non-prescription medicine to select. Makoul and Clayman (2006) described an integrated model of shared decision making which identifies key steps that can be summarized as: explain the problem, solicit patient participation, discuss options, and agree on a decision. A discussion between Mrs. Jones and her pharmacist about the management of a stomach upset from her pain medication will be used to illustrate shared decision making model.

1. To start, the pharmacist must clearly explain the problem. “Mrs. Jones, I believe your pain medication is causing your stomach upset.”
2. The pharmacist should solicit patient participation and assess patient’s preferences for information and decision making. To continue our example, “Would you like to hear a variety of options about how to manage that side effect or should I give you my recommendation?”
3. Based on the patient’s preferences, the pharmacist should present options and discuss pros and cons of each. This should incorporate and evaluate both the patient and pharmacist perspective. Mrs. Jones may share her opinions about medication effectiveness, willingness to change medications, and ability to manage a new and potentially more complex medication regime. The pharmacist may share both the clinical practice guidelines as well as advice based on clinical practice experience.

4. Finally, both parties should explicitly agree on care plan. In pharmacy practice, often pharmacists give advice, but a plan is not articulated. The pharmacist may ask, “Based on what we have talked about here today, what do you think will work best for you?” If the patient has requested the pharmacist make a recommendation, the pharmacist may still ask the patient if this plan is acceptable. Once a decision has been made, patient education may be required to help the patient successfully accomplish the care plan.

Care Plan: Education

Pharmacists are a trusted source of medication information and patients expect accurate information. Education is a part of the patient care process and should occur after assessment of a patient’s medication therapy. Patient education may be formal or informal. Several studies suggest that patients most often want information on adverse effects, basic instructions, and drug interactions (e.g., Krueger and Hermansen-Kobulnicky 2011). This section will help pharmacists find an effective approach to provide that patient education.

First, pharmacists should adjust the type and amount of education for each patient’s needs. Wherever possible, prioritize information and focus on key messages. Patients can only remember a limited number of points.

Unless the pharmacist is certain the patient has a high level of health literacy (ability to understand and use health information), the pharmacist should exercise caution when educating the patient. Techniques may include focusing on key messages, using a “teach back” or “show me” technique to check understanding, soliciting questions in an open manner, using patient-friendly educational materials to enhance interaction, and communicating numbers effectively (i.e., choose 1 in 10 over 10%) (Kripalani and Weiss 2006, Apter et al. 2008).

Pharmacists are one of many sources of information about health and medications. Linking to other sources may help patients to integrate knowledge. It is optimal to use a combination of written and verbal directions when possible. The pharmacist can draw attention to key areas of written materials, and while patients may not remember a long list of adverse effects, they can refer back to a fact sheet as required.

Despite best intentions, patients may not take in all the information they need to safely use a medication. Checking for patient understanding (i.e. teach back) is an underused communication skill that has the potential to reduce medication misuse and harm to patients. A pharmacist may say, “Just to make sure that I covered all the information, can you tell me how you are going to take this medication?” Correct any misinformation and assess the patient understanding again to make sure the patient can accurately describe how to take the medication.

Follow-up

Follow-up is an integral part of pharmaceutical care (Cipolle et al. 2004). Follow-up may be as simple as asking the patient to call with concerns or letting the patient know that the pharmacist will check to see how the medication is working at the next visit or refill. A complex case may require a follow up phone call to the patient. Patients may not be familiar with pharmacist follow-ups, so it may be best to explain the purpose of the call and find out the best time and

method of follow-up. Follow-up may also require documentation of patient care in the pharmacy profile, medical chart, and/or electronic health records in order to ensure continuity of care between health care professionals.

Close and Foster the Relationship

Taking time to close the interaction helps to foster the patient pharmacist relationship. The pharmacist may summarize key information, ask for further questions (i.e. “What additional questions do you have?”), invite the patient to call if questions or concerns arise, and close the encounter. Patients should feel comfortable coming back to the pharmacist with concerns and issues.

Summary

Communication is woven throughout the pharmaceutical care process. Attention to the patient’s preferences and needs in the assessment, care plan, and follow-up can help to both improve patient care and increase pharmacists’ professional satisfaction. Pharmacists should explain the patient care process to patients at the start and throughout an interview to ensure that patients are comfortable and able to engage in the interview to the extent they desire. Integrating communication techniques such as active listening, empathetic responding, and probing into the patient care process helps pharmacists optimize medication therapy for patients.

References and Recommended Readings

Anonymous. Pharmacist-patient consultation program (PPCP-1): An interactive approach to patient consultation. New York, NY: Pfizer Inc., 2002.

Apter AJ, Paasche-Orlow MK, Remillard JT, et al. Numeracy and communication with patients: They are counting on us. *Journal of General Internal Medicine* 2008;23:2117-2124.

Cipolle R, Strand L, Morley P. *Pharmaceutical care practice: The clinician's guide*, 2nd edition. McGraw-Hill Medical, 2004.

Cipolle RJ, Strand LM, Morley P. *Pharmaceutical Care Practice: The Patient-Centered Approach to Medication Management*. 3rd edition. McGraw-Hill Medical, 2012.

Coulehan JL, Platt FW, Egner B, et al. "Let me see if I have this right...": Words that help build empathy. *Annals of Internal Medicine* 2001;135(3): 221-227.

Haidet P, Paterniti DA. "Building" a history rather than "taking" one: A perspective on information sharing during the medical interview. *Archives of Internal Medicine* 2003;163:1134-1140.

Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. *American Journal of Hospital Pharmacy* 1990;47(3):533-543.

Hugman B. *Healthcare Communication*, Chapter 11. London: Pharmaceutical Press, 2009.

Hojat M. *Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes*. Philadelphia: Springer; 2007.

Janke KK, Tobin C. Initiating practice change: negotiating goals of therapy with patients. *Canadian Pharmacist* 1997; 130: 24–7.

Kassam R, Volume-Smith CI. Informed shared decision making: An exploratory study in pharmacy. *Pharmacy Practice* 2008; 6(2): 57-67.

Kripalani S, Weiss BD. Teaching About Health Literacy and Clear Communication. *Journal of General Internal Medicine* 2006;21(8):888-890.

Krueger JL, Hermansen-Kobulnicky CJ. Patient perspective of medication information desired and barriers to asking pharmacists questions. *Journal of the American Pharmaceutical Association* 2011;51:510-519.

Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: Enhancing the Calgary-Cambridge guides. *Academic Medicine. Journal of the Association of American Medical Colleges* 2003;78(8):802-809.

Makoul G, Clayman ML. An integrative model of shared decision making in medical encounters. *Patient Education and Counseling* 2006; 60(3), 301-312.

Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine* 2000;51:1087-1110.

Tindall WN, Kimberlin CL, Beardsley RS. *Communication Skills in Pharmacy Practice*. 5th edition. Philadelphia: Lippincott, Williams & Wilkins, 2007.



Chapter Nine: Application of the Pharmaceutical Care Model to a Clinical Hospital Setting

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In many countries, pharmacists are commonly seen on the different wards of the hospital, working clinically with the other healthcare professionals. The following examples illustrate some of the roles in patient communication that a pharmacist may experience in the hospital setting, which goes beyond patient counselling.

For the most part, patients who are admitted to the hospital are short term patients and they turnover relatively quickly; therefore, it is especially important for pharmacists to communicate to the patients effectively in the short time. The pharmaceutical care model becomes particularly helpful as a guide for the patient communication process for clinical pharmacists in the hospital.

Assessment

For any patient, it is important to assess their situation, and separate the acute issues from the chronic issues. There are a lot of sources of information in the hospital setting, including the patient's chart, laboratory data, and other healthcare professionals. It is important to gather as much information as possible prior to speaking with the patient and his or her family. They may already be overwhelmed with the situation and are less willing to speak to a pharmacist with a number of questions. Therefore, after the information gathering phase, determine what information is missing. Confirm the patient's medical history matches with the medications that the patient uses by ensuring the patient has an indication for every medication. Verify the signs and symptoms in a systematic method, such as the head-to-toe method, and determine if these signs and symptoms align with the medical condition or if it is an adverse effect of the therapy.

Remember to slow down as you enter a patient's room. This small space is the patient's private domain and please enter it as if you are entering someone's private bedroom. Introduce yourself as the pharmacist every time you enter the room. Many healthcare providers enter and exit the patient's room throughout the day and to a patient you all appear similar. Be mindful of any procedures that the patient may require during the hospitalization and always ask the patient for their permission before speaking with him or her. Try to keep the questioning to a minimum

and allow the patients to express their thoughts and concerns. It may be useful to start a patient interaction by asking the patient what concerns or questions he or she may have about the medications. Be empathic with the patient and this will allow the pharmacist to gather more information for the assessment of situation. In the hospital setting, it is possible to speak with the patient multiple times for the assessment phase. Always end each conversation by asking the patient if there is anything that you, as the pharmacist, can provide assistance with. This will provide a basis for the information and education that will be provided to the patient.

Care Plan

After assessing and prioritizing the drug-related problems, it is important to communicate the alternatives with the healthcare team and the patient. The pharmacist in the hospital acts as a liaison between the healthcare team and the patient for all medication needs. Patients should always be a part of the decision making process and always use language that the patient can understand by avoiding medical jargon. For ideas on plain language, you may consider reviewing the following plain language thesaurus (http://depts.washington.edu/respcare/public/info/Plain_Language_Thesaurus_for_Health_Communications.pdf). Once the patient has decided on the therapy, it is important to communicate the patient's needs and decision to the healthcare team.

For patients with multiple changes to their therapy, it is important to break down the information into manageable chunks. One of the advantages to hospital practice is the patient is always there in his or her room and the pharmacist can always return later to provide additional information.

Provide counselling information to the patient as well for any new therapies or changes. Ensure the patient understands the indication, directions, and the monitoring parameters associated with the medications. Consider using an open ended technique such as a teach-back to ensure patients truly do understand a care plan. If necessary, provide written information as well.

Follow Up

When the patient is ready for discharge, provide discharge counselling to the patients. This will include going through all of the medications that the patient will be using when they return home. It is especially important to highlight any new medications and any changes to medications prior to admission. Remember to ensure patient understanding through open-ended questions. Sometimes, this process is especially helpful when this information is also provided to the family and/or caregiver. If necessary, create a medication calendar that will instruct the patients when to take the medications throughout the day. This is extremely useful for elderly and paediatric patients with multiple medications. Remind the patient to follow up with his or her general practitioner and community pharmacist if needed.

It is important to close the communication loop by thanking the patient and checking to see if the patient has any further concerns. Although the pharmacist may never encounter the patient again, it is important for the patient to feel comfortable to speak with the pharmacist and understands the importance of this communication process.

Always inform other healthcare professionals of what information and resources were provided to the patient by documenting in the patient's chart. This will allow for a more seamless process when the patient is discharged from the hospital. It may be useful to contact the patient's community pharmacy and inform the community pharmacist of the changes to the patient's medical therapy.

The communication process in the hospital setting goes beyond the patient counselling and it must involve other healthcare team members. Not only is there verbal communication, but there is often a need for written communication as well. When focusing the communication using the pharmaceutical care model, the practice becomes more patient-oriented and is tailored to what the patient's needs. This is especially useful in the hospital setting as every patient is very different and will have different needs from the pharmacist.



Chapter Ten: Applying Technology in Medication Counselling

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Objectives of the Chapter

This chapter will introduce to applying technology in medication counselling and organizing telephone and Internet –based patient counselling services. Information services provided by the University Pharmacy (Owned by the University of Helsinki) in Finland and 24-hour medicines information center in Canada are used as examples. The following aspects are discussed:

- History and background of medicines information centers and services
- Utilization of telephone and the internet –based medicines information services
- Recommendations for establishing and providing these services
- Practical tips for communicating online with customers.

Introduction

Consumer health and medicines information sources have diversified along with the new information technology (Council of Europe 2007, European Commission 2007). According to previous research, community pharmacies and pharmacists are ranked high as a source of medicines information (Sleath et al. 2003, Närhi and Helakorpi 2007, Närhi 2007, Pohjanoksa-Mäntylä et al. 2010). However, consumers seek information from multiple sources, increasingly including the Internet (Närhi and Helakorpi 2007, Närhi 2007, Pohjanoksa-Mäntylä et al. 2010).

The Internet facilitates easy access to medicines information, but challenges both consumers and health care professionals with regard to the quality and reliability of information. Additionally,

people may experience difficulties in searching for and evaluating this information. These issues have led the drive to incorporate the Internet and e-mail into routine practice in health care and to develop professional medicines information sources, such as the 24 hour drug information centers providing information via telephone and e-mail. The increasing number of community pharmacies offer medicines information and email medication counselling services (e.g., ask-the-pharmacist) on their websites (Zehnder et al. 2004, Holmes et al. 2005, Pohjanoksa-Mäntylä et al. 2008).

The aim of this chapter is to provide evidence and practical information on establishing and offering telephone and internet-based medicines information services. Information services provided by the University Pharmacy (owned by the University of Helsinki) in Finland and a 24-hour medicines information center in Canada are used as examples.

Medicines information centers (MIC, also known as drug information centers or drug information call centers) are medicines information services where people can call or otherwise contact health care professionals and inquire about medicines. Those centers can be located in hospitals, medical centers, pharmacy schools or in community pharmacies.

Medicines information service (synonymous to drug information services) refers to a formal unit with appropriate resources and professional competencies engaged in the provision of medicines information. This includes also medicines information call centers and e-mail medication counselling services provided by pharmacies (Hall et al. 2006, Närhi 2006).

Medicines Information Centers as Pioneers in Applying Technology to Medication Counselling: Whom and How to Serve?

The first medicines information centers were established in the 1960s in the United States (US) and in the 1970s in the United Kingdom (UK) (Rosenberg et al. 1995, Marking and Stachnick 1996, Rosenberg et al. 2009). Since then, they have offered evidence-based medicines information to health care professionals via telephone-based question-answer services, and more recently, also by applying new information technologies, such as the Internet and email. In addition to health care professionals, they increasingly offer services to consumers (Mullrove and Vlcek 1998). According to internationally published studies, as well as experiences in Finland, medicines information centers and services are needed and actively utilized by consumers (Bouvy et al. 2002, Pohjanoksa-Mäntylä et al. 2008).

Since 1996, the University Pharmacy (UP) has run a national call center in Finland where people can call for information 24 hours daily. At the same time, UP started an email medication counselling service that was first provided via the question-answer forum in the health-portal (www.verkkoklinikka.fi), and later via the own website (www.yliopistonapteekki.fi). The number

of inquiries has grown steadily over the period of operation: the total number of telephone inquiries was approximately 273 000 and emails more than one thousand in 2010. Previous studies indicate that this type of service has multiple functions and for multiple parties: authorities, health care professionals and consumers. Consumers need services to obtain information about pharmacy services, prices and reimbursements schemes of their medicines, but also to know more about therapeutic effects of their medicines. The majority of medicines-related inquiries concern prescription medicines, antimicrobials and psychotropic medicines being the most commonly inquired (Pohjanoksa-Mäntylä et al. 2008). The most of the therapeutic inquiries relate to interactions, dosage regimens, and adverse drug reactions of medicines (Appendix 6). There are similar research findings from other countries (Bouvy et al. 2002). Also the quotation of the pharmacist working in the 24 hour pharmacist phone-line in Canada confirms the same:

“Some of the calls that I have gotten include questions about whether an OTC product will interact with certain prescription medications, adverse drug reactions from medications, and OTC recommendation and dosing. These are typically questions that customers will ask you during your regular shift in a community pharmacy. The phone line just provides people a way to get in touch with health care professionals (nurses, pharmacists, etc) when they are not able to see or contact their regular pharmacists directly. As we can get calls from all over the province, I believe that it is especially very useful for people living in out-of-town areas where some pharmacies close earlier, so that they can still obtain medical information from health professionals whenever they need to.”

Previous studies indicate that there may be some patient groups that most likely benefit from the telephone, and particularly the Internet-based medicines information sources and services (Bouvy et al. 2002, Pohjanoksa-Mäntylä et al. 2008, Pohjanoksa-Mäntylä et al. 2010). Those patient groups include people living in rural areas, adolescents and people with mental disorders. People with mental disorders, including depression have found more likely than people with other long term illnesses to use the Internet for health and medicines related information (for example Sleath 2003, Haviland et al. 2003, Powell and Clarke 2006, Pohjanoksa-Mäntylä et al. 2010). People who fear stigmatization may seek information anonymously, preferring online or telephone-based information to information provided face-to-face by their health care providers. The potential for anonymity and the opportunity to ask questions without face-to-face contact make the Internet also a valuable source of medicines information when intimate matters are concerned (Pohjanoksa-Mäntylä et al. 2009). The Internet may be an important source of additional information when specific or unexpected information needs arose during the course of treatment.

Communicating with Consumers Online

The concepts of empowerment and patient-centeredness emphasize the need to be responsive to patient needs and preferences. Patients have indicated that they would value the possibility to communicate by email with their health care providers, including pharmacists (Pohjanoksa-Mäntylä et al. 2009). Additionally, the email use between healthcare providers and patients is recognized as a mean to enhance medication counselling and communication. However, previous studies suggest that pharmacies as well as other health care professionals have been slow in adopting the email as a tool to communicate with patients. In Finland, for example, approximately 30% of the community pharmacies had a website and 94% of those provided the opportunity for email medication counselling in 2005 (Pohjanoksa-Mäntylä et al. 2009).

Along with the increasing number of pharmacies selling medicines and providing pharmacy services via the internet, the email medication counselling is likely to become more common. Therefore, pharmacists need to have knowledge and skills on how to provide counselling via email.

Communicating with patients via the email is somewhat different than communicating face-to-face or via telephone. This is due to the fact that there is no opportunity to non-verbal communication to help you express yourself. Communicating clearly on the email without creating misunderstandings is more challenging than face-to-face in the pharmacy. Minor-sounding issues, such as the order of the presentation of medicines information may significantly affect patients' judgments of the medication (Neto et al. 2002). For example, there is some evidence that people rate their medication more favorably when positive information (for example "This medication is effective") is presented before negative information ("This medication may cause some adverse drug reactions") (Neto et al. 2002).

Those providing email medication counselling should have protocols to define professional practice standards for their services. These protocols may include both practical tips for email communication, but also issues to protect patient safety and privacy. Communication guidelines for email medication counselling provided by American Medical Association (AMA), modified with the experiences from the University Pharmacy medicines information center suggest:

- Answer consumer inquiries as clearly, concisely and politely as possible.
- Follow netiquette. Use clear headlining. Use terms in a common form. Favor clear and simple sentences. Check also corrects spelling. Do not use capital letters, as it refers shouting in email. Go straight to the point and focus on the key issues in a consumer inquiry.
- Avoid anger, sarcasm, criticism, and libellous references to third parties in messages.
- When email messages become too lengthy, notify patients to come in to pharmacy or call them.
- Base your response to reliable and good quality information sources. Add references where your customer can find additional information if appropriate.
- Append a standard block of text to the end of email messages to consumers, which contains the full name of the answerer, contact information, and reminders about security and the importance of alternative forms of communication for urgent matters.
- Establish your email medication counselling policy, including the expected email response time, in your website. Suggest that customers phone or visit their pharmacy if they require a more rapid response. Exercise caution when using e-mail for urgent matters. Send a response message to inform customer if completion of request takes more time than expected.
- Inform customers who processes and answers messages.
- Inform patients about privacy issues with respect to email.

How to Establish a Good Quality Medicines Information Center or Service?

All practicing pharmacists are obliged to ensure that any service they provide is of appropriate quality. In order to meet this obligation, both the International Pharmaceutical Federation (FIP 2005) and The Council of Europe Expert Group on Safe Medication Practices (2007) have listed issues that should be taken into account when establishing and developing a medicines information center or service. Those issues include: staff with proper education, databases, equipment, process documentation and standard Operating Procedures (SOPs).

