

Division of Social Pharmacy
Faculty of Pharmacy
University of Helsinki

Implementation of the principles of patient counselling into practice in Finnish community pharmacies

HELI KANSANAHO

Doctoral dissertation

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Supervisors: Professor Marja Airaksinen, Ph.D.
Division of Social Pharmacy
Faculty of Pharmacy
The University of Helsinki

Doctor Parisa Aslani, Ph.D.
Division of Pharmacy Practice
Faculty of Pharmacy
The University of Sydney, Australia

Doctor Maria Cordina, Ph.D.
Department of Pharmacy,
The University of Malta

Reviewers: Senior Lecturer Timothy Chen, Ph.D.
Division of Pharmacy Practice
Faculty of Pharmacy
The University of Sydney, Australia

Director Lena Levander, Dr (Agr & For)
Viikki Campus Educational Development Service
The University of Helsinki

Opponent: Docent Kirsti Launis
Finnish Institute of Occupational Health

*“Gutta cavat lapidem non vi, sed saepe cadendo.
Sic homo fit doctus non vi sed saepe legendo.”*

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ABSTRACT

This study was conducted in connection with the national patient counselling development project TIPPA. Patient counselling is considered to be one of the main duties for community pharmacists. According to previous Finnish studies, pharmacists have had difficulties in understanding the principles of patient counselling, implementing patient-centered counselling into pharmacy practice and developing new medication counselling behaviors. It was understood that community pharmacists need concrete tools and instruments to implement new counselling practices and develop their own professional competency. As a consequence, a 4-year national program, TIPPA, was launched in 2000 in order to promote long-term professional development in community pharmacies. The aim of this study was to assess how the principles of patient counselling had been implemented in practical work in Finnish pharmacies during a period of two and half years from the start of the TIPPA project (2000–2002).

The first study investigated the levels of patient counselling skills of Finnish community pharmacists in the context of reflectivity. The theoretical background of the study was based on the United States Pharmacopeia (USP) Medication Counselling Stages and Mezirow's theoretical underpinning. The data consisted of narratives written by 40 practicing pharmacists (M.Sc. and B.Sc. Pharm.) before starting the one-year patient counselling courses in 2000 (n = 21) and 2001 (n=19). The data were analyzed using categorization and thematic analysis. The results showed that only one pharmacist reached the level of critical consciousness. Altogether, 22 pharmacists remained at the level of affective reflectivity (the novice level of competency) and 10 remained at the level of consciousness (the beginner level of competency).

The second study investigated community pharmacists' perceptions of the impact of a long-term continuing education (CE) course on their patient counselling skills. Three focus group discussions were conducted with the course participants (n=17) during the last module of the CE course in 2001. Data analyses was based on Grounded theory. The focus group discussions revealed eight preliminary categories that were further categorised into four themes related to the learning process in patient counselling skills. The first theme related to achieving the learning objectives. The second related to personal development, understanding principles of two-way communication, and problems in their implementation into practice. The

third theme related to actions taken by the participants in their work place, and the fourth involved the potential conflict between the new skills gained and the traditional communication culture in the participant's pharmacy.

The third study investigated implementation of the TIPPA project in Finnish community pharmacies 2.5 years after the TIPPA project had started. A survey of a random sample of 734 community pharmacists was conducted in 2002 (response rate 51%, $n = 376$). The questionnaire included an implementation scale and two open-ended questions on patient counselling, an attitudinal scale and two open-ended questions on the impact of the TIPPA project on patient counselling. Attitudes toward concordance were measured using a modified version of the LATCon scale (Raynor et al. 2001). The construct validity and internal consistency of the scale were evaluated using factor analysis and Cronbach's α . Mean summative factor scores (MSS) and 95% confidence intervals were calculated for each factor. The responses to the open-ended questions were content analyzed.

Many of the actions were not optimally implemented 2.5 years after starting the project. Some individual actions may have been taken, but the systematic long-term development process has not yet been started in many pharmacies. Almost 80% of the respondents strongly agreed that the highest priority in patient counselling was to establish a therapeutic alliance between the pharmacist and patient. Factor analysis of the attitudinal scale yielded 3 primary factors explaining 37.6% of the variance, interpreted as respecting patients' beliefs ($\alpha = 0.60$; MSS = 1.90; 95% CI 2.25 to 2.40), establishing a therapeutic alliance ($\alpha = 0.65$; MSS = 1.36; 95% CI 1.31 to 1.40), and sensitivity to patients' reactions ($\alpha = 0.66$; MSS = 2.33; 95% CI 1.83 to 1.96).

Information gathered from this study is important for the development of training at an undergraduate level, as well as continuing education courses for practicing pharmacists to support reflective learning processes in developing professional competencies such as patient counselling skills.

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Tuusula, December 2005

Heli Kansanaho

OPERATIONAL DEFINITIONS OF THE KEY TERMS (in alphabetical order)

Adherence

According to World Health Organization (WHO), the term adherence may be defined as: the extent to which a person's behaviour (e.g. taking medication, following a diet and/or executing lifestyle changes) corresponds with agreed recommendations from a health care professional, i.e. how patients adhere to their treatments (WHO 2003). Adherence implies that patients have active role in defining and following their treatments.

Community pharmacy

Community pharmacy is a health care unit that is expected to promote and contribute to rational drug use by dispensing medicines, providing drug information and compounding pharmaceutical products in a way, which provides maximum benefit to the patient (Pharmacy Act 1987).

Compliance

The term compliance suggests that patients acquiesce to, yield to, or obey health care professionals' instructions. Compliance represents a paternalistic approach with; health care professionals expecting patients to yield to their instructions e.g. to take the correct amount of the prescribed medicine at the proper time (WHO 2003).

Concordance

The term concordance is a new approach with the patient as an active member of the healthcare team in managing his/her disease (Marinker 1997). Concordance is based on the notion that the consultation between the professional and the patient is a negotiation; therefore, the aim is a therapeutic alliance between them. This approach is expected to influence the interaction between healthcare professionals and patients. In a concordant-style counselling situation health care professional and patient are reaching an agreement concerning the patient's self-management of treatment. The patient has autonomy to decide together with health care professional, whether to use medicines or choose an alternative choice for his/her disease. Concordance is not synonymous with compliance and adherence (WHO 2003).

