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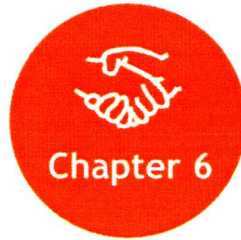
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Guidelines for Continuous Professional Development in Patient Counselling and Communication Skills

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This chapter aims to sum up facilitative steps for pharmacists to develop a new communication culture. The guidelines are based on literature and experiences in different countries. The experiences show that long-term learning processes are needed to fundamentally question the current communication practices and behaviours. The learning process needs to focus on attitudes, skills, knowledge, and to apply reflective skills to promote continuous professional development.

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, and 2001). 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 is an area of professional competence in the same way as pharmacotherapeutic skills for example. Thus competence can be continuously developed both 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).

2. Forget old myths and beliefs about passive patients

Pharmacists' communication behaviour seems to be determined by beliefs and myths which are transferred from one generation of practitioners to another (De Young 1996, Katajavuori et al. 2002). Pharmacists believe that patients do not want/require information, especially when they pick up refills as they already know or are already aware of how to use their medicines. Pharmacists believe that patients are passive, they should not be disturbed by transferring facts about medicines. Where do these myths and beliefs originate? According to studies, it is due to the fact that most practitioners lack systematic training in communication and patient counselling skills. It seems

to be that practitioners lack both the understanding of the principles of two-way communication and the role of the patient in self-managed treatment. This influences negatively their performance even though they are motivated to make a change, as most practitioners seem to be, according to the feedback collected (e.g., TIPPA Project 2005).

3. Learn a new approach with the patient/customer

It is crucial to teach practitioners a new approach to the patient/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 also mentioned as prerequisites for performing pharmaceutical care services, e.g., FIP statements (www.fip.org). The pharmacist should also have an understanding of his 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.

4. Develop new patient-centred interaction

Recorded pseudo-patient visits give a good opportunity to learn about the quality and content of pharmacist-customer interaction (e.g., De Almeida Neto et al. 2001, Puumalainen et al. 2005a). The following pseudo-patient was picking up a new prescription of a sympathomimetic inhaler (TIPPA Project 2005):

Pharmacist: Here is your medicine. Are you familiar with this product?

Patient: No, I'm not.

Pharmacist: Did the physician tell you how to use this medicine?

Patient: No, he didn't.

Pharmacist: Should I open the package and show you?

Patient: I don't know.

Pharmacist: At least read the leaflet inserted in the package. Are you going to pay by cash?

This typical real-life pharmacist-patient interaction indicates the level of competency pharmacists have acquired when communicating with the patient. This example could be from any country. If we read the conversation we can see that the patient is giving the pharmacist clear hints of their need for information but the pharmacist is not able to communicate accordingly. It seems like the pharmacist has learned to ask questions but does not know how to make use of the information provided by the customer. This can be seen throughout the discussion: patient indicates that this is a new medication, and that the physician did not instruct on how to use it. You can see that the pharmacist does not respond to this information. Finally, the pharmacist creates a confusing situation by leaving the decision up to the customer of whether or not a demonstration or explanation should be given for an unfamiliar medicine.

Based on previous studies, this pharmacist's behaviour is against the evidence of the public's trust in professionals in assuming that they have all the information they need (Makoul et al. 1995). Because the title of "professional" is associated with a perception of competence, the patient walks away with a strong assumption that all the necessary information has been given. Naturally, the

average patient may not know enough about medicines to ask the right kind of questions and relies on the professional/pharmacist in their encounter.

Let's have a look at another pseudo-patient's visit, now related to self-medication. The patient asks for two medicines using brand names, one being a ketoprofen product and the other a ranitidine product. Thus, there is a potential for iatrogenic effects. In this case, the advice of the pharmacist is focused on product facts: which package size – 8 or 15 tablets - and what kind of tablets the patient wants. There is not a word about the symptoms and choice of the medication accordingly, neither risk assessment, nor about instructions on how to use the medicines, or even a mention of switching the painkiller to a less harmful one for a patient with stomach symptoms:

Patient: Hi, I would like to buy a pack of ketoprofen.