Firstly, it is important to assure that there are enough competent pharmacists answering customer inquiries. Based on the experiences from recent interview study among the University Pharmacy staff working in the medicines information center, pharmacists should have good knowledge on pharmacology, biopharmaceutical issues, and nutrition (Lindberg and Seppinen 2011). Additionally, good oral, written and online communication skills are needed. All new staff members should have necessary interdisciplinary orientation before working independently in the medicines information center. Pharmacists should also have ongoing training to keep up their clinical knowledge, such as new medicines and current care guidelines. Both the orientation and in-house training should include practical assignments on how to answer different type of customer inquiries via telephone and email, with peer evaluation of the answers. The staff at the medicines information center should have access to standard textbooks, common medical and clinical pharmacology journals and different type of international and national databases (Appendix 7). Currently, access to the Internet and Internet-based databases has become increasingly important. Additionally, practicing pharmacists should have knowledge and skills how to use all facilities and equipment effectively, as highlighted in a process description from the Canadian 24/7 pharmacist phone line:

“The pharmacist working from 5 pm onwards, logs in to the phone-line and the computer system. Pharmacists participating in this program were trained before hand with the use of the phone line and the computer system, and how to direct or forward to calls to other health professionals when necessary. As soon as we're logged in, we will start receiving calls, and calls that are missed are forwarded to other participating pharmacies. These are calls were triaged and forwarded to health professionals that will best be able to address the call, e.g. pharmacists, nurses, Poison control, etc.”

Summary

Medicines information centers and services applying modern information technology are increasingly important both for the healthcare professionals and consumers. They are valued because of the access to information round the clock quickly and reliably. For the healthcare professionals, including pharmacists, they offer a possibility to meet the needs of special consumer groups that may not have been otherwise met. Pharmacists should proactively design new technology-based information services and encourage their customers to use accurate and reliable online medicines information sources. For this purpose, pharmacy students and practicing pharmacists should continuously develop their competency and skills in communicating with their customers online, using electronic databases and appraising the quality of information. These all are also strategic issues for the pharmacy profession for being involved in patient care.

References and Recommended Readings

- Bouvy ML, Van Berkel J, De Roos-Huisman CM, Meijboom RHB. Patients` drug information needs. A brief view on questions asked by telephone and on the Internet. *Pharmacy World & Science* 2002; 24: 43-45.
- Council of Europe. Expert Group on Safe Medication Practices. Creation of a better medication safety culture in Europe: Building up safe medication practices, 2007. Available at: http://www.coe.int/t/e/social_cohesion/socsp/medication%20safety%20culture%20report%20e.pdf
- European Commission. DG Enterprise and Industry. Draft report on current practice with regard to provision of information to patients on medicines products, 2007. Available at: http://ec.europa.eu/enterprise/pharmaceuticals/pharmacos/docs/doc2007/2007_04/draft_infopatients2007_04.pdf
- FIP, International Pharmaceutical Federation. FIP Pharmacy Information Section: Requirements for Drug Information Centres, 2005. Available at: <http://www.fip.org/files/fip/PI/RequirementsforDrugInformationCentres.pdf>
- Hall V, Gomez C, Fernandez-Limos F. Situation of drug information centers and services in Costa Rica. *Pharmacy Practice* 2006;4:83-87.
- Haviland M, Pincus H, Thomas H. Type of Illness and Use of the Internet for Health Information. *Psychiatric Services* 2003;54:1198.
- Holmes ER, Desselle SP, Nath DM, Markuss JJ. Ask the pharmacist: an analysis of online drug information services. *Annals of Pharmacotherapy* 2005;39:662-667.
- Lindberg J, Seppinen J. E-mail medication counselling at the University Pharmacy. Unpublished, 2011.
- Markind J, Stachnik J. European drug information centers. *Journal of Human Lactation* 1996;12:239-242.
- Mullerova H, Vlcek J. European drug information centers – survey of activities. *Pharmacy World & Science* 1998;20:131-135.
- Neto A, Chen T, Chan J. “Order effect” in the provision of medication information. *Medical Journal of Australia* 2002;176 (8): 401-402.
- Närhi U. 2006. Drug information for consumers and patients – a review of the research. Publications of National Agency of Medicines 1/2006.
- Närhi U. Sources of medicine information and their reliability evaluated by medicine users. *Pharmacy World & Science* 2007;29:688-694.
- Närhi U, Helakorpi S. Sources of medicine information in Finland. *Health Policy* 2007;84:51-57.
- Powell J, Clarke A. Internet information seeking in mental health: population survey. *British Journal of Psychiatry* 2006;189:273-277.
- Pohjanoksa-Mäntylä M. Medicines information sources and services for consumers - A special focus on the Internet and people with depression. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, The University of Helsinki, 2010. Available at: <http://urn.fi/URN:ISBN:978-952-10-6128-8>
- Pohjanoksa-Mäntylä M, Bell JS, Närhi U, Helakorpi S, Airaksinen MS. Is the Internet replacing health professionals? A population survey on sources of medicines information among people with mental disorders. *Social Psychiatry and Psychiatric Epidemiology* 2011; 46(5):373-379.

Pohjanoksa-Mäntylä M, Saari JK, Närhi U, Karjalainen A, Pylkkänen K, Airaksinen MS, Bell JS. How and why do people with depression access and utilize online drug information: A qualitative study. *Journal of Affective Disorders* 2009;114(1-3):333-339.

Pohjanoksa-Mäntylä M, Kulovaara H, Bell JS, Enäkoski M, Airaksinen MS. E-mail medication counselling services provided by Finnish community pharmacies. *Annals of Pharmacotherapy* 2008;42(12):1782-1790.

Pohjanoksa-Mäntylä M, Antila J, Eerikäinen S, Enäkoski M, Hannuksela O, Pietilä K, Airaksinen MS: Utilization of a community pharmacy operated national drug information call-center in Finland. *Research in Social and Administrative Pharmacy* 2008;4(2):144-52.

Rosenberg J, Fuentes R, Cynthia F. Pharmacist-operated drug information centers in the United States. *American Journal of Health-System Pharmacy* 1995;52:991-996.

Rosenberg JM, Schilit S, Nathan JP, Zerilli T, McGuire H. Update on the status of 89 drug information centers in the United States. *American Journal of Health-System Pharmacy* 2009;66:1718-1722.

Sleath B, Wurst K, Lowery T. Drug information sources and antidepressant adherence. *Community Mental Health Journal* 2003b;39:359-368.

Zehnder S, Bruppacher R, Ruppacher H, Hersberger KE. Swiss Community Pharmacies' on the Web and Pharmacists' Experiences with E-commerce: Longitudinal study and Internet-based questionnaire survey. *Journal of Medical Internet Research* 2004;6:e9.



The Medicines Information Call Center at the University Pharmacy, Finland employs approximately forty pharmacists who answer to over 200 000 phone calls concerning medications annually (Source: The University Pharmacy, Finland).





Chapter Eleven: Organizing Patient Counselling Services in Developing Countries

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Objectives of the Chapter

This chapter highlights the need for pragmatic and culturally acceptable counselling procedures in developing country settings to impact efficiently on patient outcomes.

Recommendations are also made for efficient counselling of individuals and the general public for the prevention, treatment and control of malaria, a major public health problem in sub-Saharan Africa and some other areas.

Background

Appropriate counselling of patients on their medications and disease conditions are acknowledged as important pharmaceutical care activity that is likely to impact favorably on the quality of use of medicines and other therapeutic or preventive interventions for optimal health (McGivney et al. 2007). In many low-income countries and in particular in sub-Saharan Africa, significant proportion of the population may be poor, illiterates or may have had only basic education, and thus may not be well informed about issues related to health and well-being (FIP and IPSF 2005). In addition, most of the health problems that are often seen at the hospitals/clinics, medicine outlets, and those that account for hospitalisations, deaths and disabilities may be related to poverty, poor hygiene, environmental sanitation, inappropriate use or abuse of medicines or simply due to ignorance of existing resources for good health (FIP and IPSF 2005, Sanders et al. 2005). Thus many of the health problems in developing country settings may be

preventable, treatable or easily controlled. What is needed is appropriate message that is well delivered to inform the identification, access and correct utilization of the available resources and interventions for health. However, practical challenges that may possibly affect the ability to overcome such hurdles in developing country settings could be low availability of highly skilled and well educated health providers. Others may be inequitable distribution of health facilities and resources for health, unaffordability of essential health services, and ultimately poor access to the available interventions and resources for health. This situation may be different from that prevailing in the industrialised or high income countries, where the level of education of the public may be high, and the greatest burden of disease may be chronic/non-communicable diseases that are common in the elderly.

The skills, strategies and approaches required to counsel patients in developing country settings for them to assimilate and use the information to achieve desired health outcomes may thus vary from that in industrialized country settings. However the principles and quality of information that must be given to the client/patient during counselling to achieve the objectives may be similar. In other words, no matter the setting in which counselling services are being delivered, service providers may have to establish appropriate and culturally acceptable health or therapeutic alliance with the patients, to facilitate concordance during counselling and ensure that medications and health advice are well taken and correctly used to impact on health (Sanders et al. 2005).

Health/Medicine Use Challenges in Developing Country Settings and Counselling Strategies

In many tropical and developing countries in Africa, Asia and Latin America, the health problems responsible for the highest morbidity and mortality, and also those that consumes significant portion of the health budget are infectious and parasitic diseases (WHO 2008). Among these, HIV/AIDS, malaria and tuberculosis (TB) together are believed to account for over 6 million deaths every year. Other infections that may contribute to the burden of disease include respiratory, urinary tract and gastro-intestinal infections. The later are usually linked to poor hygiene and improper management of the environment with related health risks (Drager et al. 2006, WHO 2008).

Evidence available suggests that the infectious diseases mentioned above may be avoided or minimized drastically through the delivery and utilisation of proven effective interventions, which must be clearly communicated to the people for uptake (Lugada et al. 2010). Appropriate education and communication strategy, therefore, needs to be adapted and utilized to create awareness about the diseases, their impact on health, interventions available and how they could be applied to prevent or properly treat the diseases when one get them. An example is education of the public and individuals about health, health care and efficient utilization of anti-infectives for complete cure of infections. This could be delivered through drama, popular music or using celebrities and other people of influence in society such as academicians, Members of Parliament, traditional rulers and renowned sportsmen and women adored by the public (Lugada et al. 2010, Ghana News Agency 2011). Such activities could be done at public gatherings like churches for those that are passionately religious, large community meetings and during durbar of chiefs and queens with the public in attendance. Community based radio and television programmes on health, healthy lifestyles, attitudes and behaviours could also be initiated and moderated by

various cadres of health experts including pharmacists and related practitioners for the desired impact (Lugada et al. 2010, Ghana News Agency 2011).

Inappropriate use/abuse of medicines has been well documented in developing countries and is also believed to account for a number of drug-related morbidities (Lugada et al. 2010, Smith 2009, Buabeng 2010). Example of such disorders includes gastrointestinal ulcers from the abuse of steroids and non-steroidal anti-inflammatory analgesics and resistance to common anti-infectives following inappropriate use (Buabeng et al. 2008). Strategies that could be utilized to improve the quality of medicines use include one-on-one counselling of patrons that visit medicine outlets of both public and private health facilities. Patrons need information about rational use of the dispensed medicines for best outcomes. Focus of counselling must also be on appropriate practices and behaviours for infectious disease prevention, treatment and control. In addition, both individuals and the general public could be advised on appropriate health seeking for therapeutic services once they suspect sickness, and ensure efficient use of medications for treatment and prevent re-infection (Buabeng et al. 2008, Buabeng 2010). As mentioned earlier, whatever counselling strategy utilized, must be pragmatic, appropriate and culturally acceptable so that any advice and medications offered would be properly utilized to achieve therapeutic objectives, prevent treatment failure and avoid the selection and spread of resistant strains of the parasitic infections (FIP and IPSF 2005, McGivney et al. 2007, Lugada et al. 2010).

Lifestyle-Related and Non-Communicable Diseases

Over the last decade lifestyle related and non-communicable diseases like hypertension and type II diabetes have also been found to be increasing in prevalence in developing countries, including sub-Saharan Africa (Kadiriri 2005). Appropriate counselling for individuals and the general public should include the need for healthy lifestyles, such as increasing physical activity/exercise, adequate rest, and good nutrition and reduced consumption of foods that are rich in saturated fatty acids and cholesterol. A counselling intervention of this nature, if it is well delivered, could affect the prevalence of these disorders negatively and reduce the risks of disease progression, complications and deaths. Counselling on efficient use of medications would also ensure adherence and appropriate utilization for optimal management/control, leading to improved quality of life of the patients/sufferers of the diseases.

Counselling Recommendations for the Prevention, Treatment and Control of Malaria

Prevention and control of malaria

Individuals and the general public need to have a good understanding that malaria is only transmitted from human to human through the bite of female anopheline mosquitoes. Therefore, an appropriate barrier between the mosquitoes and humans would mean no malaria infection. Such a message could strengthen the resolve of individuals and the public to contribute to good environmental management and destroy the breeding sites of malaria borne mosquitoes. Again, efficient communication of the evidence that sleeping under insecticide treated bed nets (ITNs) would induce an effective barrier and reduce malaria related deaths and morbidity is important. This would encourage pregnant women, lactating mothers and parents whose kids are five years

and below to take up and use this intervention for optimal health outcomes. Likewise, the adoption and scale use of indoor residual spraying (IRS) to reduce mosquito populations. Available evidence still suggests that the use of ITNs and other effective tools, like indoor residual spraying for malaria control are still being underutilized in many malaria endemic countries (FY-2004 Child Survival and Health Grants Program 2001, Buabeng et al. 2010, Wylie 2010).

Prompt recognition and treatment of malaria infections

The above mentioned intervention strategy has been found to be one of the most cost effective for malaria control in malaria endemic countries. Therefore, uptake of the information from appropriate counselling services on this would save a lot of lives and decrease disability adjusted years lost to malaria and its complications in developing countries. This would also gain significant savings on the health budget.

One of the biggest problems with malaria control in the past is inefficient use of medicines and the development of resistant parasites to almost all available medicines, except perhaps the artemisinin-combination products (Kingwell 2009). There are even fears that resistant strains have emerged on the Thai-Cambodia Border (Bate and Hess 2009). Focus of counselling services in medicine outlets of health facilities and pharmaceutical care should therefore be on how to ensure that effective malaria medicines are properly utilized to effect cure and halt progression of disease to complicated illness and fatalities.

Summary

In conclusion, pharmaceutical care and counselling services in developing country settings should encompass various skills, techniques and approaches, so that the services could induce the desired response in the recipients for optimal patient outcomes. This must be noted when developing or reviewing curricula/modules for the training and practices of pharmaceutical service providers in developing countries.

References and Recommended Readings

- Bate R, Hess K. Affordable medicines facility for malaria. *Lancet Infectious Diseases* 2009; 9:396-397.
- Buabeng KO. The role of the pharmaceutical sector in malaria control in Ghana. Doctoral dissertation. *Dissertations in Health Sciences* 4/2010a, University of Eastern Finland, 2010.
Available at: http://epublications.uef.fi/pub/urn_isbn_978-952-61-0015-9/urn_isbn_978-952-61-0015-9.pdf
- Buabeng KO, Duwiejua M, Matowe LK, Smith F, Enlund H. Availability and choice of antimalarials at medicine outlets in Ghana: The question of access to effective medicines for malaria control. *Clinical Pharmacology and Therapeutics* 2008;84: 613-619.
- Buabeng KO, Matowe LK, Smith F, Duwiejua M. Knowledge of medicine outlets' staff and their practices for prevention and management of malaria in Ghana. *Pharmacy World & Science* 2010; 29:25-33.
- Drager S, Gedik G, Dal Poz MR. Health workforce issues and the Global Fund to fight AIDS, tuberculosis and malaria: An analytical review. *Human Resources for Health* 2006;4:23.
- FIP, IPSE. Counselling, concordance and communication: Innovation for Education of Pharmacists. pp. 6-4, 2005.

FY-2004 Child Survival and Health Grants Program (CSHGP); Understanding malaria prevention and control in rural Cambodia: A formative research study. Available at: http://www.redcross.org/www-files/Documents/International%20Services/file_cont7349_lang0_3038.pdf

Ghana News Agency (GNA) 2011; NORST embarks on Health education in Northern Region communities. Accessed on 4th June 2011 at: <http://www.modernghana.com/news/336037/1/norst-embarks-on-health-education-in-northern-regi.html>

Kadiri S. Tackling cardiovascular disease in Africa: will need much more than just imported measures from more developed countries. *British Medical Journal* 2005; 331:711-712.

Kingwell K. Antimalarial drugs: Double whammy. *Nature Reviews Drug Discovery* 2009; 8:1038.

Lugada E, Millar D, Haskew J, et al. Rapid Implementation of an Integrated Large-Scale HIV Counselling and Testing, Malaria, and Diarrhea Prevention Campaign in Rural Kenya. *Plos one* 2010; 5:8 e12435.

McGivney MS, Meyer MS, Duncan-Hewitt W, Hall DL, Goode JR, Smith RB. Medication Therapy Management: Its Relationship to Patient Counselling; Pharmaceutical Care. *Journal of the American Pharmaceutical Association* 2007;47(5):620-628.

Sanders DM, Todd C, Chopra M. Confronting Africa's health crisis. More of the same will not be enough. *British Medical Journal* 2005; 331:755-758.

Smith F. Private local pharmacies in low and middle-income countries: a review of interventions to enhance their role in public health. *Tropical Medicine & International Health* 2009;9:655-663.

WHO. World Health Statistics 2008. Available at: <http://www.who.int/whosis/whostat/2008/en/index.html>

Wylie BJ, Hashmi AH, Singh N et al. Availability and utilisation of malaria prevention strategies in India. *BMC Public Health* 2010;10:57.