Health counselling

The features that exemplify health counselling are the concepts of health, the nature of communication, the type of health education process and the social context. Health counselling can be defined as reciprocal, interactive action in educational process between the patient and health care professional (Poskiparta 1997).

Implementation

Implementation is defined as the act of implementing (Oxford Dictionary 2005) e.g. providing a practical means for accomplishing principles of patient counselling into pharmacy practice.

Leadership

The term leadership refers to the activity of leading and the ability to lead (Järvinen 2001). From the group perspective it means behaviour, and with it e.g. presumptions and basic values of the pharmacists can be recreated or changed.

Management

The term management is defined as the process of managing (Oxford Dictionary 2005). It aims to guide individual persons, various work groups and teams to work towards a desired direction in a particular organisation. Management also aims to allow people and groups to autonomously direct themselves towards set targets and to take increased responsibility for the development of their work and activities (Schein 1992).

Patient

Individual laymen who use health services to manage health problems in the context of pharmacy. The term customer is used to define a layman who uses the pharmacy services. In this study the term "patient" is synonym for the terms "customer" and "client". The concept includes patients who use prescription drugs, those who self-medicate, those who seek information only and those who pick up medicines for someone else.

Patient counselling

According to United States Pharmacopeia (www.usp.org) patient counselling is 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 emphasises that the health professional provides and discusses medication information with the appropriate person to achieve this goal. The nature of relationship between the patient and health care professional is interactive and constitutes a collaborative learning process for both parties.

Pharmacist

A health care professional, who specializes in medicines. In the context of community pharmacy, pharmacists have a wide range of responsibilities, which include dispensing non-prescription and prescription medicines, counselling patients and preparing pharmaceutical products. In Finland, there are two pharmaceutical qualifications, Master of Pharmacy (5-year university education) ("proviisori") and Bachelor of Pharmacy (three-year university education) ("farmaseutti").

Reflection

It is the process of critically assessing the content, process, or premise(s). People reflect on the content or description of a problem, also on the strategies and the procedures of problem solving (Mezirow 1991). In a reflection process a pharmacist observes his/her own actions during and after the action. By reflecting, a pharmacist is able to develop strategies to change their own action.

Strategy

This term refers to a plan designed to achieve a particular long-term aim (Oxford Dictionary 2005).

LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the data presented in the following original papers referred to in the text by Roman numerals I–IV.

- I** Kansanaho H, Cordina M, Puumalainen I, Airaksinen M.
Practicing pharmacists' patient counselling skills in the context of reflectivity
Pharmacy Education 5(1): 19–26, 2005

- II** 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 11:153–160, 2003

- III** 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 Counselling 57:272–279, 2005

- IV** Kansanaho H, Puumalainen I, Varunki M, Airaksinen M, Aslani P.
Attitudes of Finnish community pharmacists towards concordance.
The Annals of Pharmacotherapy 38:1946–1953, 2004

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1 INTRODUCTION

Practical work in community pharmacies offers pharmacists a challenging, versatile and extensive area of operation with various possibilities for carrying out the main duty of the pharmacy. The practises and methods for carrying out pharmacy work vary according to the patients' health condition, capacity, situation of life and environment. This means that professional competence in practical work is linked to both the situation and the communal context, in addition to the business strategy and health policy regarding the role of pharmacy and other health care services in the society (Airaksinen 1996, Perälä 1997, Tippa Project 2002).

Pharmacists practicing in pharmacies are required to have both the ability to meet the requirements of the work in a changing work environment and the ability to develop themselves. Professional competence should change when the work is subjected to various change pressures (Metsämuuronen 1998). Although pharmacists have had a legal obligation to take care of the patients' proper and safe use of the medicines since 1988 (Pharmacy Act 1987), the role of patient counselling has become more and more important as the result of changes in the society and health policy (Tippa Project 2002).

One important method for creating, managing and increasing professional competence is education. The special features of the competence area determine the usefulness of education in creating and increasing professional competence. When it concerns patient counselling skills, pharmaceutical knowledge, communication skills and co-operation skills with other health care professionals, are the special features.

After graduation and gaining professional qualifications, it is work in the community pharmacy setting, that plays an important role in the maintenance and development of the pharmacist's professional competence. This requires a working environment, which supports and also enables the development of the individual. Other factors contributing to professional growth include a clear identification of professional roles of the individuals in the work community, development of metacognitive skills, understanding of reflectivity in the development of professional know-how, and encouraging leadership of the pharmacy owner.

According to previous Finnish studies, pharmacists have had difficulties in understanding the principles of patient counselling, implementing tai-

lor-made and patient-centred counselling into practice and developing new medication counselling behaviors (Airaksinen *et al.* 1994, Airaksinen 1996, Sihvo and Hemminki 1997, Sihvo and Hemminki 1999, Vainio *et al.* 1998, Närhi *et al.* 1999, Sihvo 2000, Närhi 2001, Vainio 2004). Experiences from the 1990's showed that professional competence, together with systematic long-term professional development processes are needed at the pharmacy level (Airaksinen 1996). The first attempt to promote counselling practices in Finland was the WHO EuroPharm Forum's "Questions to ask about your medicines" campaign in 1993–1996 (Airaksinen *et al.* 1998). The results of the evaluation study showed improvement in customizing the information and showing empathy to the patients. However, there was no improvement in the content of information or in the frequency of counselling. The campaign was a starting point for the long-term development of professional patient counselling at the pharmacy level. In 1998, the Association of Finnish Pharmacies conducted a pseudo customer study to assess counselling performances and to assess the implementation of the professional strategy (The Association of Finnish Pharmacies 1998, unpublished). The results indicated room for improvement in patient counselling by pharmacists.

It was concluded that community pharmacists need concrete tools and instruments to implement new counselling practices and develop their own professional competence. As a consequence, a 4-year national program, TIPPA, was launched in 2000 in order to promote long-term professional development in community pharmacies. The aim of this study was to assess how the principles of patient counselling had been implemented in practical work in Finnish pharmacies during a period of two and half years from the start of the TIPPA project (2000–2002).