Pharmacist: 8 or 15 tablets?

Patient: The bigger one. And a pack of ranitidine.

Pharmacist: A tablet to swallow or dissolve in water?

Patient: Ordinary tablets.

Pharmacist: Would you like to have anything else?

Patient: Nothing else.

Pharmacist: It comes to 11 euros and 20 cents.

It is obvious that the value of current pharmacist-patient interactions with respect to the therapy outcome is limited. It seems that pharmacists have developed a “robotic approach” to their interaction with patients and have failed to remember their duty as counsellors: that they are there to support the therapy of these patients rather than just handing out medicines. The pharmacist is not supporting self-management that is based on the understanding of the disease and its treatment. If we measure this against a criteria for good quality communication, in both of these case pharmacists failed the test and did not reach acceptable quality (Appendix 2).

It has been observed that in their very best performances, pharmacists were showing patients inhaler techniques or asking some questions about the symptoms intended for self-medication, but very rarely showed systematic counselling patterns starting with needs assessment, selection of content, customising content through different communication techniques and finally, concluding by ensuring understanding as detailed in Appendix 1.

How does one develop new patient-centred 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 (Puumalainen et al. 2005b, TIPPA Project 2005).

5. Process in-house guidelines on patient counselling

According to previous experiences, practitioners need practical guidelines and resources based on concordance to develop new practices (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 many pharmacies have been processing more specific treatment-based guidelines for patient groups that most frequent the pharmacy.

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 (Puumalainen et al. 2005b). 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. The recommended period for this action plan is two years in order to make a permanent change.

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.

The pharmacy needs to have a vision and strategy in establishing patient counselling services (Puumalainen et al. 2005b). This means that patient counselling cannot be integrated into routine services without a long-term development plan linked to the strategy of the pharmacy. Furthermore, current practices need to be evaluated in a wider perspective than the customer-pharmacist interaction in order to implement good quality patient information. There are three key dimensions and related measures in this respect, the dimensions being:

- understanding the information needs of the customers;
- modifying the service process, including resources and facilities to integrate counselling; and
- developing competency of the personnel.

8. Make patient counselling skills training available for practitioners

There is an urgent need to train practitioners in counselling skills. 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 behaviour 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).

The learning process needs to be systematic and horizontally designed, and based on constructive and experiential learning. 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

(Appendix 1). 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. 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 standardised patients.

Considerable challenges remain in the access to communication skills training. There is a lack of courses, especially long-term courses that involve the entire working society. There is also a lack of training materials, as well as competent tutors and teachers. There is a need for international cooperation to develop better training and establish a forum for sharing resources.

9. Make patient counselling visible as a process

One of the fundamental tools needed to develop patient counselling skills is an instrument that makes counselling visible as a process. One applicable instrument for this purpose is the USP Medication Counselling Behaviour Guidelines (accessible at: www.ipsf.org). These guidelines introduce practitioners to the principles of two-way communication and performance self-assessment. The USP Guidelines are a valid and reliable tool that was developed using a consensus method based on an inventory of existing assessment instruments for patient counselling. Such resources can be made known through basic and continuing education; as well as through inclusion in drug information databases and operational measures. It is important to logically follow the same principles in different resources to reinforce learning and reshape behaviour patterns consistently.

The USP Guidelines provide definitions of the concepts and medication counselling stages, starting from monologue-based information transfer and resulting in collaborative discussion and learning between customer and pharmacist (see Chapter 1: Table 1). A formatted series of 35 counselling items can help the pharmacist to properly understand the needs of the patient, and in turn, creating a healthy level of communication.

The medication counselling process starts with an introduction that aims to assess the customer's need for information (Appendix 1). The content of information is then customised on the basis of the needs assessment. On concluding the dialogue, the pharmacist needs to ensure adequate understanding. The fourth category of the process includes communication techniques needed throughout the interaction.

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 in addition to well-planned and co-ordinated actions (Kansanaho et al. 2005).

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.

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