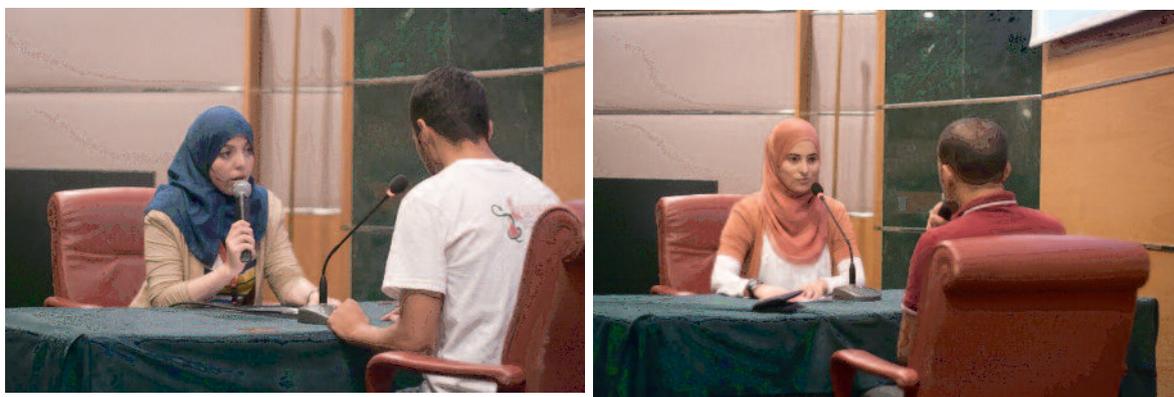
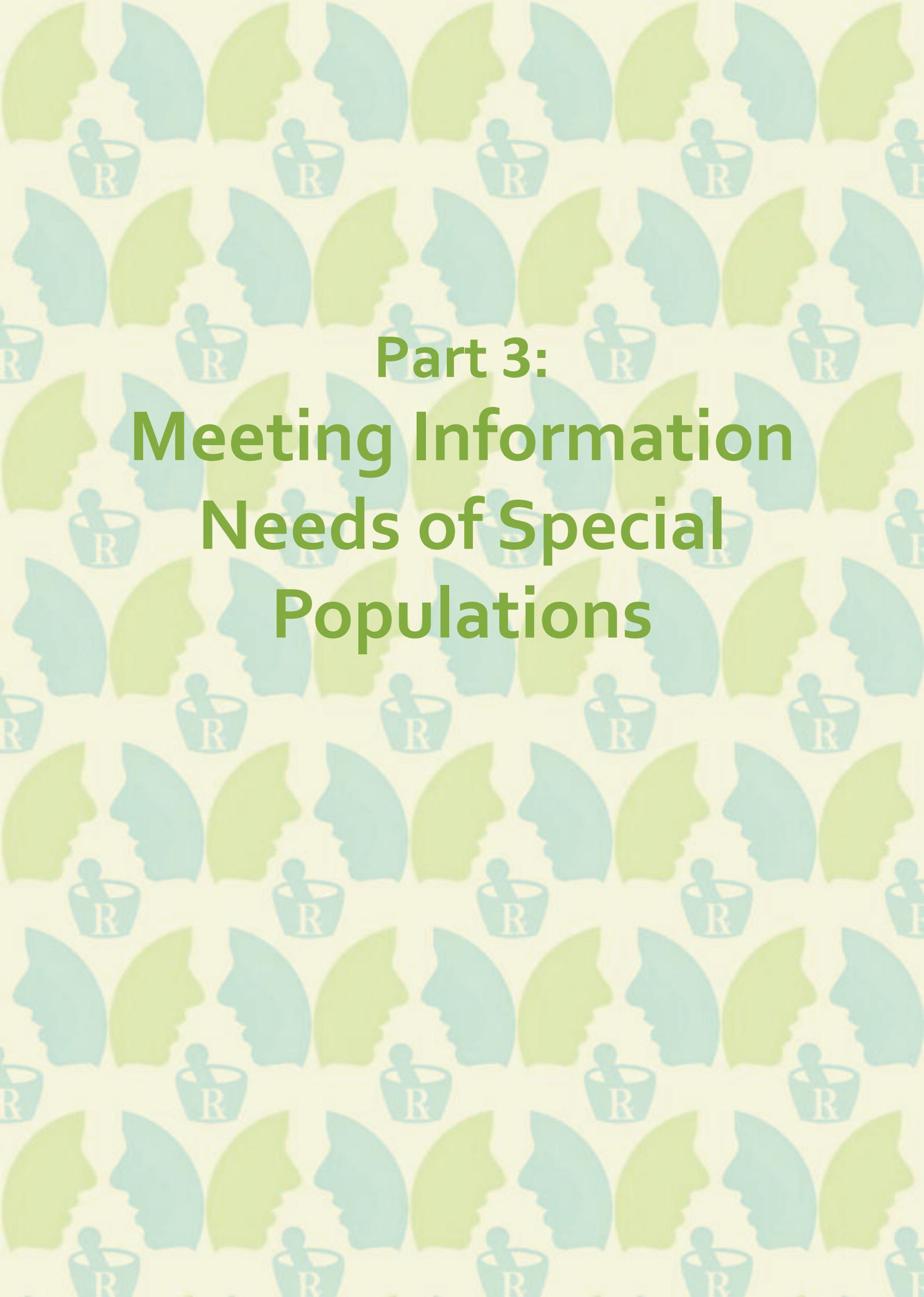


Figure 1. The concept of patient counselling is relatively new in many parts of the world. Students are now taking the initiative to expand their communication and patient counselling skills. In July 2012, the 1st IPSF African Pharmaceutical Symposium was held in Algiers, Algeria and 25 participants challenged themselves in the Patient Counselling Event. An Algerian and a Tunisian pharmacy students participating in the Patient Counselling Event at the 1st IPSF African Pharmaceutical Symposium (Source: Saddek Hamlaoui).

The background features a repeating pattern of stylized human heads in profile, alternating between light green and light blue. Below each head is a small icon of a mortar and pestle, also in the same color scheme. The text is centered over this pattern.

Part 3:
**Meeting Information
Needs of Special
Populations**



Chapter Twelve: Counselling Children - Future Medicine Users

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Objectives of the Chapter

The aim of this chapter is to

- show that children in different ages vary in their cognitive development, which have to be considered when counselling children about medicines
- encourage pharmacists to take an active role in communicating directly with children about their medications, and to go to local schools to give medicine education
- give practical tips for communicating with children about their medications

Medicine use is a common activity for all people at some point of life. Also children use medicines widely. Thus, it should be obvious that rational medicine use should be taught to children before they are granted any independent responsibility for medicine use. However, this is not the case. In fact, medicine education is rarely included in school health curricula worldwide. Lack of medicine education may not be the reason, but research has shown that problems are common when medicating children. Poor adherence has been found among children as well as among adults, knowledge about medicines is poor, and attitudes toward medicines may be overly cautious - even fear has been reported. Thus, there is a clear need to educate children about how to use medicines rationally.

Medicine education may be seen as a co-operation between children, parents, teachers, and health care professionals. School health education should focus on general principles of medicine use, while health care professionals focus on medicine use by individuals (Hämeen-Anttila 2006). Parents perform as examples for their children of using medicines in everyday life (Bush et al. 1999). This chapter focuses on the health care professionals' role in communicating with children about their medications.

In 1998, The United States Pharmacopeia developed a position statement “*The ten guiding principles for teaching children and adolescents about medicines*” (Bush et al. 1999) (Table 1). Furthermore, in 2001 the International Pharmaceutical Federation (FIP) adopted a statement of principle “*The responsibility and role of the pharmacist in teaching children and adolescents about medicines*” (International Pharmaceutical Federation 2001). These statements emphasize not only that pharmacists should communicate directly with children about their medicines, but also that the proper use of medicines should be included in school health education. Thus, there is a clear consensus within the pharmacy profession worldwide that children should be taught about medicines.

Table 1. Ten guiding principles for teaching children and adolescents about medicines: A position statement of the US Pharmacopeia¹ (Bush et al. 1999)

1. Children, as users of medicines, have a right to appropriate information about their medicines that reflects the child’s health status, capabilities, and culture.
2. Children want to know. Health care providers and health educators should communicate directly with children about their medicines.
3. Children’s interest in medicines should be encouraged, and they should be taught how to ask questions of health care providers, parents, and other caregivers about medicines and other therapies.
4. Children learn by example. The actions of parents and other caregivers should show children appropriate use of medicines.
5. Children, their parents, and their health care providers should negotiate the gradual transfer of responsibility for medicine use in ways that respect parental responsibilities and the health status and capabilities of the child.
6. Children’s medicine education should take into account what children want to know about medicines, as well as what health professionals think children should know.
7. Children should receive basic information about medicines and their proper use as a part of school health education.
8. Children’s medicine education should include information about the general use and misuse of medicines, as well as about the specific medicines the child is using.
9. Children have a right to information that will enable them to avoid poisoning through the misuse of medicines.
10. Children asked to participate in clinical trials (after parents consent) have a right to receive appropriate information to promote their understanding before assent and participation.

¹Recognizing that children of the same age vary in development, experience, and capabilities, these principles do not specify children’s ages. Medicines include prescription medicines, non-prescription medicines, herbal remedies, and nutritional supplements such as vitamins and minerals.

How and When to Communicate With Children of Different Ages?

Communicating directly with children at the level they can understand is not an easy task. Children not only have different experiences of being ill and using medicines, but their cognitive thinking processes are also qualitatively different than those of adults. All these points need to be taken into consideration when discussing medicines with children.

According to Piaget's cognitive development theory, thinking develops through different stages from infancy through childhood to adolescence (Piaget 1932). The sequence of development is the same for all individuals; however, the rates at which individuals develop cognitive skills vary. It is noteworthy, that sometimes even adults may not be able to think on the most advanced stage: One needs to have interest and motivation on the topic at hand. The stages are sensory motor stage (birth to 2 years); preoperational stage (2 to 7 years); concrete operational stage (7 to 12 years); and formal operational stage (12 years to adulthood). Table 2 shows features of each of the stages and suggestions how the cognitive level of the child may be taken into consideration when communicating with children about medicines. More examples of how to take into consideration the cognitive development of the child can be found from literature (e.g., Yoos 1988, O'Brien and Bush 1993, Sleath et al. 2003, Hämeen-Anttila 2006, Bush and Hämeen-Anttila 2009).

If cognitive development is taken into account as described in Table 2, it is possible to communicate about medicines even with children under 7 years. If the child is expected to engage in independent medicine use, as are many chronically ill children, e.g., children with asthma or diabetes, counselling is even more important. Research shows that American children as young as 5 years perceive themselves as active participants in their medicine use and report they are more autonomous in using medicines than their mothers indicate (Bush and Davidson 1982, Bush et al. 1985). Research from different countries has shown that after age 12 years independent medicine use increases considerably (Bush et al. 1985, Rudolf et al. 1993, Sloan and Vessey 2001, Hämeen-Anttila et al. 2005). Thus, there should be education about the rational use of medicines before children become adolescents and are using medicines independently.



The age of children and adolescents is important to take into account when communicating with them about their medications (Source: The University Pharmacy, Finland).

Table 2. The stages of cognitive development according to Piaget’s cognitive development theory (based on Piaget 1932)

Stage (age, years ¹)	Typical features	Example how to discuss with children at different stages about medicines
Sensory motor (0–2)	Little connection to objects outside the self.	No learning about medicines can occur.
Preoperational (2–7)	Cannot understand cause and effect Considers only single aspect of a situation Magical thinking predominant Egocentricity Wants to please the adult and answers readily “yes” to questions	Avoid yes/no questions Ask about previous experiences (egocentric child is pleased to tell you) Discuss any concerns the child raises about the previous experiences of medicine use, e.g., bad taste Give only 1–2 messages, without cause and effect explanations
Concrete operational (7–12)	Thinking becomes logical and systematic Can understand cause and effect, and multiple aspects of a situation Can solve problems Thinking is still very concrete and based on own experiences	Explain the purpose of each medicine the child needs to use, e.g., an asthmatic child who needs to use control and relief medicines Use concrete examples when explaining medicine use to the child
Formal operational (12–)	Capable of hypothetical and abstract thinking Typical for adolescents: Invincibility fable: feeling that one will never be harmed. Falsely secure in the belief in own immunity which explains a lot of teen risk taking. Personal fable: belief that own life and feelings are unique. Imaginary audience: typical fantasies about how others react to one’s appearance and behaviour.	Concrete patient counselling as to adults Be nonjudgmental, keep discussion confidential Counsel in private place Remember that adolescents may be embarrassed easily, even when discussing very common medicines such as painkillers. Explain carefully that the questions you ask are necessary to help you choose the correct medicine. Notice that the adolescent may be inexperienced in how to behave in a pharmacy.

¹The age ranges are crude approximations. Children of the same age vary in development, experience, and capabilities. Furthermore, the rates at which individuals develop cognitive skills vary.

Practical Tips for Communicating with Children about Their Medications

Table 3 provides some hints you may try when encountering children and counselling them in the pharmacy. However, children are seldom seen, and especially, adolescents are rarely seen in the pharmacy. In fact, it is usually the mother who takes care of the family’s medicine use and picks up the medicines. It may be necessary to start educating parents first and encourage them to bring their children to the pharmacy with them. Furthermore, you may also want to encourage parents to gradually give more responsibilities to the child and involve the child in decisions concerning their own medicine use – even though the main responsibility for the child’s wellbeing and medicine use will naturally remain with the parents until the child is mature enough to take full responsibility. When this time comes depends on the individual child and has to be negotiated within the family.

Remember that medicine education is not about urging children to use more medicines or to use medicines independently. On the contrary, it is part of health behaviour. The child needs to learn how to do it properly before being granted any, and eventually all, responsibility for that health behaviour.

Table 3. Tips for communicating with children about their medications (modified from Bush and Hämeen-Anttila 2009)

Immediately focus on the child; tell the parent you are going to speak directly to the child

- Bring yourself to the child's eye level and make eye contact, smile
- Ask for previous experiences with medicine use
- Ask the child for solutions
- React to child's concerns: answer the child's questions and encourage the child to be active in future communications with health care professionals

Attempt to communicate at the child's developmental level

- Assess cognitive development level by asking open-ended questions such as "How did you get sick?" or "How does this help you get better?"
- The answers along with the age of the child will give a hint of the cognitive level of the individual child.

Ask open-ended questions rather than those requiring only a yes-or-no response

- Ask follow-up questions to make sure the child understands

Use simple declarative sentences for all children (and adults!)

- Modelling an appropriate communication style will help the parent continue communicating with the child about medicines

Encourage children to ask questions

- Tell the child which are the most important questions to be asked about medicines before use

Augment oral communications with written material

- Average adults only recall about 30% of what they are told by a doctor – most likely the children won't remember any more
- Encourage parents to read the material with the child at home

Give children tasks

- Giving tasks related to the medicine will commit the child to use the medicine and may overcome potential problems (e.g., bad taste)
- Task could be (taken into account the child's age), for example:
 - remind Mom or Dad to give the tablet in the morning and in the evening
 - remember to eat something before taking the tablet
 - give calendar and ask the child to cross off a date after each day until the tablets are gone (e.g., with a course of an antibiotic)

Go to local school and give medicine education

- School health education typically focuses on illegal drug use (i.e., "don't do drugs"). As a health care professional you may contact a local teacher and tell him/her the importance of learning the everyday life skill of rational medicine use, and volunteer to teach children the basics
- Ask children what they know and do and want to know relative to medicines before teaching them what you think they should know
- The Guide to Developing and Evaluating Medicine Education Programs and Materials for Children and Adolescents (Bush 1999) is a useful resource
- Medicine education website developed in Finland may be adapted to your local situations and used while planning and giving the lessons. You'll find lesson plans for different age groups as well as ready-to-use assignments at: http://www.uku.fi/laakekasvatus/english-introduction-dear_reader.shtml

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References and Recommended Readings

Bush PJ, Davidson FR. Medicines and “drugs”: what do children think? *Health Education Quarterly* 1982;9:113/209-128/224.

Bush PJ, Iannotti RJ, Davidson FR. A longitudinal study of children and medicines. In: Breimer DD, Speiser P, eds. *Topics in Pharmaceutical Sciences*. p. 391-403. New York: Elsevier, 1985.

Bush PJ, Ozias JM, Walson PD, Ward RM. Ten guiding principles for teaching children and adolescents about medicines. *Clinical Therapeutics* 1999;21:1280-1284.

Bush PJ, Hämeen-Anttila K. Children and Adolescents. In: Rickles NM, Wertheimer A, Smith M, eds., *Social and Behavioural Aspects of Pharmaceutical Care*. 2nd edition. p. 299-320. Boston: Jones and Bartlett Publishers, 2009.

Bush, PJ (ed): *Guide to Developing and Evaluating Medicine Education Programs and Materials for Children and Adolescents*. United States Pharmacopeial Convention, Inc, & American School Health Association. 1999.

Hämeen-Anttila K. Education before medication: Empowering children as medicine users. Doctoral dissertation. Faculty of Pharmacy, University of Kuopio, Finland, 2006.

Available at: http://epublications.uef.fi/pub/urn_isbn_951-27-0059-X/index_en.html

Hämeen-Anttila K, Englund A, Ahonen R. Miten usein koululaiset käyttävät itsehoitolääkkeitä? (How often school children use OTC-medicines?) *Dosis* 2005;21:182-190 (English abstract).

International Pharmaceutical Federation (FIP). Statement of principle. The pharmacist’s responsibility and role in teaching children and adolescents about medicines 2001.

Available at: http://www.fip.org/www/uploads/database_file.php?id=180&table_id=

O’Brien RW, Bush PJ. Helping children learn how to use medicines. *Office Nurse* 1993;6:14-19.

Piaget J. *The Moral Judgement of the Child*. Gabain M, trans. New York: Harcourt, Brace, World, 1932.

Rudolf MC, Alario AJ, Youth B, Riggs S. Self-medication in childhood: observations at a residential summer camp. *Pediatrics* 1993;91:1182-1184.

Sleath B, Bush PJ, Pradel FG. Communicating with children about medicines: A pharmacist’s perspective. *American Journal of Health-System Pharmacy* 2003;60:604-607.

Sloand ED, Vessey JA. Self-medication with common household medicines by young adolescents. *Issues in Comprehensive Pediatric Nursing* 2001;24:57-67.

Yoos L. Cognitive development and the chronically ill child. *Pediatric Nursing* 1988;14(5):375.



Chapter Thirteen: Aging People and Those with Multiple Medications

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Objectives of the Chapter

This chapter focuses on special counselling needs of the elderly patients and those with multiple medications to assure rational and safe medicine use. Communication strategies for these patients need to be carefully planned and should take into account:

- age-related physical impairment (such as vision impairment and polypharmacy)
- adherence
- safe use of medications that can be potentially inappropriate for the elderly or can have higher risk of adverse events

Elderly patients have several special features that affect their needs regarding counselling and medicines information. Firstly, older people have several age-related changes in their body function, including pharmacokinetic and pharmacodynamic alterations (EIDesoky 2007). These changes may affect their ability to tolerate medicines. Some of them, for example, memory impairment may also result in diminished capacity to receive and apply medicines-related information. Secondly, elderly patients commonly have several comorbidities, and as a consequence, multiple medications. Multiple medications complicate the drug regimen, and thus, may impair adherence, as well as increase the risk for harmful drug-drug interactions and adverse drug events (Field et al. 2004, Johnell et al. 2007). All these issues necessitate pharmacist's special attention during patient encounters. This chapter aims to address the special patient counselling needs of the elderly patients from the practical viewpoint.

General Counselling Needs Related to Aging

Elderly patients may have several physical impairments that can possibly affect their ability to communicate about their diseases and treatments. These include

- impaired vision
- decreased hearing
- weak hand strength, impaired motor skills
- impaired cognitive function, particularly memory

For all elderly patients counselling must be understandable and clear. This means that the pharmacist should avoid complex, long sentences and difficult terminology. Particularly, patients with hearing loss or impairment require careful pronunciation and loud-enough voice. In order to increase the effectiveness of counselling, it is useful to provide written materials in addition to face-to-face communication. For the elderly patients, the materials should be written by using a simple font and a font size that is readable also if the patient has poor eyesight. Thus, the package leaflets with small print size may not be useful information sources.

Communication with the elderly patients should occur in a peaceful atmosphere and place. Visit at the physician's office may be too exiting and busy for actively asking about own condition and treatment or for remembering given advice afterwards. It is also known that elderly patients underreport adverse drug events to their physicians (Lampela et al. 2007). Thus, the pharmacists should allow the patients enough time to express or ask all mind-bothering issues, including possible adverse drug effects. For dementia patients, slow and uninterrupted counselling is especially important, because their sensitivity/responsiveness to nonverbal communication and to the tones of speech may be pronounced.

Adherence

A meta-analysis of methods to improve adherence found that one-on-one educational interventions significantly improved medication adherence and clinical outcomes (Roter et al. 1998). Thus, pharmacists have an important role in improving adherence among the aged (Bubalo et al. 2010).

Some of the actions to improve adherence are related to making the actual drug taking easier. Some age-related changes may affect the ability of elderly patients to use certain drug forms (e.g., eye drops, tablets in a container that is difficult to open). It is important for the pharmacist to recognize these changes and associated problems in medicine taking, and, if possible, provide the patient with appropriate drug forms.