In this dissertation patient counselling has been examined in the context of community pharmacists, even though the other health care professionals such as doctors and nurses in hospitals and clinics may also provide patient counselling about medicines.

2 The Finnish pharmacy system

The Finnish community pharmacy system has experienced the same fundamental changes as other community pharmacies in other Western countries. In the beginning of last century, most drugs dispensed from pharmacies were prepared extemporaneously by pharmacists. About 100 years ago, the pharmaceutical industry started to manufacture medicines. The number of prescriptions began to rise, and that has changed the structure of the pharmacy system, so that the dispensing medicines and drug information became more important services for pharmacies (Peltonen 1987).

Pharmacies are estimated to have overall 50–60 million client contacts per year, which is more than any other health care point of service has (Kos-tiainen 2004). In Finland pharmacies have remained professional, the system is highly regulated and they are expected to be part of health care. In Finland both prescription (Rx) and non-prescription medicines (OTC) are sold and supplied only in pharmacies under the supervision of a pharmacist. Only persons with a bachelor's or master's degree in pharmacy are allowed to counsel patients, dispense medicines and prepare medicines (Pharmacy Act 1987). In many Finnish municipalities, the pharmacy is the main health care unit where patients have open access and can seek help for minor. Pharmacists, as health care professionals, can help people to maintain good health, to avoid ill health and make the best use of medicines through concordance based patient counselling (Airaksinen 1996, Cox *et al.* 2002).

The importance of skills required in customer service and patient counselling have been taken into account in curricular changes, especially since a major reform in 1994 (Asetus farmasian tutkinnoista 1994/246). Earlier, the curriculum mostly consisted of traditional natural sciences. Education at the university was drug-centred and lacking of a patient-centred approach. Nowadays, the curriculum contains also biomedical and social sciences (e.g. biopharmacy, pharmacology, pharmacotherapy and social pharmacy), in addition to traditional natural sciences (e.g. chemistry and pharmacognosy). According to a recent Finnish study (Katajavuori 2005a), the current curriculum at the University of Helsinki should contain much more clinical studies (e.g. biomedical and social sciences) for pharmacy students in order to maintain the expert skills of graduated pharmacists. Also university teachers need to develop and re-educate themselves in order to support and foster an advancing learning society (Bereiter and Scardamalia 1993,

Entwistle *et al.* 1993, Marton *et al.* 1993, Jonassen *et al.* 1993, Vermut 1995, Volet *et al.* 1995, Lonka and Ahola 1995, Tynjälä 1996).

There are two pharmaceutical qualifications in Finland, one qualification is the Master in Science of Pharmacy degree, which takes five to six years to complete, including six months' practical training in a pharmacy or in a hospital pharmacy, and can be obtained from either Helsinki or Kuopio University. In order to own a pharmacy, one must have the Master in Science of Pharmacy qualification. This is the only Finnish qualification entitling a pharmacist to practise in any EU member state. The other qualification in Finland is the Bachelor in Science of Pharmacy degree, which takes three years to complete including six month's practical training in a pharmacy or hospital pharmacy and can be obtained from either University of Helsinki or Kuopio or Åbo Academi. The staff of an average pharmacy consists of about 10 people, six of them having a bachelor degree in pharmacy and one having a master degree in pharmacy. In big pharmacies (number of prescriptions 100 000 or more per year) there may be 2 or 3 professionals with master's degree and a total staff up to 30 people.

Finland has the densest community pharmacy network compared to other countries with. This means that there are 145 pharmacies per 100 000 inhabitants in Finland, in Sweden the number is 69, in Great Britain 75, in USA 71 and in Australia 60 (www.fip.org, www.euro.who.int/europharm). The first Finnish community pharmacies were established in 1689. In 2004, there were 602 community pharmacies with 181 subsidiaries, which are privately owned. The Kuopio University Pharmacy is owned by the University of Kuopio and Helsinki University Pharmacy chain, owned by the University of Helsinki (a main pharmacy and 16 subsidiaries). The number of pharmacies, the constitution of new pharmacies or subsidiary pharmacies in Finland is regulated by the National Agency for Medicines (www.nam.fi). One pharmacist can have no more than one pharmacy and three subsidiary pharmacies at the same time. The pharmacy licence is personal, not transferable or hireable.

3 CONCEPT OF PATIENT COUNSELLING AND HEALTH COUNSELLING

3.1 Definitions used in patient counselling

The terms advice-giving and patient counselling have been used to describe the interaction between a health care professional and a patient. The term "advice-giving" is mostly used in the British literature (Raynor 1996). A specific definition for patient counselling has been difficult to find. The definitions have reflected their time and have not generally been deduced from any theoretical backgrounds. The definitions of patient counselling have been rather technical in nature focusing on the content, i.e. the information that the pharmacist gives to the patient. The definitions have not taken a stand on the nature of interaction between the professional and the patient, that is, whether communication has been a pharmacist's monologue or a dialogue between the pharmacist and the patient. Changes in patient counselling have taken place gradually. Discussion on patient counselling within the profession started as early as in the 1960's (Hepler 1987, Vainio 2004, Puumalainen 2005a). In the USA, De Young (1996) has reviewed patient counselling from the 1960's until to the mid 1990's. According to his review, the quality and quantity of patient counselling had not changed during the research period nor was there any change that would have taken place in the interaction between the pharmacist and the patient (De Young 1996).

Few researchers have tried to define the term patient counselling in their studies (Puumalainen 2005a). Puckett *et al.* (1978) and Ross *et al.* (1981) have defined the term as "any oral or written communication from the practitioner relating to the drug product and its use". Kirking (1982) defined patient counselling as "*the provision of verbal information that will help patients to use their medications properly*". According to Thomas and Ortiz (1986), patient counselling "*is advice given by a person qualified in the relevant field e.g. whenever a pharmacist gives advice about health care matters.*" Aslanpour and Smith (1997) defined counselling as "*the provision of information on medications and related health issues*". Holland (1992) defined counselling as "*the process of giving professional advice about medicines and other health matters*". According to Schommer and Wiederholt (1994), "*patient counselling is the provision of advice that is the reasoned opinion of a pharmacist, is subjective, and is patient-oriented within a medication-taking context.*"

In Finland, the discussion concerning patient counselling as part of the professional role of the pharmacists was initiated in the 1970s (Vainio 2004). However, according to studies conducted in the 1990s, counselling practices were still drug oriented in nature and it seemed that the principles agreed on the content of counselling in the 1980s existed still in counselling practices (Lilja *et al.* 1996, Itkonen 2000, Vainio 2004).