Dryness of mouth is common at old age, and may also be caused by several drugs. As a result, it may be difficult to swallow large or uncoated tablets/capsules. Soluble tablets or liquid drug forms may be better alternatives for some elderly patients. For sublingual tablets, such as nitroglycerin, the onset of drug effect may be delayed due to dryness of mouth. Then a lingual spray may produce more appropriate effect.

Poor motor skills or weakness of hand strength, for example, due to rheumatic diseases, may impair elderly patients' ability to use asthma inhalers or insulin pens, or open drug containers.

During the dispensing, the pharmacist should ascertain that the patient is able to use the drug form as instructed. The pharmacist can instruct the proper use by utilizing placebo devices. If opening containers is a problem, a dose dispensing device or automated unit dose dispensing can be recommended, if available at the pharmacy.

Polypharmacy patients may have complicated drug regimen with multiple daily dosing times. Sometimes the daily drug doses are split to several lower doses in order to avoid adverse effects. Still, simplification of drug regimen may have positive effect on adherence (George et al. 2008). This can sometimes be achieved by using combination products or long-acting (depot) drug forms. Usually the pharmacists are not allowed to make such drug changes at the pharmacy, but may inform the patients of such possibilities to be discussed with the physician.

High drug costs, a common consequence of polypharmacy, may impair adherence among the aged with limited income. Older adults trust pharmacists' advice on comparative prices and effectiveness of prescription drugs (Donohue et al. 2009). The pharmacists should inform patients on lower-cost generic alternatives and, if possible, recommend generic substitution. In many countries pharmacists are actually required to switch automatically to the generic medications unless otherwise indicated by the physician. However, the potential confusion and safety risks caused by changing the product (e.g., different brand names and appearances of tablets) must be carefully considered. Paradoxically, these issues can also decrease adherence.

Polypharmacy

Polypharmacy may increase the risk of harmful drug-drug interactions and adverse drug events (Field et al. 2004, Johnell et al. 2007). Even if automated drug-drug interaction decision support systems are becoming more common, they are of little use if the entity of used medicines is not known. Thus, during counselling the pharmacist should ascertain which medicines are being taken and check the entity for drug-drug interactions. Regarding over-the counter (OTC) medicines, the counselling is especially important. This is because OTC medicines are often used without physician's permission and awareness, and they may cause severe adverse effects and drug-drug interactions with prescribed medications.

Patients need to be advised to tell about all medicines they are taking to their physician. Also, they need to be advised to keep a timely medication list always available, e.g., for an acute hospitalization. In addition to prescription medications, this up-to-date medication list should include OTC medications as well as herbal supplements, because these can have significant interactions with prescription medicines (Hoblyn and Brooks 2005, Qato 2008). A complete medication list makes it easier to identify potential (new) symptoms suggestive of adverse drug reactions, define and eliminate inappropriate duplications and potentially inappropriate medications, and to avoid harmful drug-drug and drug-disease interactions (e.g., Leikola 2012).

Drugs that Require Special Counselling

Age-related alterations in pharmacokinetic and pharmacodynamic functions may alter medicines effects (Mangoni and Jackson 2003). The reduction of body water and relative increase in body fat result in higher serum levels of water-soluble medicines in older people. On the other hand,

the distribution volume for lipid-soluble medicines increases, resulting in prolonged half-life. Also hepatic and renal elimination may impair at old age. All these alterations may increase the risk for adverse drug effects and account for the need to decrease dose or avoid certain medicines (ElDesoky 2007). Several criteria that list these potentially inappropriate medicines have been developed, the Beers criteria being the most well-known and widely used (Fick et al. 2003, Dimitrow et al. 2011, American Geriatrics Society 2012). However, in some circumstances, the use of these medicines can be justified. Then the patient and, if possible, caregivers should receive appropriate education about the use of these medicines and their potential adverse effects. The most critical drug groups in relation to adverse effects among elderly patients are discussed here.

Benzodiazepines

Benzodiazepines increase the risk for falls and fractures, may impair cognitive function and cause daytime drowsiness among elderly patients (Glass et al. 2005). Even if their use may be justified in the treatment of insomnia or anxiety, long-term treatment is rarely appropriate. For patients with insomnia, the pharmacists should also introduce non-medical treatments, e.g., daytime exercise, avoidance of napping or caffeine-containing drinks, and keeping the bedroom cool and dark. The patients should also be made aware that benzodiazepine use in treatment of insomnia cannot last long.

Drugs with Strong Anticholinergic Properties

Tricyclic antidepressants, medicines for urinary incontinence, gastrointestinal antispasmodics and first-generation antihistamines are examples of medicines with strong anticholinergic properties. Anticholinergic adverse drug reactions are diverse and vary from constipation, dry mouth and dry eyes to confusion and cognitive decline (Tune 2001). If an anticholinergic medicine is necessary for an elderly patient, the pharmacist may recommend some actions to reduce their negative effects (Minzer and Burns 2000). The patient should be informed that the discomfort of dry mouth can be relieved by taking sips of water or by chewing sugarless sweets. Artificial tears are effective for dry eyes. Fiber supplements, increased fluid intake and greater patient mobility can relieve constipation.

Central Acting Muscle Relaxants

Many central acting muscle relaxants (e.g., carisoprodol, orphenadrine, tizanidine) can cause the above mentioned anticholinergic adverse effects, but also sedation and weakness. Patients should be told that these medicines are intended only for temporary use and should be avoided when possible.

Non Steroidal Anti-Inflammatory Drugs (NSAIDs) and Aspirin

Use of NSAIDs is associated to increased risk of gastrointestinal (GI) bleeding, adverse renal reactions and cardiovascular toxicity (Schneider et al 2006, van der Linden et al. 2009). As these medications are also available OTC, special attention should be paid to counselling. GI bleeding risks should be discussed. If a patient is prescribed NSAIDs without gastroprotective agents and has special risk factors for GI bleeding (e.g., aged over 75 years, peptic ulcer disease, history of GI bleeding, chronic NSAID use) he or she should be informed to contact a physician to discuss co-administration of a gastroprotective agent (Shrank et al 2007, American Geriatrics Society 2009). The patients should also be aware that regular use of NSAIDs can lead to renal adverse effects including elevated blood pressure, preventing the beneficial effects of antihypertensive medicines; peripheral edema and fluid retention (Schneider et al. 2006).

Pharmacists need to be aware that elderly patients likely have some level of renal impairment, which would increase their risk of acute renal dysfunction when using NSAIDs. In most cases, NSAIDs are intended only for temporary use and not more than one NSAID should be taken for pain control. When selling over-the-counter NSAIDs the patient should be informed of an alternative therapy with topical NSAIDs in hope of preventing systemic NSAID-related adverse reactions. Because paracetamol/acetaminophen has a good safety profile it should be considered as initial pharmacotherapy on pain treatment.

Long-term use of stimulant laxatives

Constipation is a common health problem in the aged. When using laxatives the patients should be aware that long-term use of stimulant laxatives may exacerbate bowel dysfunction (Fick et al. 2003). For patients with constipation the pharmacists should recommend bulk laxatives and non-medical treatments, such as proper fluid and fiber intake, importance of exercise and regular purgative routines.

Summary

- Elderly patients need to be well educated about their medications in a peaceful environment without disturbances
- Adherence can be improved by simplifying drug regimen and assuring usable forms of medicines
- Attention should be paid to adverse reactions and drug-drug interactions, also in regard to OTC medicines
- Pharmacists need to be educated to recognize potentially harmful medicines and solve these problems in cooperation with the patients and other health care providers
- All elderly patients should have an up-to-date medication list

References and Recommended Readings

American Geriatrics Society. American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. *Journal of American Geriatrics Society* 2012;60(4):616-631.

American Geriatrics Society. Panel on Pharmacological Management of Persistent Pain in Older Persons: Pharmacological management of persistent pain in older persons. *Journal of American Geriatrics Society* 2009; 57(8):1331-46.

Bubalo J, Clark RJ Jr, Jiing SS, et al. Medication adherence: pharmacist perspective. *Journal of the American Pharmaceutical Association* 2010;50:394-406.

Dimitrow M, Airaksinen MS, Kivelä SL, Leikola SN. Comparison of prescribing criteria to evaluate the appropriateness of drug treatment in individuals aged 65 and older: A systematic review. *Journal of American Geriatrics Society* 2011; 59(8):1521-30.

Donohue JM, Huskamp HA, Wilson IB, Weissman J. Whom do older adults trust most to provide information about prescription drugs. *American Journal of Geriatric Pharmacotherapy* 2009;7:105-116.

Fick DM, Cooper JW, Wade WE, Waller JL, Maclean JR, Beers MH. Updating the Beers criteria for potentially inappropriate medication use in older adults: results of a US consensus panel of experts. *Archives of Internal Medicine* 2003;163(22):2716-2724.

EIDesoky ES: Pharmacokinetic-pharmacodynamic crisis in the elderly. *American Journal of Therapeutics* 2007;14(5):488-498.

Field TS, Gurwitz JH, Harrold LR, Rothschild J, DeBellis KR, Seger AC, Auger JC, Garber LA, Cadoret C, Fish LS, Garber LD, Kelleher M, Bates DW. Risk factors for adverse drug events among older adults in the ambulatory setting. *Journal of American Geriatrics Society* 2004;52(8):1349-1354.

George J, Elliott RA, Stewart DC. A systematic review of interventions to improve medication taking in elderly patients prescribed multiple medications. *Drugs Aging* 2008;25(4):307-324.

Glass J, Lanctôt KL, Herrman N, Sproule BA, Busto UE. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. *British Medical Journal* 2005;331(7526):1169.

Hoblyn JC, Brooks JO 3rd. Herbal supplements in older adults. Consider interactions and adverse events that may result from supplement use. *Geriatrics* 2005;60(2):18,22-3.

Johnell K, Fastbom J, Rosén M, Leimanis A. Inappropriate drug use in the elderly: a nationwide register-based study. *Annals of Pharmacotherapy* 2007;41(7):1243-8.

Lampela P, Hartikainen S, Sulkava R, Huupponen R. Adverse drug effects in elderly people – a disparity between clinical examination and adverse effects self-reported by the patient. *European Journal of Clinical Pharmacology* 2007;63:509-515.

Leikola S. Development and application of Comprehensive Medication Review procedure to community-dwelling elderly. Doctoral dissertation. University of Helsinki, 2012.

Available at: <https://helda.helsinki.fi/handle/10138/30203>

Van der Linden MW, van der Bij S, Welsing P, Kuipers EJ, Herings RM. The balance between severe cardiovascular and gastrointestinal events among users of selective and non-selective non-steroidal anti-inflammatory drugs. *Ann Rheum Dis* 2009; 68(5):668–673.

Mintzer J, Burns A. Anticholinergic side-effects of drugs in elderly people. *Journal of the Royal Society of Medicine* 2000; 93(9):457-462.

Qato DM, Alexander GC, Conti RM, Johnson M, Schumm P, Lindau ST. Use of prescription and over-the-counter medications and dietary supplements among older adults in the United States. *Journal of the American Medical Association* 2008;300(24):2867-78.

Roter DL, Hall JA, Merisca R, Nordstrom B, Cretin D, Svarstad B. Effectiveness of interventions to improve patient compliance: a meta-analysis. *Medical Care* 1998;36(8):1138-61.

Schneider V, Lévesque LE, Zhang B, Hutchinson T, Brophy JM. Association of selective and conventional nonsteroidal anti-inflammatory drugs with acute renal failure: A population-based, nested case-control analysis. *American Journal of Epidemiology* 2006;164(9): 881–889.

Shrank WH, Polinski JM, Avorn J. Quality indicators for medication use in vulnerable elders. *Journal of American Geriatrics Society* 55 2007;55(Suppl 2): S373–282.

Tune LE. Anticholinergic effects on medication in elderly patients. *Journal of Clinical Psychiatry* 2001;62(suppl 21):11-14.



Chapter Fourteen: Counselling Ethnic Minority Patients

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Objectives of the Chapter

Many countries in the world now have ethnically diverse populations, and counselling patients from another ethnic group can present challenges. This chapter argues that ethnic diversity is increasing, ethnic minority patients often experience poorer care and poorer health outcomes, and that there are a range of reasons for this, including different cultural models of health and illness. It concludes with practical advice for pharmacists. Throughout the chapter, suggestions are made for topics to be covered in pharmacy education.

Understanding the Context

One of the striking features of modern nations is their ethnic diversity. Some nations have had ethnically mixed populations for a long time, such as Malaysia (Central Intelligence Agency 2011), while others have experienced recent change because of the recent dramatic increase in international migration. The number of international migrants more than doubled between 1975 and 2003 and it has been estimated that 2.9% of the world's population are now international migrants. Europe, Asia and North America are home to many millions of migrants (Bach 2003, Väinänen 2008).

The ethnic composition of modern countries is complex and diverse. Some countries such as the USA, Canada, Australia and New Zealand have significant indigenous populations (for example, in New Zealand 14.6% of the population are Maori, the indigenous people (Statistics New Zealand 2011)). Historical migrations, such as the Chinese to what is now Malaysia, have also led to multicultural nations. Modern migration has led to rapid increases in ethnic diversity. For example, in 2006, almost a quarter of the Canadian population aged 15 year or more (23.9%)

were born outside Canada. Their ethnic origins include Chinese, Indian, Filipino, Vietnamese, Italian, German, Polish, Portuguese, and British (Statistics Canada 2008). Descendants of migrants, who are born and grow up in the new country, now form a large part of ethnic minorities in a number of countries. For example, in Germany around 17% of the Turkish population was born in Germany. They are mostly children of immigrant workers who have been coming to Germany since the 1960s (Wikipedia 2011). Similarly large numbers of immigrant workers from the Pacific Islands countries came to New Zealand from the 1970s, and now more than 60% of Pacific people in New Zealand were born there (Ministry of Pacific Island Affairs 2011). These children of immigrants are likely to be influenced by their parents' culture and that of their host country.

Many people do not fit into one ethnic category. Inter-marriage between ethnic groups is common in many countries and the children of these marriages are likely to feel they belong to more than one ethnic group. For example in the USA in 2008, nearly one in seven marriages was between people of different ethnicities (Haq 2010).

Countries vary markedly in how much data they collect on the ethnicity of their population. As much as possible, it is useful for pharmacy academics and students to investigate and discuss the ethnic composition of their country.

Ethnic minorities often fare less well than the majority group in a range of social areas. For example, they are often (but not always) poorer, socially marginalised, and have poorer health status. The latter is likely to be due to a range of social determinants of health (such as poorer housing, education, stress and anxiety, poorer food, less protection from climate extremes, exposure to more accidents) (Bollini and Siem 1995, Williams et al. 2003). There is also evidence that people from ethnic minorities have less positive interactions with healthcare providers (Ferguson et al. 2002, Klonoff 2009). For example, in New Zealand a study found that Māori people's visits to general practitioners (GPs) tended to be shorter, and GPs reported feeling less rapport with Māori patients (Crengle et al. 2005).

More generally, people from ethnic minorities often experience worse outcomes from their interactions with the healthcare system. For example, in the US, black women are less likely to suffer from breast cancer than white women, but more likely to die from it (Washington 2006). There is far less evidence about interactions between ethnic minority patients and pharmacists, but there is little reason to expect that the pattern is different in pharmacy.

Pharmacy students should research, or academics should present, information on the social situation and health status of minorities in their country, so that students are aware of the extent of health problems suffered by minority groups. If the health status of minority groups is poor, substantial gains may be obtained by targeting these problems appropriately.

Possible reasons for poor outcomes for ethnic minority patients include:

Language ability and health literacy: members of immigrant groups vary in their fluency with the language of their host country. Some who have lived in the host country for many years may still have poor language skills, particularly if they have not been in the workforce (e.g., Väänänen 2008). Poor health literacy (the ability to understand and use health information) is strongly associated with poor health outcomes.

Experience of different health systems, understanding of the health system: Immigrants may not know what services are available, where to find them and how to access them (Väänänen 2008, Väänänen et al. 2009). For example, if you move from a country which has a strongly hospital-based system, you might find it strange to visit a general practitioner in a small suburban building. In many developing countries, medicines are sold by unqualified drug sellers, sometimes in street markets, rather than pharmacists working in community pharmacies.

Experience of trauma: Refugees, in particular, are likely to have experienced significant trauma, and many (between 4 and 35%) have been tortured (International Rehabilitation Council for Torture Victims 2010). As a result, they may experience mental and physical problems that are outside the experience of many health professionals, and hard for them to understand. Many refugees may have had very negative experience of health professionals before arriving in their host country, such as those involved in torture, so this is likely to make developing trust and rapport difficult.

Trust in healthcare and healthcare providers: This is an issue for many ethnic minority groups (Klonoff 2009). It has been particularly well documented in the US, where high profile scandals about the treatment of African Americans in the 20th century continued a tradition of poor treatment of African Americans by the medical profession (Washington 2006).

Different cultural ideas about health and medicines: Cultures differ dramatically in what they define as normal bodily functioning, how they interpret symptoms, define illnesses, and how they think they should be treated. For many cultures, the causes of illness are much broader than the biomedical model suggests. For example, many cultures have a more holistic view of health, where disruptions and problems in a wide range of areas, such as family life affect health. For some cultures, the spiritual world is a major source of ill-health (Fadiman 1997, Capstick et al. 2009, Heydon 2009). Many cultures have different understandings of anatomy. For example in Traditional Chinese Medicine, chi, the basic life force, flows along twelve main meridian lines with numerous tributaries (Low and Ang 2010). For many cultures, a balance between heat and cold is important in maintaining health and treating illness. Foods and liquids are classed as heating or cooling (Manderson 1987).

Many people are now exposed to some kind of traditional views and healing options, and biomedicine. People often use more than one system of healing, sometimes using one for some kinds of symptoms, and one for other symptoms. Traditional cultural beliefs can affect people's interpretation of and inclination to use Western medicines. For example, in Nigeria some people believe that diarrhoea is the result of excess heat in the stomach. Health workers recommend oral rehydration solution, using boiled (and therefore clean) water. ORS is then seen as heating because it has been boiled, and the local people are reluctant to use it (Whyte et al. 2002). Some cultures believe that Western medicines are very strong and harsh, making them reluctant to use them, particularly long-term (Nichter and Nichter 1996). Another cultural factor that can affect how people access care and adhere to healthcare advice is the level of family involvement in decision making (Norris et al. 2002, Klonoff 2009). In some cultures a wide range of family members may have the right to comment and give advice on treatment (Norris et al. 2002).

Many pharmacists themselves belong to an ethnic minority group in the country where they practice. They have valuable personal experience which could provide insights into different cultural beliefs about health and medicines. It is useful to encourage students to reflect on their own culture and experiences of other cultures, especially in relation to health and medicines.

Challenges in Counselling Patients from Another Culture

When we talk about cultures and cultural beliefs we are talking about views that are largely shared within a group of people. But there are limitations in making inferences from groups to individuals within those groups.

You cannot always guess a person's cultural identity from their appearance. It is not possible to know about the cultural beliefs about health and healing, and how to behave in a culturally appropriate manner, for every culture in the world. Even if you did, you cannot assume that an individual group member shares all the views of the group. For example, young people who are children of immigrants may reject traditional views and embrace biomedical views.

Suggestions for dealing with ethnic minority patients

- Because you cannot know everything, you have to ask. This makes the consultation a learning experience on both sides. Some useful questions are in the text box below (adapted from Fadiman 1997).

Questions to Ask:

- What do you call the problem?
- What do you think caused the problem?
- Why do you think it started when it did?
- What do you think the sickness does? How does it work?
- How severe is the sickness? Will it have a long or short course?
- What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?
- What are the chief problems the sickness has caused?
- What do you fear most about the sickness?

- Be alert for cues that a cultural misunderstanding may be occurring: e.g., if the patient says something that seems strange to you
- Be respectful: do not belittle other people's views, which may be different from yours
- Be prepared to explain your role and the reason you are asking questions, because people may not understand this
- Work towards concordance (interacting as equals and forming a therapeutic alliance)
- If there is a large cultural group in your area, you should consider engaging with this group, developing relationships that help you understand their health beliefs and identify their health needs, and provide better services

- Find out about other services to which you can refer people, for example services for refugees or for particular ethnic groups, Explain to individuals from these groups that that you are happy to provide care, but these are additional sources of care and support.

References and Recommended Readings

Bollini P, Siem H. No real progress towards equity: Health of migrants and ethnic minorities on the eve of the year 2000. *Social Science & Medicine* 1995; 41(6):819-828.

Capstick S, Norris P, Sopoaga F, Tobata W. Relationships between health and culture in Polynesia - A review. *Social Science & Medicine* 2009;68:1341-1348.

Central Intelligence Agency. The World Factbook: Malaysia, 2011 [cited 2011 21 Jan]; Available at: <https://www.cia.gov/library/publications/the-worldfactbook/geos/my.html>.

Collins K, Hall A, Neuhaus C. US Minority Health: A Chartbook. The Commonwealth Fund, 1999.

Crengle S, Lay-Yee R, Davis P, Pearson J. A Comparison of Maori and non-Maori Patient Visits to Doctors: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 6. p. 140. Ministry of Health: Wellington, 2005.

Fadiman A. The spirit catches you and you fall down: A Hmong child, her American doctors and the collision of two cultures. New York: Farrar, Straus and Giroux, 1997.

Ferguson W, Candib L. Culture, Language, and the Doctor-Patient Relationship. *Family Medicine* 2002;34(5):353-61.

Haq H. Interracial marriage: more than double the rate in the 1980s. In: *Christian Science Monitor*, 2010.

Heydon S. Modern Medicine and International Aid: Khunde Hospital, Nepal, 1966 1998. *New Perspectives in South Asian History*. Hyderabad: Orient Black Swan, 2009.

International Rehabilitation Council for Torture Victims, I. About refugees, asylum seekers, IDPs and torture. 2010 [cited 2011 21 Jan]; Available at: www.irct.org/Admin/Public/DWSDownload.aspx?File.

Klonoff E. Disparities in the provision of medical care: an outcome in search of an explanation. *Journal of Behavioral Medicine* 2009;32(1):48-63.

Low P, Ang S. The Foundation of Traditional Chinese Medicine. *Chinese Medicine* 2010;1:84-90.

Manderson L. Hot-cold food and medical theories: overview and introduction. *Social Science & Medicine* 1987;25(4):329-330.

Ministry of Pacific Island Affairs. About Pacific peoples in New Zealand. 2011 [cited 2011 21 Jan]; Available at: <http://www.minpac.govt.nz/pacific-peoples-in-newzealand/>.

Nichter M, Nichter M. *Anthropology and International Health: Asian Case Studies*. p. 455. New York: Routledge, 1996.

Norris P, Fa'alau F, Va'ai C, Churchward M, Arroll B. Navigating between illness paradigms: treatment-seeking by Samoan people in Samoa and New Zealand. *Qualitative Health Research* 2009;19(10):1466-1475. Statistics Canada, Canada's Ethnocultural Mosaic: 2006 Census, C.n. 97-562-X, Editor. Statistics Canada: Ottawa, 2008.

Statistics New Zealand. QuickStats about culture and identity. 2011 [cited 2011 21 Jan]; Available at: <http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/quickstats/about-a-subject/culture-and-identity/ethnic-groups-in-new-zealand.aspx>.

Turks in Germany. Wikipedia 2011 [cited 2011 20 Jan]; Available at: http://en.wikipedia.org/wiki/Turks_in_Germany.

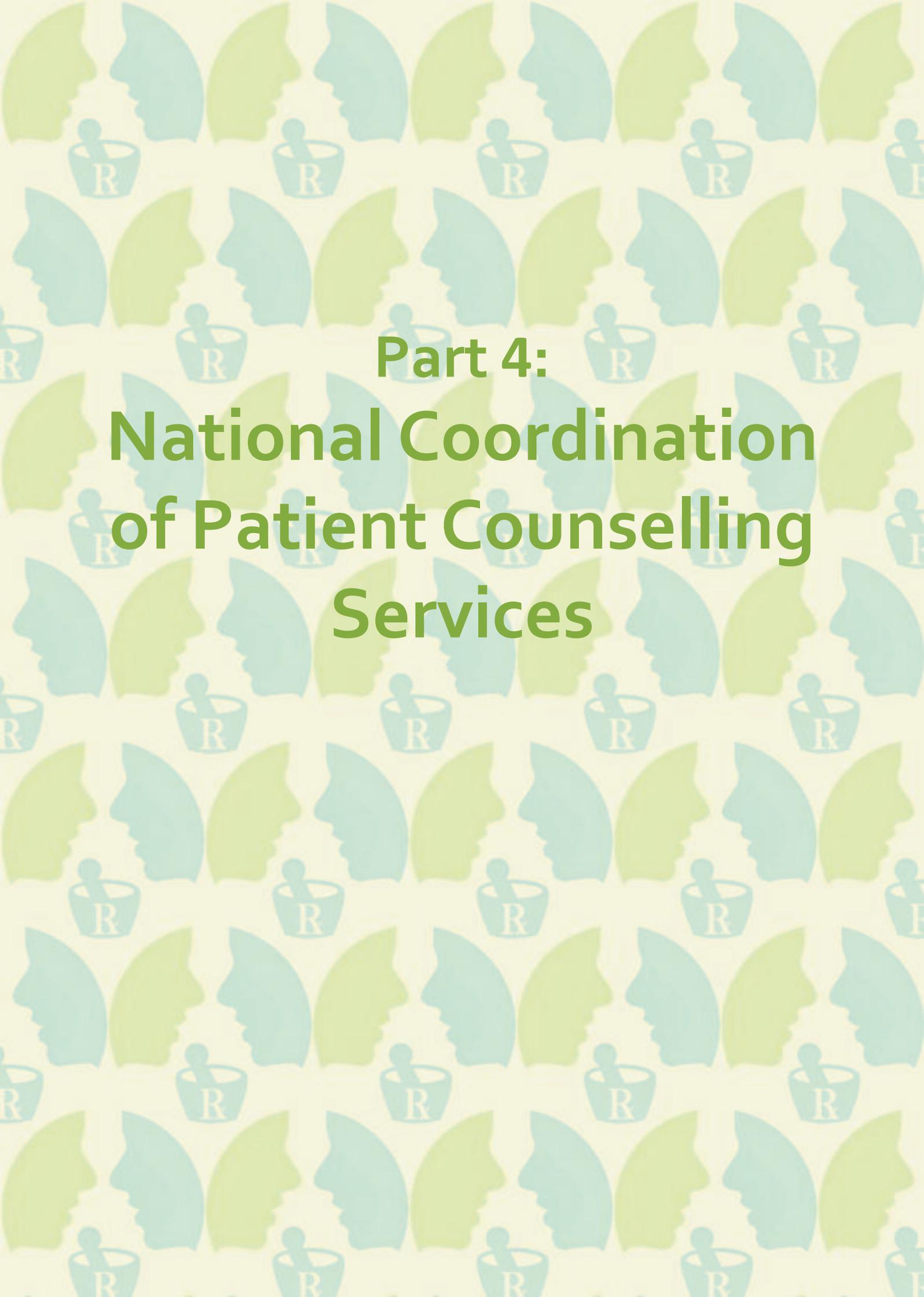
Väänänen M. Community pharmacies and the needs of mobile EU citizens - A study on Finns living in Spain. Academic dissertation. University of Helsinki. Available at: <https://helda.helsinki.fi/handle/10138/19161>

Väänänen MH, Lyles A, Airaksinen M. The symptom mitigation path of mobile community residents: Community pharmacy's role. *Health Policy* 2009;89(1):14-25.

Washington H. *Medical Apartheid: the Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Harlem Moon Broadway Books, 2006.

Whyte S, Van der Geest S, Hardon A. *Social Lives of Medicines*. Cambridge studies in medical anthropology. Cambridge: Cambridge University Press, 2002.

Williams D, Neighbors H, Jackson J. Racial/Ethnic Discrimination and Health: Findings From Community Studies. *American Journal of Public Health* 2003;93:200-208.

The background features a repeating pattern of human profiles in shades of teal and light green, alternating with mortar-and-pestle icons. The profiles are facing right, and the mortar-and-pestles are positioned below them. The text is centered over this pattern.

Part 4:
**National Coordination
of Patient Counselling
Services**



Chapter Fifteen: The Role of Professional Organizations in Promoting Patient Counselling Services

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Objectives of the Chapter

This chapter provides insights in the role of the professional organizations in promoting systematic and coordinated development of pharmaceutical services and their integration in health care. The special focus is on patient counseling services.

- The professional organizations' actions are needed within the profession and towards health care and society to facilitate the change and assure resources for the new functions and services.
- Professional organizations can operate through partnerships to create long-term commitment to strategic development plans.
- Different stakeholders should be involved, representing pharmacy owners and personnel, education and continuing education units, researchers, authorities, funders and health care providers.
- This chapter applies experiences of successful development programs. Particularly, it refers to the long-term strategic program to develop patient counselling services in Finnish community pharmacies which was initiated by the Association of Finnish Pharmacies (pharmacy owners' association) in 2000 (TIPPA Project). The ongoing Project has involved key stakeholders and has extended from patient counselling services to accredited collaborative medication review services.

Professional organizations play a vital role in defining and promoting the role of the pharmacists in health care. Patient counseling is one of the key professional functions of pharmacists, which has earned legislative recognition in many countries. Despite this positive recognition from the society, it has been challenging for pharmacists to commit to these new professional tasks (Puspitasari et al. 2009). Several studies have tried to identify factors influencing pharmacists' professional performance, particularly communication with medicine users (e.g., Norris 2002, Puspitasari et al. 2009). Most of these studies have applied variables related to individual pharmacists or customers as those influencing patient counseling performance (e.g., age, gender, education, geographic location of the pharmacy, type of the medication).

Understanding Organizational Factors Influencing Professional Performance

Quite recently, research has extended to explore the role organizational factors play in determining quality and range of services provided by pharmacies (Vainio et al. 2002, Svarstad et al. 2004, Mermoud 2007, Roberts et al. 2007 and 2008, Feletto et al. 2010 and 2011). Svarstad et al. (2004) demonstrated in the US that legislation has positive impact on patient counseling practice, but it alone cannot make a difference. Roberts et al. have studied organizational facilitators and barriers for service development in Australia (Roberts et al. 2007 and 2008). They concluded that in order to promote the uptake of professional services in community pharmacies, the effective engagement of pharmacists and their staff, policy makers, educators, and researchers is required (Roberts et al. 2008).

The same conclusion can be drawn on the basis of the national TIPPA Project in Finland (TIPPA Project 2004, Kansanaho 2005, Puumalainen 2005, Leikola 2012). Internationally, TIPPA has been one of the most systematic attempts to change professional performance in community pharmacies that has ever been taken on at the national level and documented. TIPPA was started as a national four-year project to implement a new counselling approach based on concordance and two-way communication (Table 1). TIPPA stands for “Customized Information for the Benefit of the Patient from the Community Pharmacy”. All the key pharmacy stakeholders, including authorities, universities, continuing education centers and professional organizations were involved in this extensive program. For the first time, also the Ministry of Social Affairs and Health and a major third-party payer (Social Insurance Institute) took part in a joint project related to the professional development of community pharmacy services in Finland.

Table 1. Outline of the national joint project TIPPA and its pharmaceutical policy and operational goals in Finland in 2000-2003 (TIPPA Project 2004, Puumalainen 2005).

TIPPA (2000–2003): Patient Counselling

TIPPA was a 4-year national joint project to promote the implementation of a professional strategy by enhancing patient counselling in Finnish community pharmacies. The Project was operated by the Ministry of Social Affairs and Health, the National Agency for Medicines, the Social Insurances Institute, the Association of Finnish Pharmacies, the Finnish Pharmacists' Association, the University of Helsinki and the University Eastern Finland, the Pharmaceutical Learning Centre, and the University of Eastern Finland's Centre for Training and Development.

Pharmaceutical policy goals

TIPPA aimed at promoting the rational use of medicines; decreasing the negative effects of inappropriate use of medicines, including self-medication; and decreasing costs by enhanced patient counselling.

Operational goals

Step 1 (2000–2001): Introducing practitioners to new counselling behaviours (raising awareness), developing resources and tools specifically for patient counselling (e.g. easy-to-use electronic prescription drug database, handbook on self-medication, manual on quality assurance of counselling practices, handbook on patient counselling and communication).

- Step 2 (2001–2002): Facilitating self-assessment of counselling practices and processing long-term development plans, training of TIPPA tutors.
- Step 3 (2002–2003): Implementing and promoting the use of patient-counselling resources; assessment of the implementation of TIPPA resources and tools.
- Step 4 (2003): Evaluation and reporting. Constructing a new action plan based on the evaluation. The core of the new action plan was Comprehensive Medication Review procedure and related accreditation training for pharmacists (Leikola 2012).

What National Coordinators and the Coordination Group Can Do?

Figure 1 illustrates the role of national coordination in promoting and implementing new professional services in community pharmacies. It is essential for the national coordination to set the shared vision and strategic goals, which should be clearly stated and communicated.

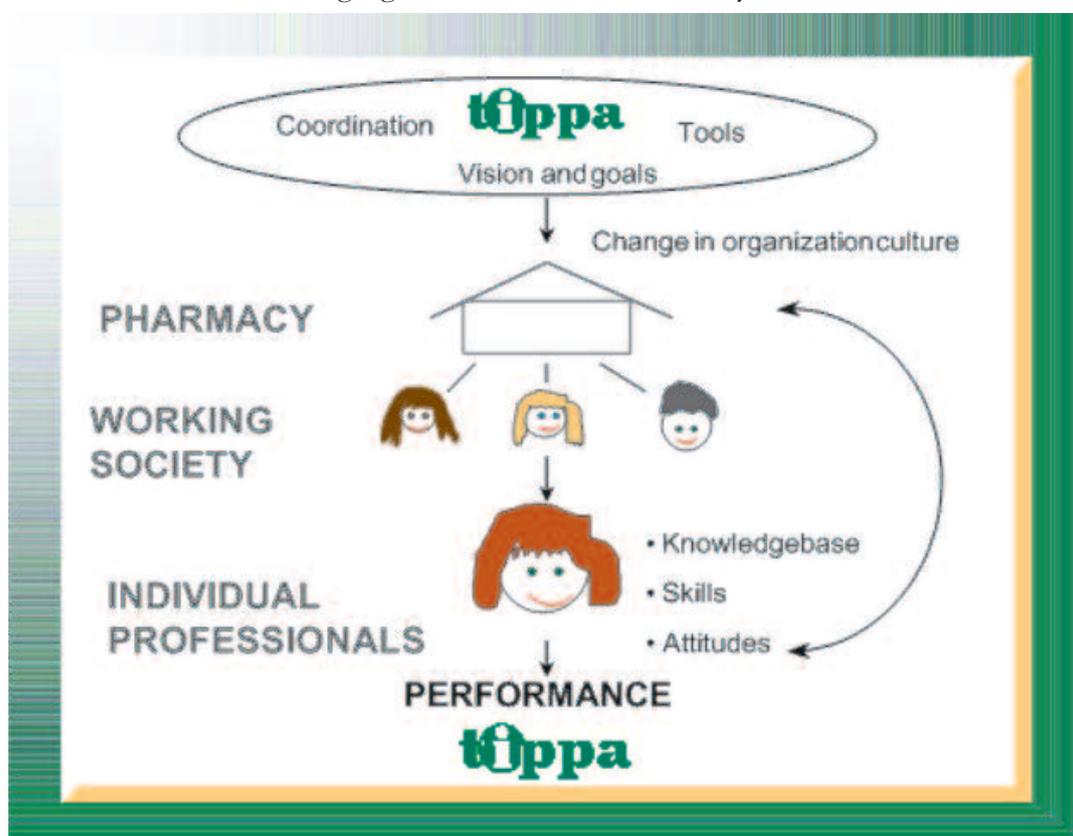


Figure 1. Illustration of the role of national coordination in promoting and implementing new professional services in pharmacies (Source: TIPPA Project 2004, Finland).

The national level stakeholders should have a good understanding of the status of the practice and the ways it is possible to influence performance (Figure 1). Some of the actions should focus on leadership in pharmacy outlets, regardless of their owner (private/chain/public). This affects all of strategic leadership, service development, quality management, and development of personnel’s attitudes, knowledge and skills required in performing the services. Some other actions should assure nationally pharmacists’ access to databases and information sources needed in evidence- based practice, as well as development of information technology to improve feasible

use of databases and tools at the individual pharmacy level (Westerling 2011). It may also be necessary to make changes to the pharmacy curriculum in order to assure required competence development of the new pharmacists' generation. Likewise, new training may be needed for practicing pharmacists as short courses, but also as long-term training (e.g., Kansanaho 2005, Benrimoj et al. 2009, Leikola et al. 2009).

In order to ensure broad representation and commitment, the TIPPA Project in Finland has involved all the important parties in the field of pharmacy from the planning phase of the Project in 1999-2000. These stakeholders formed the national coordination group, which today, being established in 2000, still has regular meetings and has an important role in pharmacy practice development. The Project has consisted of various planned and co-ordinated activities supporting a long-term development process at the pharmacy level (Puumalainen 2005). That includes daily support services, long-term professional development processes and short-term campaigns directed to the public. The most demanding part of the support is long-term development (Kansanaho et al. 2005).

There have been three consecutive long-term project plans in TIPPA Project (2000-2003, 2004-2010 and 2011-2015) which have built on the previous developments (patient counselling services -> collaborative comprehensive medication reviews to home-dwelling elderly -> pharmacists contributions to medication safety from a system approach). Each year, a detailed annual project plan has been constructed to ensure systematic progress of the project. The actions have mostly consisted of actions taken and funded by each individual stakeholder. The key has been the shared vision and goal which have given direction and synergy to the coordinated actions (both national and local actions).



Figure 2. Consecutive long-term project plans in TIPPA Project (2000-2003, 2004-2010 and 2011-2015) which have built on the previous developments (TIPPA Project 2004, Leikola 2012).

Patient Counselling Services as the Primary Operational Goal of TIPPA Project in 2000-2003

When TIPPA Project was initiated in 2000, the primary operational goal was to implement a new patient counselling culture based on concordance and two-way communication (Table 1, Figure 1, Chapter 2: Figure 1). This was promoted by encouraging pharmacies to develop long-term strategic plans. These long-term plans included a present state analysis of counselling practices and a step-wise plan to achieve strategic goals (Chapter 7, Kansanaho 2005, Puumalainen 2005).

TIPPA Project also influenced pharmacy education. In basic education, patient counselling and communication skill courses were modified to better meet the needs of customer-oriented counselling practices (see Chapter 6). In continuing professional development, new long-term patient counselling courses were developed (Kansanaho et al. 2003, Kansanaho 2005). It was discovered that in order for training to be effective it needs to be planned so that there are more than one participant from the same workplace. Learning and practice change need to be supported by assignments that require reflective involvement of peers.

The progress of the actions needs to be systematically communicated with the pharmacy practitioners, because the vision of the future must be shared with pharmacy owners and the staff. This requires a communication plan and involvement of editors of the key pharmaceutical journals so that they can plan and schedule the contents accordingly. In Finland, national pharmaceutical journals published articles related to on-going activities and follow up research of TIPPA on regular basis, particularly during the first, most intensive years of actions. Part of the articles was designed to be suitable for in-house training and self-study (e.g., ongoing series of medication review case studies and disease-specific patient counselling guidelines).