The ideal definition so far for the term counselling is *"the means by which one person helps another to clarify their life situation and to decide upon further lines of action"*, and its aim is *"to give the client an opportunity to explore, discover, and clarify ways of living more resourcefully and towards greater well-being"* (Blenkinsopp *et al.* 1999). According to this, counselling seeks to enable or empower the patient or client to decide on a particular course of action and see it through. The key point is that the counsellor is helping the patient to make his/her own decision, even if that decision is different from the one the counsellor thinks should be made (Blenkinsopp *et al.* 1999).

3.2 Concept of patient counselling according to the United States Pharmacopeia (USP)

The United States Pharmacopeia (USP) has established state-of-the-art standards to help ensure the quality of medicines for human and veterinary use and to promote public health (www.usp.org). The USP also has developed authoritative information about the appropriate use of medicines. National health care practitioner reporting programs support USP's standards and information programs. In addition, USP has been supporting many public service programs.

During 1994–1997, the United States Pharmacopeia (USP) dedicated its attention to the development of a comprehensive medication counselling assessment. The aim was to develop a tool that could be used by health care professionals in order to assess and improve their patient counselling skills. The goal was to create an evaluation tool that contains items having potential application to a variety of medication counselling contexts. The tool would take into account the entire counselling process; interactive communication between the health care professional and the patient and; the patient's information needs in self-management of treatment; and setting goals for the treatment.

Whether the patient counselling episode is short- or long-term, the same steps can be identified. These steps include the introduction, the content, the process, and the conclusion. In this process, communication skills are

important to customize medication counselling for the patient. The specialists came out with a form comprised of 35 items that is designed to measure behaviour associated with medication counselling components (Appendix 1). The validity and suitability of the Medication Counselling Behaviour Guidelines has been tested (Puumalainen 2005b).

The difference between medicine-centred counselling and patient-centred counselling can be described by the concepts developed by the United States of Pharmacopeia (USP) (Appendix 1). The concepts are: *Medication Information*, *Medication Information Transfer*, *Medication Information Exchange*, *Medication Education* and *Medication Counselling* (Appendix 1). Patient counselling can be understood as interactions, which take place during various stages of counselling. The USP Guidelines help to understand the continuum from limited interaction (monologue) to involved interaction (discussion). According to USP Medication Counselling Stages, patient counselling can be divided into four stages that are *Monologue of the pharmacist*; *Dialogue between patient and pharmacist*; *Conversation*; and *Discussion*.

3.3 Formats in health counselling

Patient counselling stages reflect the concepts created in health counselling, which have been analysed using similar stages as in patient counselling. The features that exemplify health counselling are the concepts of health, the nature of communication, the type of health education process and the social context. Health counselling can be defined as reciprocal, interactive action in educational process between the patient and health care professional (Poskiparta 1997). Poskiparta (1997) discusses the forms of health counselling through the concepts created by Ingrosso (1993): magisterial health counselling, participative health counselling and promotional health counselling.

Magisterial health counselling is considered to be neutral and asymmetric and it is founded on the behavioural learning theory, according to which learning is based on the adoption of a ready-given performance (this can be compared for the monologue of the pharmacist, see also the Appendix 1, Medication Counselling Stages) (Tynjälä 1999). The human being is regarded as a performing and executing mechanism, to whom information is transferred unidirectionally. In the monologue of the pharmacist, the patient is a passive object of information transfer. The uniqueness of human beings is not taken into account and people are not seen as reflecting beings, capable of independent problem solving. The process of magisterial health counselling is short-term. Patients are controllable and they follow

the orders dutifully given by health care professionals without thinking, if the treatment is adapted for their conditions. In magisterial health counselling the health care professional tries to affect on patient's action by denying, directing and ordering the patients (Shemeikka 1991).

In participative health counselling (this model can be compared for the dialogue between the patient and the pharmacist, see also the Appendix 1, Medication Counselling Stages) the patient has autonomy to do independent choices concerning his/her treatment and this model emphasises the rationality of the patient. The aim of participative health counselling is to help the patient to do conscious decisions in order to advance his/her health condition (Shemeikka 1991). Participative health counselling is founded on the humanistic learning theory. According to this theory, learning is based on a bilateral dialogue, in which the individual and case-specific nature of events is utilised as part of the learning event (Engeström 1985). The patient is conscious about his/her own disease and medication, and is interested to find out more about the treatment. In this model the process of counselling can be considered as sharing information between the patient and the health care professional. Still, the patient is not able to think reflectively and critically evaluate his own actions concerning the treatment (Mezirow 1991, Jarvis 1992, Poskiparta 1997).

Promotional health counselling situation involves a collaborative learning experience, which increases reflective thinking, and critical assessment of own action (as compared to conversation and discussion between the pharmacist and the patient, see also the Appendix 1, Medication Counselling Stages). It also enhances problem-solving skills and it is founded on cognitive psychology and the theory of cognitive action (Ausubul 1985, Mezirow 1991). Learning is based on the constructive learning concept, according to which information is not transferred to the learner, but the learner constructs the information on his own (Rauste-von Wright and von Wright 1994). Learning is two-way and interactive, and the consciousness and own thinking of the human being is emphasised in the learning event (Engeström 1985). The learner interprets his observations based on previous knowledge and experiences, continuously constructing new information.

Although health counselling is based on different learning theories, less is known about the theoretical basis of patient counselling in the community pharmacy context. In this thesis, theoretical framework of learning as a professional via the application of reflection and reflective practice by community pharmacists is introduced.

4 REFLECTION IN PROFESSIONAL DEVELOPMENT

4.1 Definitions of reflection used in the literature

In the field of pharmacy, reflectivity has not previously been examined from the point of view of the professional development. On the contrary, reflectivity of the professional activity of teachers, nurses and polytechnic students has been studied to some extent in the context of developing as experts (Järvinen 1990, Poskiparta 1997, Boud and Walker 1998, Boud 1999 and Ora-Hyytiäinen 2004). In this chapter the literature of reflection has been reviewed mainly from Mezirow's (1981), point of view, and taking into consideration the works of Van Manen (1977), Schön (1987) and Kolb (1984).

The concept of reflectivity is closely related to professional work. There is no single generally acceptable definition for it. Mezirow (1981) defines reflectivity as consciousness of own observations, interpretations of meaning or behaviour or of one's own ways of seeing, thinking and acting. According to Mezirow (1981), the meaning of reflection, is the way of observing, thinking and acting. Reflectivity can also mean observation, recognition and expression of one's own internal states and those of the others as well as the attitude towards them. This means that the individual attempts to recognise other people's internal conditions through his/her own states (Tiuraniemi 2002). According to Mezirow (1981) there are seven levels that can be detected in the reflectivity:

A. CONSCIOUSNESS

1. Reflectivity: People can simply become aware of a specific perception, meaning or behaviour of own or of habits they have of seeing, thinking or acting.
2. Affective Reflectivity: People become aware of how they feel about the way they perceive, think or act.
3. Discriminant Reflectivity: People assess the efficacy of their perceptions, thoughts, actions and habits of doing things; identify immediate causes; recognize reality contexts in which they are functioning and identify their relationship in the situation.
4. Judgmental Reflectivity: People are involved in making and becoming aware of their value judgements about their perceptions, thoughts, actions and habits in terms of their being liked or disliked, positive or negative.

B. CRITICAL CONSCIOUSNESS

5. Conceptual Reflectivity: The act of self-reflection which might lead one to question whether the terms e.g. "good" and "bad" are adequate concepts for understanding some phenomenon.
6. Psychic Reflectivity: Leads one to recognize in oneself the habit of making precipitant judgements about people on the basis of limited information about them (as well as recognizing the interests and anticipations which influence the way they perceive, think or act).
7. Theoretical Reflectivity: People becomes aware that the reason for this habit of precipitant judgement or for conceptual inadequacy is a set of taken-for-granted cultural or psychological assumptions which explain personal experience less satisfactorily than another perspective with more functional criteria for seeing, thinking and acting.

For the levels of reflectivity defined by Mezirow (1981), conceptual, psychic and theoretical reflection are related to critical consciousness, by which Mezirow (1981) means critical orientation towards one's own action and the ways of thinking and making observations. Achieving the level of theoretical reflection makes it possible to challenge earlier assumptions and ways of action. This, for one, is of significant importance in changing one's own ways of action, such as occupational practices.

In Mezirow's book entitled "Transformative Dimensions of Adult Learning" (1991) a different categorisation is used. Three forms of reflection are discussed: content, process and premise (Mezirow 1991). Content reflection means reflection on what people perceive, think, feel or act upon. Process reflection is an examination of how people perform these functions of perceiving, thinking, feeling, or acting and an assessment of their efficacy in performing them. Premise reflection involves peoples' becoming aware of why they perceive, think, feel, or act as they do and of the reasons for and consequences of their possible habits of hasty judgement, conceptual inadequacy, or error in the process of "theoretical reflectivity". According to Mezirow (1991) premise reflection involves the process of "theoretical reflectivity".

Van Manen (1977) distinguishes between three different levels of reflectivity: technical rationality, practical action and critical reflection. At the first level of reflectivity (technical rationality) sufficient knowledge and the ability to apply it are central elements. At the second level (practical action) of Van Manen's classification, the person takes over the tools of reflective thinking. At the level of critical reflectivity, the moral and ethical criteria of

practical thinking are examined. Van Manen's third level is close to Mezirow's (1981) critical consciousness.

According to Schön (1983, 1987), reflective expert assesses his/her own actions while doing (reflection-on-action) and after doing it (reflection-in-action) (Figure 1). Cowan (1998) has added the third type to Schön's model; preparing for the future (reflection-for action) (Figure 1).

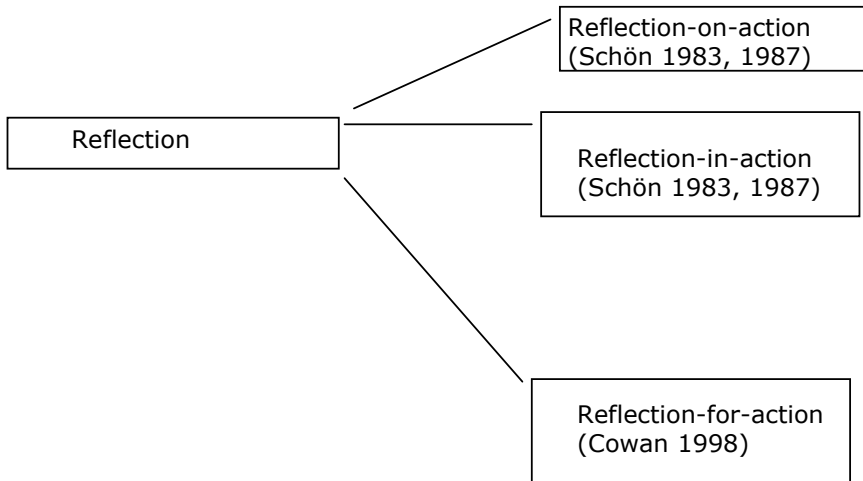


Figure 1. Three dimensions of reflection (related to Schön (1983, 1987 and Cowan 1998).

Learning new communication practices requires reflecting and changing earlier behaviour patterns. In the model of experiential learning by Kolb (1984) (Figure 2, page 26) the focus is on the ability of the individual to reflect and conceptualise personal experiences. Learning proceeds in a circular form in which new experiences are continuously produced through active performing; these experiences are then conceptualised by means of reflective thinking. This constructs again a basis for a new way of action. The development of action requires reflective examination of the professional's own cognitive processes, i.e. self-reflection, during which it is attempted to develop and evaluate one's own action through earlier successful ways of action. According to Miettinen (2000), Kolb has created a theory, which cannot optimally work in practice because the model of Kolb has not been confirmed empirically, and the validity of the indicator Kolb used in his model is low.