In addition to communicating the progress of the Project within the profession, the progress needs to be regularly communicated to the authorities. To fulfill society's expectations, the progress and steps forward must be widely accepted by the decision makers, authorities, collaborative actors and customers. In TIPPA, regular stakeholder meetings were organized to influence policy making.

Role of Research and Evaluation in Guiding National Long-Term Development

Evaluation of the project implementation and its impact on practices should be integrated into the project planning from the early phase. Research and evaluation have multiple functions in a long-term development process. First, evidence is needed to give an idea for the national coordinators of the extent to which the intended actions are actually implemented (i.e., formative evaluation). This feedback is required to guide decisions for reinforcing implementation. It also gives an idea which actions are well-implemented and which need further efforts (i.e., where to focus efforts, whether new ways of reinforcing change are needed).

The second key function of evaluation is to assess the outcomes of the intervention program (i.e., summative evaluation). The study design and outcomes measures need to be carefully planned to reflect the goals of the desired change and its sustainability. The measures can value clinical, humanistic and/or economic outcomes. Evaluation should cover also structures and processes as outcomes (compare Puumalainen et al. 2005a).

Various methods, both qualitative and quantitative, are needed to give a comprehensive understanding of the practice change and its facilitators and barriers. E.g., in Finland, evaluation of TIPPA Project consisted of regular follow ups of patient counselling performance by a pseudo customer method (Puumalainen et al. 2005b), evaluation of community pharmacists' attitudes towards concordance and patient-centeredness (Kansanaho et al. 2004), implementation of databases, in-house guidelines on patient counselling, and long-term development plans which

were recommended to be integrated into the quality management system of each individual pharmacy (Kansanaho et al. 2005, Puumalainen et al. 2005c). Research was also focused on evaluating leadership in community pharmacies: to what extent leadership practices followed principles of learning organization and staff involvement in generation of new services and practices (Lehtonen 2003).

Another leadership aspect of interest was pharmacy owners' vision and strategy, and to what extent it reflected professional pharmacy practice (Lehtonen 2003). It seemed that a majority of the pharmacy owners were committed to the principles of professional practice, but many pharmacies were missing a long-term strategic plan. Patient counselling services were most typically reported to be the way of implementing professional practice.

At the later phase, organizational factors were studied to learn why some pharmacies have a sustainable and standard quality in patient counselling and some do not (Mermoud 2007). It was also studied what makes some pharmacies to improve remarkably their patient counselling performance. For that purpose, pharmacy owners, pharmacists responsible for managing customer service (mostly MSc pharmacists) and those pharmacists involved in customer service and patient counselling (mostly BSc pharmacists) were interviewed from pharmacies with the best, poorest and most improved patient counselling performance. The study revealed four components involved in the success of a project implementation to improve the practice: 1) the project characteristics; 2) the resources used for the implementation; and factors related 3) to pharmacy leadership and 4) to the practicing pharmacists. Future development projects should take into account importance of leadership and professional strategy as tools for showing the direction of action and quality management system as a method of implementation at the pharmacy level (Figure 3).



Figure 3. Role of leadership, professional strategy and quality management in implementing professional services, such as patient counselling services in community pharmacies (TIPPA Project, Finland 2004).

What a Professional Association Can Do as a National Coordinator of a Development Program?

In many countries, pharmacy associations wish to promote new professional services in order to improve quality use of medicines. However, change processes require systematic approach and strong coordination of activities. Change processes take time (i.e., years): this should be taken into account when planning the activities. In Finland, the evaluation of the national joint project TIPPA has shown some changes in counselling practices, but the fundamental challenges in patient involvement in their care still remain the same. Thus, community pharmacies need further support in their development processes, support covering such competences as leadership, professional service provision and understanding medicine user behaviors.

In Finland, the professional associations have used several approaches to promote professional services from community pharmacies. All the actions have been based on a long-term professional strategy which was first established in 1992. It was renewed in 1997, and updated in 2005 and 2011. The key message of the strategy is that pharmacies are part of the health care and their goals and functions are consistent with it. One of the key functions of making this message concrete has been through patient counselling services. The slogan has been that dispensing consists of the medicine package and essential information of its use. This message has been disseminated through such activities as Community Pharmacists' involvement in national Public Health Programs, particularly in Asthma, Diabetes and Heart programs and elderly care. There are also national collaborative procedures for outpatients under alcohol and drug withdrawal and smoking cessation.

From Patient Counselling to Pharmaceutical Care Services

Even if patient counseling as such is not considered as an implementation of pharmaceutical care, patient counseling services may serve as a first necessary step for community pharmacists towards taking more responsibility in patient care (Figure 4, FIP 2010). This happened e.g., in Finland: the evolution of pharmaceutical care services started from national, coordinated efforts to improve patient counseling services in community pharmacies (Figure 2). As pharmacists started to communicate more with medicine users they started to see more of the many problems people have with their medications (Leikola 2012). It became evident that all of the problems cannot be solved by counselling, and community pharmacists could not solve them alone, without cooperating with other health care providers involved in patient's care. As a result, the follow-up program for TIPPA focused on developing more advanced community pharmacy services and strengthening collaboration between pharmacists and other local health care providers. The most important development under the follow-up program was establishment of the national procedure for collaborative comprehensive medication review (CMR) and related accreditation training (Leikola 2012).

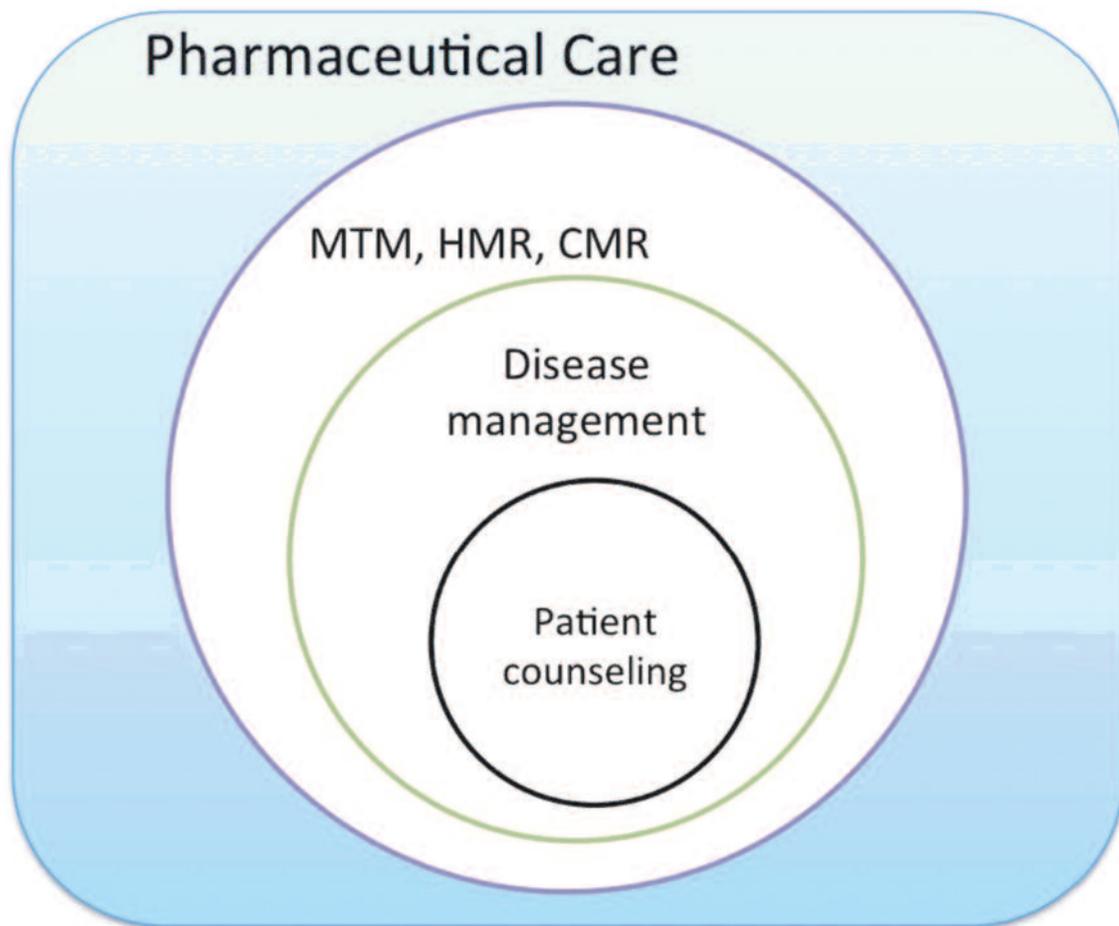


Figure 4. Comprehensiveness of patient-oriented services based on the philosophy of pharmaceutical care (Leikola 2012, modified from McGivney et al. 2007). MTM=Medication Therapy Management (APhA and NACDS 2008), HMR= Home Medicines Review (Sorensen et al. 2004), CMR= Comprehensive Medication Review (Leikola 2012).

Summary: How to Promote a Change?

The change process can be supported using different strategies. There are different levels that need to be taken into account to ensure implementation of intended actions. Also a feedback system is required for formative and summative evaluation to guide change management.

At the national level, a strong coordination is needed and the professional associations have a major role in this. At the pharmacy level, pharmacy owners and pharmacy staff require on-going support and tools to change existing practices and behaviors. These include, e.g., management systems, medicines information systems and databases, and up-to-date basic and continuing education. At individual pharmacist level, competences should be updated to meet the needs of patient-centered practice.

As changing processes are long (even several years), they require long-term commitment to a common goal. The national coordinator's functions include at least the following:

1. Assure long-term commitment of parties involved
2. Establish an action plan in cooperation with parties involved
3. Assure that individual pharmacies have adequate and updated resources for quality practice (e.g., medicines information sources and databases, information technology systems, training for managers and personnel involved in service provision)
4. Take responsibility of systematic communication about the actions planned and progress made to pharmacy practitioners, stakeholders and other parties that may benefit of the information and could promote the change (e.g., policy makers and health care providers)
5. Assure that the changing process is evaluated on the continuous basis and the evidence gained is applied to making decisions for further actions (-> a reflective process)
6. Coordinate actions for influencing health and pharmaceutical policy making
7. Assure sufficient long-term funding for the changing process in cooperation with parties involved.

References and Recommended Readings

American Pharmacists Association (APhA), National Association of Chain Drug Stores Foundation (NACDS). Medication therapy management in pharmacy practice: core elements of an MTM service model (version 2.0). *Journal of the American Pharmaceutical Association* 2008;48:341–353.

Benrimoj SI, Gilbert AL, de Almeida Neto AC, Kelly F. National implementation of standards of practice for non-prescription medicines in Australia. *Pharmacy World & Science* 2009;31(2):230-237.

Felletto E, Wilson LK, Roberts AS, Benrimoj SI. Flexibility in community pharmacy: A qualitative study of business models of cognitive services. *Pharmacy World & Science* 2010;32(2):130-138.

Felletto E, Wilson LK, Roberts AS, Benrimoj SI. Measuring organizational flexibility in community pharmacy: Building the capacity to implement cognitive pharmaceutical services. *Research in Social and Administrative Pharmacy* 2011;7(1):27-38.

FIP. Reference Paper: Collaborative Practice. FIP 2009.

Kansanaho H. Implementation of the principles of patient counselling into practice in Finnish community pharmacies. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, University of Helsinki, 26/2005. Available at: <http://ethesis.helsinki.fi/julkaisut/far/farma/vk/kansanaho/implemen.pdf>

Kansanaho HM, Puumalainen II, Varunki MM, Airaksinen MS, Aslani P. Attitudes of Finnish community pharmacists toward concordance. *Annals of Pharmacotherapy* 2004;38(11):1946-1953.

Kansanaho H, Puumalainen I, Varunki M, Ahonen R, Airaksinen M. Implementation of a professional program in Finnish community pharmacies in 2000-2002. *Patient Education and Counseling* 2005;57(3):272-279.

Lehtonen A. Implementation of principles of learning organization in community pharmacies (Oppivan organisaation periaatteiden toteutuminen ammattiapteekissa). Master's thesis, University of Kuopio, Finland, 2003 (English summary).

Leikola SNS, Tuomainen L, Ovaskainen H, et al. Continuing education course to attain collaborative comprehensive medication review competencies. *American Journal of Pharmaceutical Education* 2009;73(6):article 108.

Leikola S. Development and application of Comprehensive Medication Review procedure to community-dwelling elderly. Doctoral dissertation. University of Helsinki, 2012. Available at: <https://helda.helsinki.fi/handle/10138/30203>

McGivney MS, Meyer SM, Duncan-Hewitt W, Hall DL, Goode JV, Smith RB. Medication therapy management: its relationship to patient counseling, disease management, and pharmaceutical care. *Journal of the American Pharmaceutical Association* 2007;47:620–628.

Puumalainen I. Development of instruments to measure the quality of patient counselling. Doctoral dissertation. Faculty of Pharmacy, University of Kuopio, Finland, 2005. Available at: <http://urn.fi/URN:ISBN:951-27-0053-0>

Puumalainen II, Kause JM, Airaksinen MS. Quality assurance instrument focusing on patient counseling. *Annals of Pharmacotherapy* 2005a;39(7-8):1220-1226.

Puumalainen II, Peura SH, Kansanaho HM, Benrimoj CSI, Airaksinen MSA. Progress in patient counselling practices in Finnish community pharmacies. *International Journal of Pharmacy Practice* 2005b;13(2):149-156.

Puumalainen I, Kansanaho H, Varunki M, Ahonen R, Airaksinen M. Usefulness of the USP Medication Counselling Behavior Guidelines. *Pharmacy World & Science* 2005c;27(6):465-468.

Mermoud D. Facilitators and barriers to patient counselling in community pharmacies – an organizational perspective. Master's thesis, University of Helsinki, Finland, 2007.

Norris P. Which sorts of pharmacies provide more patient counselling? *Journal of Health Services Research and Policy* 2002; Jul 7; Suppl 1:S23-8.

Puspitasari HP, Aslani P, Krass I. A review of counseling practices on prescription medicines in community pharmacies. *Research in Social and Administrative Pharmacy* 2009;5:197-210.

Roberts A, Benrimoj SI, Chen T, Williams K, Aslani P. Practice change in community pharmacy: Quantification of facilitators. *Annals of Pharmacotherapy* 2008;42:861-868.

Roberts A, Benrimoj SI, Dunphy D, Palmer I. *Community pharmacy: Strategic change management*. McGraw-Hill Medical Australia, 2007.

Svarstad BL, Bultman DC, Mount JK. Patient counseling provided in community pharmacies: effects of state regulation, pharmacist age, and busyness. *Journal of the American Pharmaceutical Association* 2004;44(1):22-29.

Sorensen L, Stokes JA, Purdie DM, Woodward M, Elliot R, Roberts MS. Medication re-views in the community: result of a randomized, controlled effectiveness trial. *British Journal of Clinical Pharmacology* 2004;58:648–664.

TIPPA Project. Final Report, 2004 (see description of the project in the following references of this chapter: Kansanaho 2005 and Puumalainen 2005).

Vainio KK, Airaksinen MS, Hyykky TT, Enlund KH. Effect of therapeutic class on counseling in community pharmacies. *Annals of Pharmacotherapy* 2002;36(5):781-786.

Westerling A. *Information Technology Development Needs in Community Pharmacies: A Strategic Approach*. Doctoral dissertation. Division of Social Pharmacy, Faculty of Pharmacy, The University of Helsinki, 2011. Available at: <https://helda.helsinki.fi/handle/10138/28196>

WHO EuroPharm Forum. Project Management tool kit.



Chapter Sixteen: Continuing Professional Development in Patient Counselling and Communication Skills

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Objectives of the Chapter

- This chapter provides steps for pharmacists to develop a new, more patient-centered communication culture.
- The experiences show that long-term learning processes are needed to fundamentally question drug-centered and paternalistic communication behaviors which are dominating in health care, also in pharmacy practice. The learning process needs to focus on attitudes, skills, and knowledge and to apply reflective skills to promote continuous professional development. It also should have a strong theory base.
- The chapter is useful for those planning and providing continuing education and in-house training, as well as for every individual pharmacist who wants to develop communication skills through self-study and self-evaluation.

Step 1. Change your attitude: It is possible to learn communication skills!

Many pharmacists spontaneously say “Of course pharmacists interact with patients throughout their practice”. The work in the pharmacy is regarded as expert work requiring good communication skills (e.g., Hepler and Strand 1990, FIP 1997, 1998, 2001, FIP and WHO 2011, Cipolle et al. 2012, Leikola 2012). Nevertheless, little attention has been paid to developing competency in this field. Quality communication has been regarded as self-evident. Pharmacists also seem to believe that it is not possible to learn communication skills. They feel it is an inherited feature: some pharmacists are good communicators by nature and some are not.

The first step towards better performance is to be aware that communication skills are an area of professional competence in the same way as pharmacotherapeutic skills for example. Thus, competence can be continuously developed through self-evaluation of performance and setting

new goals for personal development. The development can be supported by different types of long-term and short-term continuing education, as well as in-house training (de Almeida Neto et al. 2001, Kansanaho et al. 2003, Benrimoj et al. 2009, Chapter 7). New exciting prospects are provided by educational technology, which offers not only the potential to improve access to training but also to deepen the training experience, e.g., through the use of immersive online environments (Mitchell et al. 2011).

Learning new communication can be fun! Start by setting goals and asking feedback from colleagues. You can start by focusing on introduction, how do you initiate contact with the patient and how do you start the discussion. Then you can move on into the content of the counseling etc. (see Chapter 7).

Step 2. Learn a new approach with the patient/customer

It is crucial to teach practitioners a new approach to the patient or customer. Patients should be regarded as active medicine users and active partners in communication; with whom pharmacists are expected to establish a professional relationship based on trust, open communication, and mutual decision-making. These principles are mentioned as prerequisites for performing pharmaceutical care services, e.g., FIP statements (www.fip.org, e.g., FIP and WHO 2011). The pharmacist should also have an understanding of his or her role in the multidisciplinary team supporting the patient and be aware of the flow of information to the patient from different sources with an emphasis on electronic information where appropriate (see Chapter 2: Figure 1).

Step 3. Understand theory on medicine use behaviors

In addition to knowing communication techniques and pharmacological effects of medicines, as well as principles of their clinical use, pharmacists should acquire understanding of factors influencing individual's medicine use. This means that pharmacists should learn basic psychology of medicine use behaviors and theories explaining such behaviors. The key theories include empowerment, stages of change, medicine taking strategies in long-term therapies, adherence, self-care and sick role (e.g., WHO 2003). The classical theory on diffusion of innovations provides a basis for understanding adoption of new services, as well as their generation and evolution process (Rogers 2003). One should also remember the importance of communication theories: quite often they are ignored as unnecessary, while skills development is focused on learning practical hints and tricks in medication counselling (Salmon and Young 2011). A useful resource for communication theories is the University of Twente website (University of Twente 2012).

Step 4. Develop new patient-centered interaction

How does one develop new patient-centered interaction? According to previous experiences, an extensive learning process is needed at the pharmacy level involving individual pharmacists in developing personal competency; the entire working society to change the communication culture; pharmacy owners to incorporate professional services into the vision and business strategy of the pharmacy; local consumers to educate/empower them to take an active role in self-management; and other health care providers to agree on the new roles in multidisciplinary teams (see Chapter 2: Figure 3, Chapter 7).