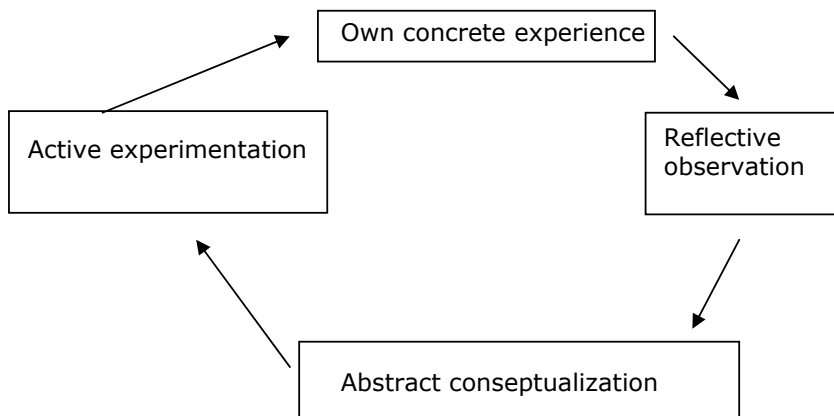


Figure 2. The model of experiential learning by Kolb (1984).

4.2 Reflection in patient counselling

The concept of reflectivity has been applied in the development of professional activity (Eteläpelto 1997). In professional work, reflectivity means examination of one's own professional performance from various points of view and development of performance based on this examination. In professional work, the focus is often in social observation, interaction and meanings given to various situations (Tiuraniemi 2002). For example, while counselling patients, pharmacist must observe, ask questions of, discuss and evaluate the patient in many ways in order to receive a versatile view of the guidance needed by the patient. At the same time the pharmacist must be aware of the effect of his/her own action.

The development into a professional can be seen as a process, during which professional skills undergo a change. The basis for the development of skills is knowledge. Formal knowledge is not sufficient for the foundation of the professional work, but other types of knowledge are also required. Eteläpelto (1997) examines the development of professionalism through three forms of knowledge (Van Manen 1977): formal, practical, and meta-cognitive. By formal knowledge Eteläpelto (1997) means information received from textbooks, which form the basis for practical knowledge. Practical knowledge means unconscious knowledge, consisting of competence and knowledge, which is bound up with practices related to a certain task. Practical or pragmatic knowledge is created through experiences and it is context sensitive, whereas formal knowledge can be considered universal (Tynjälä 1999). The third type of professional knowledge is meta-cognitive

knowledge, which is related to the person's own performance. It is reflective knowledge involving an examination of the various sides of expertise and thus an assessment of various activities.

Tiuraniemi (2002) also considers the development of professional skills as a hierarchy; the lowest level of it consists of professional techniques, the intermediate level of it consists the ways of action, and the highest level of it consists of operative strategies. The change of knowledge is based on the three forms of knowledge defined by Eteläpelto (1997). The hierarchy of professional skills defined by Tiuraniemi (2002) could also be applied to patient counselling of community pharmacists.

At the lowest level of professional skills, i.e. at the level of techniques, knowledge is based on formal automated knowledge, which is used to facilitate the performance of automated activities. This is analogous to the monologue of the pharmacist according to the USP Medication Counselling Behaviour Guidelines, Appendix 1: Medication Counselling Stages. The activities of a professional involve learning new techniques and therefore continuous training is necessary. Reflectivity on this level is related to situational reflection. In various situations, the professional must be able to assess and select the most suitable way of action for each situation. In the context of patient counselling by community pharmacists, professionalism means that the pharmacist commands the basics related to patient counselling, mastering thus the necessary elementary knowledge and skills for providing the guidance. By means of continuous education and by reflecting on patient counselling situations, the pharmacists might be able to change their old automated ways of providing guidance, or form completely new automated practices. The practices remain, however, formal from one situation to another and the actual situational adaptation of patient counselling is not noticeable.

At the intermediate level of professional skills, i.e. the level of ways of action, the central form of knowledge is practical. This level can also be called the level of ways of action and practices. In professional activities, both formal and practical knowledge are utilised to help turn the action into flexible functional entities instead of the earlier automated activities. This is analogous to the dialogue between the pharmacist and the patient according to the USP Medication Counselling Behaviour Guidelines, Appendix 1: Medication Counselling Stages. At this level, reflectivity means reflection of one's own experiences. At this level the pharmacist can determine which way of action is the best in each patient situation. Professionalism on this level means assessment of decisions made and evaluation of fitness and functionality of the approaches. By reflecting his/her own experiences gathered

in the previous patient counselling events, the pharmacist develops his/her own action and competence. The special needs of the patients are taken into account in patient counselling, which enables creation of customised counselling situations

At the highest level of professional skills, i.e. at the level of operative strategies, the knowledge is extensive reflective knowledge, which helps to form target-oriented entities of action. On this level the reflection is critical reflection (Mezirow 1991). By using critical reflection, the professional can re-define his/her own work and thus improve his/her action. At this level, the professionalism of the pharmacist is based on the utilisation of one's own personality as a tool. Critical reflection provides the means for the re-definition of one's own action for the pharmacists. Grounds are searched for one's own professional activities and the position as a patient counsellor is called into question. A new attitude towards one's own work and way of action prepares the way for an equal role of the pharmacist and the patient in a counselling situation.

Carr and Kemmis (1986) have also examined professional skills as action taking place on three different levels. They distinguish between static professional skills proportional to individual tasks, ideal professional skills proportional to the individual action, and dynamic professional skills proportional to the working environment and community. Turpeinen (1998) has used the classification of Carr and Kemmis (1986) as the basis of his study. On the various levels of professional skills, knowledge, action and feeling are differently proportioned to each other. In static professional skills, knowledge, action and feeling are separate from each other. On this level, professional skills are related to a flawless mastery of knowledge and separate tasks. In ideal professional skills, the action and the feeling are intertwined. On this level professional skills are focused on intellectual and theoretical mastery of action. On the level of dynamic professional skills, knowledge, action and feeling are all combined. Professional competence depends on how professional skills have been defined in various working environments and communities. The core of professional skills is its adaptation in complex and unpredictable working situations (Turpeinen 1998). Professional skills and the actual expertise are created gradually along with the experiences gathered and their evaluation. During their careers, pharmacists encounter a great number of different working situations based on which they gradually form different ways of action. Along with the experiences, part of the expertise changes into automated operating models (technical/statical professional skills, Katajavuori 2005a). At the same time, professional capacity is freed for more demanding problem solving situations.