Recorded pseudo-patient visits and other observational methods that can be easily carried out even in everyday practice give a good opportunity to learn about the quality and content of pharmacist-customer interaction (e.g., Makoul et al. 1995, de Almeida Neto et al. 2001, Roter et al. 2004, Puumalainen et al. 2005a, Benrimoj et al. 2009). Particularly, a qualitative analysis of communication provides insights in the dynamics of interaction and its structure as a social script (Roter and Hall 2006, Cavaco and Roter 2010). The exercise in the end of Chapter 2 demonstrates a way of using real-life patient counselling scripts in learning. This kind of exercise can be taken in basic education, continuing education, or in an in-house training workshop. It even applies to self-study.

Step 5. Process in-house guidelines on patient counselling

According to previous experiences, practitioners need practical guidelines and resources based on concordance in acquiring a new practice (Puumalainen et al. 2005b). They also need to learn how to process in-house guidelines, such as protocols or standard operating procedures (SOPs) 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 done at a general level, but some pharmacies have been processing treatment-based guidelines for the patient groups that most frequently visit the pharmacy (TIPPA Project 2004, Kansanaho et al. 2005). A new area where an agreement on the patient interview protocol is necessary relates to clinical medication reviews (Chen et al. 2010, Leikola 2012 and Leikola et al. 2012, see also Chapters 8 and 9).

Step 6. Make a long-term development plan

Pharmacists require systematic and planned training, or even coaching to make use of new tools to support patient counselling (Chapter 7). To make this happen, pharmacy owners can be encouraged to develop a long-term action plan that takes into account local conditions by applying principles of strategic planning (Puumalainen et al. 2005b). The recommended period for this action plan is two years in order to make some sustainable changes.

According to previous experiences, pharmacy owners and pharmacists responsible for organizing patient counselling and customer service need special management training on strategic planning and service development (TIPPA Project 2004).

Step 7. Incorporate patient counselling specific measures into the quality management system

As a part of long-term development, it is useful to incorporate patient-counselling-specific feedback measures into the quality management system of the pharmacy (Puumalainen et al. 2005b). Try to find easy-to-use counselling-specific measures that would apply to real-life practice or develop the measures by yourself to guarantee regular follow up and feedback. You can brainstorm to develop quality factors (see Chapters 2 and 7).

Step 8. Make training on patient counselling skills available for practitioners

There is an urgent need to train practitioners in counselling skills (Cavaco and Roter 2010). Undergraduate students need to be taught principles of patient-oriented counselling, and adopt that approach from the very beginning. Practitioners need to be trained to change their routines and adopt new behavior patterns instead of the old ones.

The effective learning process needs to focus on the principles of two-way communication, patient-orientation and concordance, self-evaluation and personal development, collective learning, strategic planning and quality assurance (Aslani et al. 2002, Kansanaho et al. 2003, see Chapters 5, 6 and 7).

The learning process needs to be systematic and horizontally designed, and based on constructive and experiential learning (Chapters 5, 6 and 7). It needs to start 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 (Chapters 2 and 8, Kimberlin 2006). It is also important to integrate theory and practice to change the interaction.

The learning methods should consist of a mixture of labs, lectures, seminars, group-work, self-study and role play. We have found role play and socio-drama to be especially useful (see Chapter 4). They help in processing a picture of patient needs and in rehearsing one's own skills and interaction. Learning can be intensified by using real patients as standardized patients. Also verbatim transcripts of counselling episodes can perform as a useful tool for learning.

Step 9. Be empowered - use different kinds of resources for self-study

Even if organized training was not available on patient counseling and communication skills, there are many useful materials and resources that can be easily applied to self-study and in-house training. You can start with an inventory of drug information and current care databases and sources available in your workplace. You can study the following aspects: What information each of them contain? How is the information structured? How the information can be used in advising people about their medicine use? How to make the information easily available when dispensing (should the dispensing process be changed?).

We have good experiences of using package leaflets and therapeutic guidelines as learning materials in community pharmacies (TIPPA Project 2004). Package leaflets help pharmacists to focus on the key issues in their communication with medicine users. At the same time pharmacists learn about the limitations of written consumer information (Raynor et al. 2007). Therapeutic guidelines can be used to update understanding of different diseases and role of pharmacotherapy in their treatment, which are essential for effective and goal-oriented communication.

Different kinds of search engines, such as Google, are valuable in searching for materials and evidence-based information on health communication, interaction between health professionals and patients, and specifically, on medication counselling. Even practicing pharmacists would also benefit of scientific publications in the field, which can be easily accessed online, e.g., through

PubMed/Medline. Some of the scientific publications are fully available without payment, but at least an abstract of each can be freely accessed. Pharmacy schools should assure that graduating pharmacists know how to use scientific literature in searching for professional information and how to apply it in practice development. These skills should be part of the learning objectives of any kinds of continuing education.

Step 10. Prepare for slow progress in practice but keep the vision clear

The progress towards value services is slow but achievable. It takes a lot of resources, and well-planned and coordinated actions. Leadership in pharmacies will have a crucial role in bridging the quality chasm. Pharmacy owners will determine the vision and strategy of their outlet and its professional or commercial orientation. They should know the national professional strategy and be willing to implement it into their business accordingly. They also need to understand the philosophy of quality to assure the provision of services to meet the needs of their customers and improve therapeutic outcomes.

References and recommended readings

de Almeida Neto AC, Kelly F, Benrimoj SI. Shaping practice behaviour: novel training methodology. *International Journal of Pharmacy Practice* 2001;9:203-210.

Aslani P, Bosnic-Anticevich S, Sainsbury E, Koo M, Roberts A, Krass I. The 12th International Social Pharmacy Workshop: A report of the Teacher's Workshop held in Sydney, Australia, 2002. *Pharmacy Education* 2002;2:213-219.

Benrimoj SI, Gilbert AL, de Almeida Neto AC, Kelly F. National implementation of standards of practice for non-prescription medicines in Australia. *Pharmacy World & Science* 2009;31(2):230-237.

Cavaco A, Roter D. Pharmaceutical consultations in community pharmacies: utility of the Roter Interaction Analysis System to study pharmacist-patient communication. *International Journal of Pharmacy Practice* 2010;18(3):141-148.

Chen T, Moles R, Nishtala P, Basger B. *Case Studies in Practice. Medication Review: A Process Guide for Pharmacists*. Second Edition. Pharmaceutical Society of Australia, 2010.

Cipolle RJ, Strand LM, Morley P. *Pharmaceutical Care Practice: The Patient-Centered Approach to Medication Management*. 3rd edition. McGraw-Hill Medical, 2012.

FIP, WHO. Joint FIP/WHO guidelines on good pharmacy practice: standards for quality of pharmacy services. WHO Technical Report Series, No. 961, 2011. Geneva: World Health Organization, 2011. Available at: http://www.fip.org/www/uploads/database_file.php?id=331&table_id=

Hepler C, Strand L. Opportunities and responsibilities in pharmaceutical care. *American Journal of Hospital Pharmacy* 1990;47:533-543.

International Pharmaceutical Federation (1997). *Standards for Quality of Pharmacy Services*. (accessible at: www.fip.org).

International Pharmaceutical Federation (1998). *Statement of Professional Standard: Pharmaceutical Care*. (accessible at: www.fip.org).

International Pharmaceutical Federation (2001). *FIP Statement of Principle: The pharmacist's responsibility and role in teaching children and adolescents about medicines*. (accessible at: www.fip.org).

Kansanaho H, Pietilä K, Airaksinen M. Can a long-term continuing education course in patient counselling promote a change in the practice of Finnish community pharmacists? *International Journal of Pharmacy Practice* 2003;11:153-160.

Kansanaho H, Puumalainen I, Varunki M, Ahonen R, Airaksinen M. Implementation of a professional programme in Finnish community pharmacies in 2000-2002. *Patient Education and Counselling* 2005;57:272-279.

Kimberlin CL. Communicating with patients: Skills assessment in US colleges of pharmacy. *American Journal of Pharmaceutical Education* 2006;70(3):Article 67.

Leikola S. Development and application of Comprehensive Medication Review procedure to community-dwelling elderly. Doctoral dissertation. University of Helsinki, 2012.
Available at: <https://helda.helsinki.fi/handle/10138/30203>

Leikola S, Tuomainen L, Peura S, et al. Comprehensive medication review: development of a collaborative procedure. *International Journal of Clinical Pharmacy* 2012;34(4):510-514.

Makoul G, Arntson P, Schofield T. Health promotion in primary care: physician-patient communication and decision making about prescription medications. *Social Science and Medicine* 1995;41:1241-1254.

Mitchell S, Heyden R, Heyden N, et al. A pilot study of motivational interviewing training in a virtual world. *Journal of Medical Internet Research* 2011;13(3):e77.

Puumalainen I, Peura S, Kansanaho H, Benrimoj SI, Airaksinen M. Progress in patient counselling practices in Finnish community pharmacies. *International Journal of Pharmacy Practice* 2005a; 13(2):149-156.

Puumalainen I, Kause J, Airaksinen M. Quality assurance instrument focusing on patient counselling. *Annals of Pharmacotherapy* 2005b;39(7-8):1220-1226.

Raynor DK, Svarstad B, Knapp P, et al. Consumer medication information in the United States, Europe, and Australia: A comparative evaluation. *Journal of the American Pharmaceutical Association* 2007;47(6):717-724.

Rogers EM. *Diffusion of Innovations*. 5th Ed. Free Press, New York, 2003.

Roter DL, Hall JA. *Doctors talking to patients/patients talking to doctors: Improving communication in medical visits*. 2nd Ed. Praeger Publishing, Westport, CT, 2006.

Roter D, Larson S, Shinitzky H, Chernoff R, Serwint, JR, Adamo G, Wissow L. (2004). Use of an innovative video feedback technique to enhance communication skills training. *Medical Education*. 38:145-157.

Salmon P, Young B. Creativity in Clinical Communication: From Communication Skills to Skilled Communication. *Medical Education* 2011; 45: 217-226.

TIPPA Project. Final Report 2000-2003 and A New Action Plan. Ministry of Social Affairs and Health, Social Insurance Institution, National Agency for Medicines, The Association of Finnish Pharmacies, The Finnish Pharmacists' Association, University of Kuopio, University of Helsinki, Pharmaceutical Learning Centre, University of Kuopio, Centre for Training and Development, 2004 (in Finnish).

University of Twente. Theory Clusters.

Available at: <http://www.utwente.nl/cw/theorieenoverzicht/Theory%20Clusters/>

WHO. Adherence to long-term therapies: Evidence for action. World Health Organization 2003. Available at: <http://whqlibdoc.who.int/publications/2003/9241545992.pdf>

De Young M. A review of the research on pharmacists' patient-communication views and practices. *American Journal of Pharmacy Education* 1996;60:60-77.

The background features a repeating pattern of stylized human profiles in shades of teal and light green, alternating with mortar-and-pestle icons. The profiles are facing right, and the mortar-and-pestles are positioned below them. The text is centered in a bold, green, sans-serif font.

Part 5: Appendices

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Appendix 1: USP Medication Counselling Behaviour Guidelines: Definitions of Core Counselling Items (USP 1997, Puumalainen et al. 2005)

1. Conducts appropriate counselling introduction by identifying self and the patient or patient's agent.

The health care professional should introduce himself or herself to the patient or patient's agent, and ask if the person is the patient, the caregiver, or someone simply picking up the prescription/OTC medication for the patient.

2. Explains the purpose of the counselling session.

The health care professional should prepare the patient or caregiver for the information to be presented and explain why the information is important to the patient. It is important to tell patients why the counselling session is important from their perspective.

3. Reviews patient records prior to counselling.

It is important to be familiar with the patient's history and file before the encounter. This will save time, identify areas of special emphasis, and assure the patient that the counselling session was as thorough as possible.

4. Obtains pertinent initial drug related information (e.g., allergies, other medications, age, etc.)

This involves both verifying that the profile information is up-to-date and if the information points to any possible problems (e.g., drug/drug, drug-disease interactions).

5. Determines if the patient uses any other medications, including OTCs, herbals/botanicals, and alcohol which could inhibit or interact with the prescribed medication.

Patients generally are not aware of other medications, foods, or diseases that may interfere with the drug they are taking or the condition for which they are being treated. Therefore, this information is essential to prevent drug-related problems. For example, a patient with high blood pressure should be told to ask the pharmacist before taking any medicines for coughs or colds. The patient should be told why these precautions are necessary.

6. Determines if the patient has any other medical conditions which could influence the effects of this medication or enhance the likelihood of an adverse reaction.

See item 5.

7. Assesses the patient's understanding of the reason(s) for the therapy.

It is extremely useful to find out what the patient already knows. Doing this has the potential for saving time in the counselling session and reinforces learned information. In addition, any incorrect information could be corrected at this time. It would be important to assess what the patient understands about the seriousness of the illness, the treatment, dietary restrictions, etc.

8. Assesses any actual and/or potential concerns or problems of importance to the patient.

Patients are often reluctant to vocalize concerns unless they are asked. It is important to deal with this issue early in the conversation: otherwise patients may not be listening to the information as attentively. The health care professional should make every effort to understand the concerns of the patient and give those concerns the attention they deserve.

9. Discusses the name and indication of the medication.

Practitioners should tell patients the name of their medication(s) to help them get used to identifying their medications. Saying the indication reinforces the diagnosis and confidence in the appropriateness of the therapy.

10. Explains the dosage regimen, including scheduling and duration of therapy when appropriate.

Many patients cannot read; therefore, it is important that they be told the dosage regimen. Even patients who can read should be told this information to reinforce what the prescriber told them or to inform them for the first time.

11. Assists the patient in developing a plan to incorporate the medication regimen into his/her daily routine.

Any assistance the healthcare professional can provide the patient in connecting the medication regimen with a daily routine will enhance adherence (e.g., identifying when the patient wakes up and goes to bed, which meals the patient eats, etc.).

12. Explains how long it will take for the drug to show an effect.

Patients may stop taking a medication if the onset of action is longer than they expected or they may take too much medication, thinking one dose did not work. Therefore, the health care professional should inform patients of how long it will take for the drug to show an effect.

13. Explains in precise terms what to do if the patient misses a dose.

These instructions should be as specific as possible. Actual times of day and specific examples should be used to make it clear. For example, if they realize they have missed a dose five hours later should they take the dose or not, or should they ever double-dose.

14. Emphasizes the benefits of completing the medication as prescribed.

Patients should be made aware of the benefits of completing the medication as prescribed in order to give them confidence in the therapy, thus increasing adherence.

15. Explores with the patient potential problems in taking the medication as prescribed (e.g., cost, access, etc.)

Even if the patient does not mention any problems, the health care professional should address potentially problematic issues to make sure there are no hindrances to taking the medication.

16. Helps patient generate solutions to potential problems.

The health care professional needs to help the patient to define potential problems and help him/her generate solutions to those problems in order to increase adherence.

17. Discusses significant adverse effects and interactions (drug-drug, drug-food, and drug-disease) and how to prevent or manage those if they do occur.

Patients need to be aware of adverse effects so they do not unnecessarily seek medical attention if they occur. It is erroneous to think that telling patients of adverse effects will deter them from using the medication. Withholding information may be unethical and patients are entitled to be fully aware of what to expect. Patients should be told whether the adverse effects will go away in

time, and if so, what is a reasonable period of time. It is best to be very specific. The health care professional should also outline steps that can be taken to prevent, alleviate, or manage the adverse effects and what they should do if they do not go away. Furthermore, patients need to know which are such adverse effects that need immediate contact to the physician or pharmacist if they occur.

Patients often are not aware of potential interactions. Therefore, this information should be provided by the health care professional. Additionally, patients should be told why these precautions are necessary. For example, a patient with high blood pressure should be told to ask the pharmacist before taking any medicines for coughs or colds.

18. Discusses precautions (activities to avoid, etc.).

It should not be assumed that the prescriber has discussed precautions with the patient. Rather than making assumptions, the health care professional should ask the patient if the prescriber has discussed this subject. If not, information should be provided.

19. Provides accurate information.

Self explanatory and fundamental for evidence-based professional practice.

20. Discusses storage recommendations, ancillary instructions, e.g., shake well, refrigerate, etc.)

Most patients will store their medications in medicine cabinets in the bathroom, probably the worst place in the house to keep medicine because of heat and humidity. Therefore, in addition to general storage recommendations for all medicines, specific storage recommendations (refrigeration, etc.) and ancillary instructions must be made clear to the patient.

21. Verifies patient's understanding, via feedback.

The health care provider should verify patient understanding via patient feedback. For example, "Mrs. Jones, just to be sure that I am clear, could you tell me how you are going to take your medication?" The same would be done with adverse effects, missed doses, storage conditions, etc. A more direct approach would be: "Mrs. Jones, what time will you take your first dose?" Correct answers can be praised and incorrect information can be corrected. Praising has been shown to reinforce adherence.

22. Summarizes by acknowledging and/or emphasizing key points of information.

The health care provider should summarize key points of the counselling session. This does not mean simply asking the question, "Do you understand?" because patients might be reluctant to say "no". The health care provider, for example, could say to the patient, "To be sure I have not left anything out, let me summarize."

23. Provides an opportunity for final concerns and questions.

The health care professional should also reassess real or anticipated problems the patient has concerning the disease and/or treatment. After the counselling session the patient may have had pre-existing fears alleviated, but may have developed new fears based on the information conveyed during the session. Every attempt should be made to discuss all remaining questions and to offer reassurance.

24. Tells the patient when he/she is due back to a re-fill.

This information helps the patient in planning, which in turn, leads to adherence.

25. Helps the patient to plan follow-up and next steps.

The health care professional should assist the patient in planning and goal setting such as telling him/her if or when they need to come for a re-fill. They should also remind them if their provider has requested a follow-up visit.

Definitions of the counseling items related to communication skills and techniques used in the entire counselling session

1. Uses language that the patient is likely to understand.

Health care professionals should avoid technical jargon when counselling patients. For example, “high blood pressure” is generally more understandable than “hypertension”. Technical language is only appropriate when the health care professional feels that the patient understands it.

2. Uses appropriate counselling aids to support counselling.

It has been shown that the combination of written and oral information is more effective in educating patients. It provides the patient with information to refer to in case they forget what they have heard the practitioner say. The use of videos, graphics, and other tools could also be used to support counselling.

3. Responds with understanding/empathic responses.

This skill is absolutely essential to an effective counselling session. If the patient sees the health care professional as competent, trustworthy, and someone who cares about what happens to them, it increases their adherence.

4. Presents facts and concepts in a logical order.

Information should be presented from simple to complex. In addition, the most important point should be communicated to the patient first, then repeated again at the end of the counselling session. It has been shown that people retain information longer when information is presented this way.

5. Maintains control and direction of the counseling session.

While the emotional needs of the patient relative to drug therapy should be addressed, the counselling session needs to move forward. Patients may dwell on certain areas even after reassurance and explanation. The health care professional needs to assertively address the concern and move on to be sure all important issues are covered.

6. Probes for additional information.

The health care professional should ask if there are any additional questions or concerns and listen respectfully and carefully to what the patient has to say.

7. Uses open-ended questions.

The use of open-ended questions (e.g., “What did your health care provider tell you this medicine is for?”) rather than close-ended questions (e.g., “Did your health care provider tell you what this medicine is for?”) helps the health care provider determine what information the patient needs. Answers to open-ended questions may help the health care provider determine the patient’s level of understanding.

8. Displays effective nonverbal behaviours.

Generally speaking, the most effective interviewers are ones who talk less than the client and spend more time listening. Listeners convey their understanding and concern through nonverbal gestures (facial expressions, eye contact, nodding) and through short verbal prompts (“I see”, “Uh huh”, “Really”, etc.).