5 PROFESSIONAL COMPETENCE OF THE PHARMACIST

5.1 Definition of professional competence used in the literature

The term "professional" is used to refer to a person who, based on education and experience, can provide detailed analyses and answers for special questions in his/her professional field (Launis 1997). Professional competence can be defined as the ability of the individual to accept challenges of developing his/her own competence and that of the work community; to apply the current information; and create new (Hilden 1999). Education and experience play a major role in the development of a professional. Professional competence is a continually developing characteristic, in which the know-how develops as a part of operation. A professionally qualified person can continuously redefine his/her tasks and operation and thereby develop the ways of action, the changing of which is based on experiences and self-reflection (Tynjälä 1999).

Professional competence can be developed best in learning processes in which the person participates in developing his/her own work, i.e. is a developer, not merely a performer of the work. This is because a major part of professional competence must be acquired within the actual profession (Leppänen 1994a,b). Professional competence does not only imply that pharmacists are licensed health care professionals. They also increase their professional knowledge in providing information about medicines to patients. The foundation for the competence of a community pharmacist is created by the pharmaceutical know-how, reflective interaction skills and experience acquired in the work. In addition, the pharmacist continuously seeks to develop his/her expertise in the profession by educating him/herself and acquiring information on the latest scientific and professional development.

Carnevale *et al.* (1990) and Rush and Evers (1986) have studied professional competence among leaders and academics working at universities and in high technology companies. The findings could be in principle applied in the practice of pharmacy work as well. The study of Carnevale *et al.* (1990), dealt with the types of competence required of employees. They were expected to have skills in learning how to learn, communication skills, adaptation, creative thinking and problem solving. The following

list of characteristics included in professional competence is based on the research of Evers and Rush (1996). Their results have been modified into pharmacy context by the author of this dissertation.

Initiation of innovations and changes: This comprises the ability to combine relevant information, to integrate the information into a general context and to apply the information in a new and wider context. In the pharmacy context this means that pharmacists should maintain and expand their pharmaceutical knowledge and change it to a form that is understandable to the patient in a counselling situation.

Management of people and tasks: This involves the ability to co-ordinate and take decisions. It applies to pharmacists and pharmacy owners working in managerial positions in pharmacies. It includes leadership and influencing skills required to work as well as the ability to understand the reasons for conflicts, and the ability to plan and organise.

Communication: This includes the co-operation skills required in practical pharmacy work and managerial work, listening skills and communication skills.

Self-management: This comprises learning and self-organisation skills including problem solving skills, ability of analytical thinking and awareness of one's own strengths and weaknesses.

Elements of professional competence

Professional competence consists of several different elements. One part of professional competence is a pharmaceutical knowledge base. In addition, it is necessary to update the latest information, applications and achievements of one's own and the related professional fields. The skills to combine relevant information and ability to integrate the information into a context are also required (Evers and Rush 1996). Interaction, co-operation and teamwork skills are needed above all in human relations and service jobs (Ellström 1992, Evers and Rush 1996, Wolgin 1998) such as the pharmacist's work in a pharmacy.

Interaction skills are necessary when providing counselling to the patient, discussing with the patient's relatives and other interest groups, such as other health care professionals, or when working with own colleagues as experts. The characteristics of professional competence are well identi-

able in patient counselling provided by pharmacists. The objective of the work is the patient, whose situation is analysed and appropriate patient counselling is then provided for enhancing the appropriateness of the patient's use of medicines. Every patient has a unique situation. This means that the content of patient counselling cannot be identical for all patients (i.e. monologue of pharmacists), but patient counselling should be adapted to the needs of each patient (i.e. the dialogue between the pharmacist and the patient).

Implementation of the philosophy of pharmaceutical care supports, for its part, the professional nature of the pharmacy (Hepler and Strand 1990, Närhi 2001). According to the principle of pharmaceutical care, pharmacy work does not only involve the delivery of medicines to the patients but also includes the responsibility that pharmaceutical care is beneficial for treatment outcomes (Hepler and Strand 1990). The importance of the professional role of pharmacist is made visible in publications of the Association of Finnish Pharmacies (AFP) (e.g. Guidelines for Professional Community Pharmacists 1997, Pharmacy and Health Promotion 1998a). Professional pharmacy means that the foundation of the pharmacy's activities is based on professional competence (Ethical guidelines for pharmacies, The Association of Finnish Pharmacies and The Finnish Pharmacists' Association 1998) and that pharmacy services should be integrated into health care. Full utilisation of the specialist know-how of the pharmacy personnel is defined as professional target of the pharmacy.

5.2 Professional roles in patient counselling

In patient counselling encounters, the patient and the pharmacist act according to certain roles (Alkhawajah and Eferakeya 1992). The concept of role is related to social interaction, based on the expectations of the environment related to the behaviour that is appropriate in each situation (Sulkunen 1989). According to the theory created by Irwin Goffman (1971), a significant developer of the social role theory, everyday life of people is like a theatre in which each individual is playing his/her own role. Individuals attempt to play the roles in such a way that others would receive as favourable as possible a view of that role (Goffman 1971).

Obtaining and maintaining a role requires a continuous interaction with the environment (Sulkunen 1989). For example, receiving the role of the pharmacist requires many kinds of interactive processes, which are related to basic education, the certification of the profession and working in practice.

Maintaining the role, requires control of necessary knowledge and skills. Symbols facilitating the recognition of the role, such as the white uniform are also related to the maintenance of the role.

When acting in society each individual is constantly facing others through social expectations (Sulkunen 1989). For example, in patient counselling situations in a pharmacy, the patient has certain expectations of how the pharmacist should act, and similarly, the pharmacist has certain expectations for the patient's action. When both individuals act in the way required by their roles, the interactive situation flows according to the expectations.