- a. Appropriate eye contact.
- b. Voice is audible: tone and pace are good.
- c. Body language, postures, and gestures support the spoken message.
- d. Distance between the health care professional and the patient is appropriate.

Appendix 2: A Modified Version of the USP Medication Counselling Behaviour Guidelines Developed By FIP/IPSF in 2005 (FIP and IPSF 2005).

A medication counselling session based on concordance			
<p>Making contact Approach the patient. Explain the purpose of the counselling session.</p>	<p>Needs assessment Assess the patient's needs, beliefs, feelings, concerns, knowledge about the medication, and patient's expectations for the counselling session by:</p> <ul style="list-style-type: none"> • Using patient history appropriately. • Taking the patient's medical history into account. • Openly exploring how the patient is using prescription, non-prescription medication or alternative therapies. • Establishing whether the patient is both willing and able to adhere to the medication and what practical support may be needed. • Determine whether the information provided by the patient is evidence based or subjective. 	<p>Providing information Provide information in manageable parts and aim to provide solutions to potential problems through covering:</p> <ul style="list-style-type: none"> • Indication. • Adoption of the dosage regimen, scheduling and duration, into a daily routine. • How long it will take for the drug to show an effect. • Interactions (food, drug, disease). • Side effects. • Precautions and contraindications (e.g. CNS). • Recommendations (e.g. storage, shake well). • When the patient is due back for a refill/ repeat. • Other information if needed. 	<p>Summarise and review Summarise the information and advice discussed, check how much the patient has understood and gain feedback. In closing, ensure that:</p> <ul style="list-style-type: none"> • An opportunity for final concerns and questions is provided. • There is an opportunity for follow up. • Agreed actions are reinforced. • Prescribers are followed up with when required. • Monitoring where necessary is arranged.
<p>Communication</p> <ul style="list-style-type: none"> • Use easily understandable language and avoid jargon. • Use counselling aids to develop understanding. • Use non-verbal communication techniques to facilitate the counselling process towards dialogue-based negotiation. • Control and direct the counselling session to maintain logical flow and relevance. • Use open-ended questions where relevant and employ good questioning techniques. • Avoid being aggressive or forceful in approach. • Facilitate responses and listen to the patient. • Be perceptive to the patient's verbal and non-verbal cues. • Demonstrate empathy, concern, understanding, and patience. 			

Appendix 3: Patient Counselling Event - Evaluation Form Currently Used by the IPSF

Evaluation Component	Marks
Counselling Process	
Introduction (/5) Appropriate introduction Identifies the patient States time factor & privacy	0 1 2 3 4 5
Information Gathering (/10) Assessment of symptoms (what, how long, had before) Checks to see if the patient has seen a doctor or other healthcare professional for it Thorough assessment of medical history including current medications (OTC & prescription) and medical conditions Determines allergy status of the patient	0 1 2 3 4 5 6 7 8 9 10
Recommendation (/10) Provides appropriate non-drug options for the patient Recommends correct pharmacological therapy (name, how it works, how to use, how long to use the medication, when to seek physician if patient is not experiencing benefit) Discussion of possible side effects, interactions (if no interaction, reminds the patient to seek a pharmacist's/doctor's help when selecting any OTC products), and any other special directions	0 1 2 3 4 5 6 7 8 9 10
Conclusion (/5) Summarize key points Checks patient's understand (have the patient repeat the instructions) Encourages the patient to contact pharmacist if there are further questions Thanks the patient for their time	0 1 2 3 4 5
Communication Skills	
Question & Listening Skills (/10) Appropriate use of open & close ended questions Listened to patient attentively and supportively	0 1 2 3 4 5
Counselling Session Flow (/10) Entire consultation had a clear and logical flow that was not confusing for the patient Proceeded at a pace that was suitable for the patient Able to handle the patient's questions throughout the session Checked the patient's understanding throughout the recommendation	0 1 2 3 4 5 6 7 8 9 10
Verbal Communication Skills (/10) Used appropriate language (patient-friendly terms) Counselling session was a conversation (i.e., not just the pharmacist speaking) Appropriate use of empathy	0 1 2 3 4 5 6 7 8 9 10
Non-Verbal Communication Skills (/10) Made appropriate eye contact with the patient Pace and tone of speech was appropriate Body movements are not distracting Smile!	0 1 2 3 4 5 6 7 8 9 10
TOTAL	/70

Appendix 4: A Checklist for Patient Counselling Event Coordinators

With any successful event, there are a number of steps that are required during the preparation phase. The following checklist aims to guide some of the necessary steps for any Patient Counselling Event (PCE) coordinators. This list is non-exhaustive and can be elaborated based on needs.

1. Before the Event (at least 1 – 3 months in advance)

- Pick a date for the event
- Determine the venue(s)
- Enlist volunteers for the day of the event to ensure smooth operations
- Contact judges and secure their availability for the date(s) required
- Contact potential actors or standardized patients and secure their availability
- Decide how the participants will be recognized (prizes, certificates, etc.)
- Develop the patient cases and send them to judges for their opinion if necessary
- Promotion for the event
- Ensure the participants have thorough directions for how the event will be conducted (know when and where to show up for the event)

2. The Day of the PCE

- Ensure the volunteers are clear with their roles for the event (timing, directing the participants, etc.)
- Have the available resources/references, cases and any other materials needed at the venue
- Greet judges and present them with the case and judging criteria
- Ensure the participant is clear on the timing of the event (how much time to prepare, how much time for counselling, and how they will be informed of the time – buzzer, bell, etc.)

3. After the PCE

- Thank all the judges and volunteers for their time
- Gather all of the judging forms from the judges and distribute amongst the participants
- Provide recognition for the winner of the competition
- Ask judges and participants for feedback for the event

Appendix 5: Outline of the lecture series (34 hours) on patient education and counselling in the University of Helsinki, Finland.

L= lecture (session of 2 hours)

I THEORETICAL BASIS OF PATIENT COUNSELLING AND COMMUNICATION IN THE COMMUNITY PHARMACY SETTING

L1: Introduction: Course design, learning objectives, content, teaching methods and assignments

L2: Communication skills and how they can be learned 1 (Orientation to role play rehearsals): Different ways to rehearse counselling skills, Why and how to use drama techniques and videotaping, practicalities relating to role play sessions

L3: Communication in community pharmacy setting: Patient counselling session as a process, main concepts and theories relating to counselling and communication

L4: Communication skills and how they can be learned 2 (Orientation to role play sessions): Feedback giving and self-assessment as tools to develop professional skills and competence

L5: Communication skills 1: Listening and question asking

L6: Communication skills 2: Non-verbal communication in counselling, how to motivate and support the customer/patient with his/her treatment

L7: Medicines information sources available in community pharmacies to support patient counselling

II MEETING THE NEEDS OF DIFFERENT TYPES OF PATIENTS

L8: OTC medication counselling (Includes patient cases)

L9: Prescription medication counselling (Includes patient cases)

L10: Counselling elderly patients and patients using multiple medicines (Includes patient cases)

L11: Counselling deaf persons and people with vision impairment (Lecture by patients)

L12: Counselling children and adolescents

L13: Multicultural aspects in counselling

L14: How to deal with challenging customers

III HOW TO DEVELOP COUNSELLING SERVICES AT THE ORGANIZATION LEVEL

L15: Medicines information and information services in the future: Applying technology in medication counselling

L16: Development of counselling services in a community pharmacy

L17: Conclusions and feedback from the course

Appendix 6: Examples of common telephone and email inquiries in the 24/7 medicines information center operated by a community pharmacy chain (the University Pharmacy, Finland).

My physician prescribed me heart medicine for hypertension for the first time in my life. What kind of medicine is it? What are the benefits of taking it? Is it necessary to use the medicine for the rest of my life?

I'm using two kinds of painkillers. Should I take these at the same time? Are there some interactions between them?

I'm on a penicillin course right now. Could I drink a glass of wine during the medication?

I have hay fever and I am using antihistamine tablets for it. I feel tired every now and then. Is this because of my medicine? Is there a different kind of medication available, which doesn't cause any adverse drug reactions?

My girlfriend forgot to take a contraceptive pill. Should she use an emergency contraception?

I will be traveling abroad during the next holiday, and I use a lot of medicines. Do I need to bring a special verification of the medications prescribed or only the prescriptions?

My son is 2 years old and he has the flu with a fever. We have some painkiller suspension at home. What is the right dosage for him?

I have three dogs and they are suffering from diarrhea right now. Are there any over-the-counter medicines for them? When should I consult a veterinarian?

My mother is 82 years old and she is using 10 different kinds of medicines. Are all of these medicines useful for elderly people?

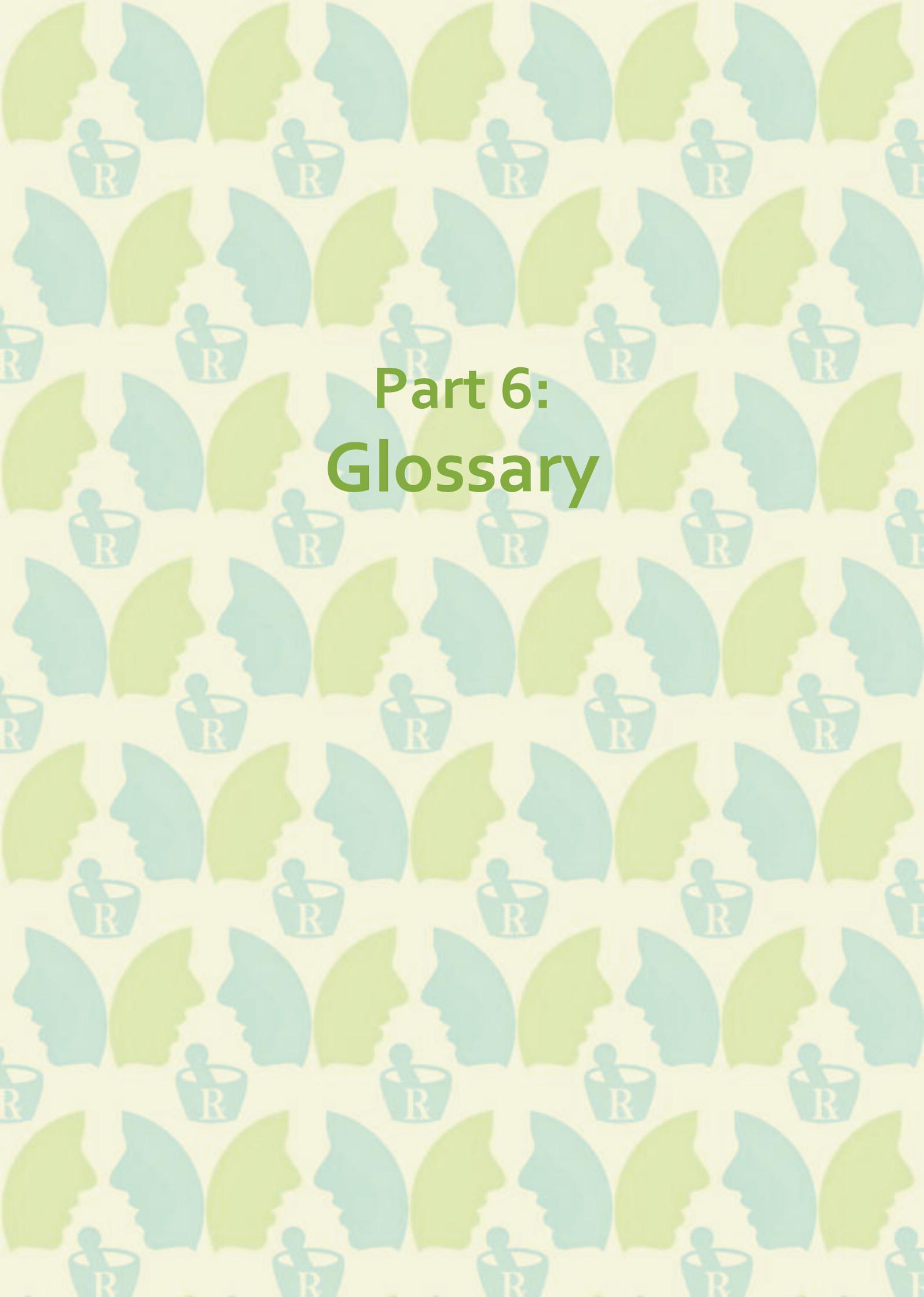
Appendix 7: Examples of the most commonly used databases and drug information sources in a medicines information call center (based on the experiences of the University Pharmacy Medicines Information Center in Finland).

INTERNATIONAL DRUG INFORMATION SOURCES

- **Micromedex:** Evidence-based database containing comprehensive medicines information, possibility to check drug interactions, information about herbal and alternative therapies, drug overdoses, toxicology, service to identify tablets and capsules. There is a possibility to combine other databases (e.g. Index Nominum and Martindale) to Micromedex. It contains also manufacturer brand names of medicines in different countries (www.micromedex.com).
- **Martindale:** Concise, unbiased information on drugs in clinical use, investigational and herbal drugs, diagnostic agents, pesticides, coloring agents, preservatives, and noxious substances. Summaries of relevant information, referenced abstracts, and reviews with expanded detail are included as well as therapeutic data, synonyms, and manufacturer brand names. Used especially when people ask about medicines from other countries.
- **The Merck Veterinary Manual** contains comprehensive animal care and medicines information, accurate information on treatments, drugs and dosages for all common domestic animals as well as for exotic animals and pets (www.merckvetmanual.com).
- **Authorities on medicinal products (E.g., European Medicines Agency EMA and U.S. Food and Drug Administration FDA):** Reliable information about authorized medicines, up-to-date legislation and other guidelines, and information about medication safety and adverse drug reactions (www.ema.europa.eu; www.fda.gov).

NATIONAL INFORMATION SOURCES IN FINLAND

- **Terveysportti:** Finnish national health portal for healthcare professionals. It is easy to find the day-to-day medical information quickly and reliably at one source. The service consists of more than 35 databases (www.terveysportti.fi).
- **The National Institute for Health and Welfare (THL):** A research and development institute under the Finnish Ministry of Social Affairs and Health that works to promote the well-being and health of the population, prevent diseases and social problems, and develop social and health services. THL research widely the development of new vaccines and introduce useful information for medical professionals (www.thl.fi).
- **Poison Information Centre (Located in the Helsinki University Central Hospital):** Answers both consumer and healthcare professional's inquiries about the prevention and treatment of acute poisonings on a daily basis around the clock (www.hus.fi/default.asp?path=59).
- **The Teratology Information Service (Located in the Helsinki University Central Hospital, in conjunction with the Poison Information Centre):** provides information on the possible risks of exposure to drugs and other exogenous agents during pregnancy and lactation. Provides counselling to health care professionals and lay people (www.hus.fi/default.asp?path=59).
- **The Social Insurance Institution of Finland:** provides reimbursements for the cost of medical treatment and pays sickness allowances on account of loss of earnings. There are comprehensive databases about medicine prices and their reimbursements (www.kela.fi).
- **Wholesalers (Oriola Net and Tamro Web):** Web services of wholesale firms, practical source of information for pharmacies. Pharmacies have access to availability and delivery information of products. Wholesale firms also import many special licensed medicines to Finland and deliver them to pharmacies. These web services provide up-to-date information from manufacturers to pharmacies.



Part 6: Glossary

Glossary

Adherence

Adherence can be defined as the extent to which a person's behaviour – taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider. Adherence differs from the compliance in a sense that adherence requires the patient's agreement to the recommendations. This highlights that patients should be active partners with health professionals in their own care and that good communication between patient and health professional is a must for an effective clinical practice (World Health Organization 2003, National Institute for Health and Clinical Excellence 2007).

Compliance

Degree to which a patient's behaviour coincides with medical or health advice. In clinical trials, the term compliance simply refers to a measure of how well a participant has taken their study medication (Royal Pharmaceutical Society of Great Britain 1997, Alghabban 2004).

Concordance

Concordance is an approach to the prescribing and taking medicines (Royal Pharmaceutical Society of Great Britain 1997, Dickinson et al. 1999, Horne et al. 2005, National Institute for Health and Clinical Excellence 2007). At the core of the concordance is an agreement reached after negotiation between a patient and a healthcare professional that respects the beliefs and wishes of the patient in determining whether, when, and how medicines are taken. Concordance is related to patient-centered care.

Empowerment

Empowerment is the enhanced ability of consumers to actively understand and influence to their health status (Rodwell 1996). Information is the core of the empowerment. Without sufficient information people cannot engage in meaningful discussions or make thoughtful decisions regarding their care and treatments.

Medicines information

Medicines information (British) and drug information (American) are synonyms that refer to all kinds of medicines -related information accessible to the public via different sources and modes of delivery (face-to-face, written, and electronic). (Närhi 2006, Pohjanoksa-Mäntylä 2010).

Patient counselling

Patient counselling is closely to the concepts of medication counselling, patient education, pharmacist-patient-communication, patient information and advice-giving. Those all have been used to refer to the communication between pharmacists and patients (Puumalainen 2005, Shah and Chaewning 2006, Puspitasari et al. 2009). In this booklet, patient counselling is seen as an approach that focuses on enhancing the problem solving for the patient to improve or maintain quality of health and quality of life. This conceptualization highlights that counselling should be a dialogue between customer and pharmacists, not just an one-way action in which pharmacist is the provider and the medicine user is the receiver of information.

Patient counselling event

Patient counselling event (PCE) is an occasion where pharmacy students can practice and refine their communication skills against each other by applying role play techniques. The participants are provided a scenario in which they get to discuss medical information with the patient while being mindful of the patient's needs. The competition component is supplemented with a workshop to discuss the components of a counselling session. This is an International Pharmaceutical Students' Federation (IPSF) initiative that was first held at the congress in 1989.

References

Alghabban A. Dictionary of Pharmacovigilance. Pharmaceutical Press, 2004.

Dickinson D, Raynor DK. Ask the patients—they may want to know more than you think. *British Medical Journal* 2003; 327:861-864.

Horne R, Weinman J, Barber N, Elliot R, Morgan M. Concordance, adherence and compliance in medicine taking. Report for the National Coordinating Centre for NHS Service Delivery and Organizing R & D (NCCSDO), 2005.

National Institute for Health and Clinical Excellence. Medicines concordance and adherence: involving adults and carers in decisions about prescribed medicines, 2007.

Available at: <http://www.nice.org.uk/nicemedia/pdf/CG76FullGuideline.pdf>

Närhi U. 2006, Drug information for consumers and patients – a review of the research. Publications of National Agency of Medicines 1/2006.

Pohjanoksa-Mäntylä M. Medicines information sources and services for consumers: A special focus on the Internet and people with depression. Doctoral dissertation. The University of Helsinki, 7/2010. Available at: <http://www.doria.fi/bitstream/handle/10024/59516/medicine.pdf?sequence=1> (23 June 2011)

Puspitasari HP, Aslani P, Krass I. A review of counselling practices on prescription medicines in community pharmacies. *Research in Social and Administrative Pharmacy* 2009; 5:197-210.

Puumalainen I. Development of Instruments to measure the quality of patient counselling. Doctoral dissertation. Kuopio University Publications A. Pharmaceutical Sciences 83. University of Kuopio, 2005.

Rodwell CM. An analysis of the concept of empowerment. *Journal of Advanced Nursing* 1996; 23:305-313.

Royal Pharmaceutical Society of Great Britain. From compliance to concordance: Achieving shared goals in medicine taking, 1997.

Shah B, Chaewning B. Conceptualizing and measuring pharmacist-patient communication: a review of published studies. *Research in Social and Administrative Pharmacy* 2006;2:153-185.

World Health Organization. Adherence to long-term therapies. Evidence for action, 2003. Available at: http://www.who.int/chp/knowledge/publications/adherence_full_report.pdf

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