Szasz and Hollander (1956) have created a classical model that describes the roles of a doctor and a patient. According to them, the relationship between the doctor and the patient can be one of the following:

- Active/Passive model, in which case the doctor plays the active role and the patient is passive. This can be compared to the monologue of the pharmacist according to the USP Medication Counselling Behaviour Guidelines USP, Appendix 1: Medication Counselling Stages.
- Counselling/Co-operation model, in which both the doctor and the patient have active roles. This can be compared to the dialogue between the patient and the pharmacist according to the USP Medication Counselling Behaviour Guidelines, Appendix 1: Medication Counselling Stages.
- Promotional counselling model, in which both parties are equal and lean on each other. This can be compared to the discussion and consultation according to the USP Medication Counselling Behaviour Guidelines, Appendix 1: Medication Counselling Stages.

The above-mentioned models also can be applied to the roles of the patient and the pharmacist in the patient counselling situations in community pharmacy. The pharmacist and the patient, then, do not have a single role only, but depending on the situation, they can act at least in three different roles. In patient counselling the object can diversify: the focus can be on the patient, or the health care professional or the relationship between the patient and health care professional. This is illustrated in figure 3 (page 33), which is based on the model developed by Dryden and Thorn (1991).

In the figure 3 (page 33), big circles are supposed to describe working environments. The lowest small circle describes the role of the doctor and the lowest big circle describes the co-operation area between the patient

and the doctor. The upper small circle describes the role of the pharmacist and the upper big circle describes the co-operation area between the patient and the pharmacist. From the patient's point of view these two big circles are supposed to be partly one on the other. This means that while the patient is in the pharmacy, his/her thoughts might be concentrated on the pharmacist and (s)he might be remembering the visit with the doctor at the same time, but pharmacist should be concentrated mainly on the patient while counselling.

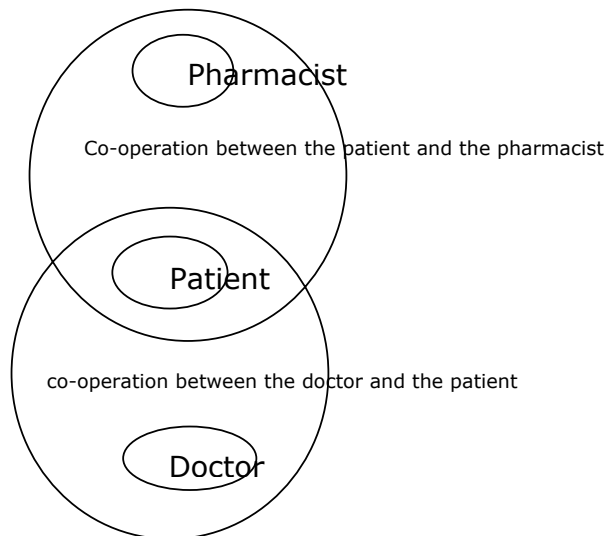


Figure 3. Roles between the patient, pharmacist and doctor in patient counselling modified from the model developed by Dryden and Thorn (1991).

According to the empirical studies from 1985 in different countries, the patients have had a passive role in patient counselling situations (Thomas and Ortiz 1986, Airaksinen *et al.* 1998, Cox *et al.* 2002). Patients do not ask actively about their medicines even if they have difficulties with their medication (Vainio 2004). Patients want information about their medication (Airaksinen 1996, Katajavuori 2005a), but they expect to be given information spontaneously by pharmacists (Airaksinen *et al.* 1993). A Finnish study in 1992 showed that pharmacists attempted to have problems in communicating with patients (Vainio *et al.* 1998). There were patients in 1992s that did not receive information about their asthma medication, but there were also attempts to find out the need for counselling and also some ad-hoc spontaneous counselling without any structured model (Vainio *et al.*

1998). However, pharmacists could be able to detect problems in asthma patients' medication by using simple tools such as prescription reviews and short patient interviews (Närhi 2001). According to some studies, patients buying non-prescription medicines from the pharmacy could be counselled well by the pharmacists about medicines' indications, interactions and side-effects (Isonen and Eerikäinen 1998, Snellman and Airaksinen 2000, Sihvo 2000, Katajavuori *et al.* 2002). On the basis of these studies, the role of the pharmacist cannot be considered very active in advice giving. According to a Finnish study of people who bought non-prescription medicines from pharmacy, in most cases (53%, n=458) pharmacists helped the patient to find the medicine they needed, and in 40% of the cases the pharmacist provided therapeutic counselling (Katajavuori *et al.* 2002).

Evidence from the beginning from the 1990 and 2000 indicates that pharmacists might still be experiencing difficulties in carrying out their counselling role in practice (Koistinen *et al.* 1993, Katajavuori 2005a). Reasons for this could be the pharmacists' lack of competence and the attitudes of the patients towards counselling and counselling model they have adapted (Erwin *et al.* 1996, Lisper *et al.* 1997). When discussing prescription drugs, doctors occupy the key position, but the role of community pharmacists in this area has increased (Närhi 2001, Vainio 2004). According to a Finnish study in 1985 and 1995 (Vainio *et al.* 1998) community pharmacist have become as important a source of information as are physicians.

The demand for better outcomes of drug therapy has increased the need to improve communication and co-operation between doctors and community pharmacists (Hepler and Strand 1990). As in other countries, Finnish community pharmacists are physically separate from primary health care units, and that hinders co-operation. According to a Finnish study in 1994, there has been a need to improve and increase co-operation between physicians and pharmacists (Tanskanen *et al.* 1997). The same study indicated that many physicians wished that pharmacists would contact them more about therapeutic issues. Many doctors have found patient counselling in community pharmacies to be needed, but they still had some prejudices, especially on counselling about psychotropic medicines (Tanskanen *et al.* 2000). According to the studies (Hemminki and Herxheimer 1996, Tanskanen *et al.* 1997, 2000) there is need and willingness for open discussion about pharmacists' participation in patient information. But the pharmacists have the key for co-operation with the other health care professionals.

6 FROM COMPLIANCE TO CONCORDANCE IN PATIENT COUNSELLING

6.1 Compliance or adherence?

Medications are the preferred treatments for many diseases and disorders. It has been estimated, however, that patients' overall compliance with medicines is only around 50% (Blenkinsopp *et al.* 1999, WHO 2003, Osterberg and Blaschke 2005). The term "compliance" has been defined as "*the extent to which a person's behaviour in terms of taking medications, following diets or executing other lifestyle changes coincides with medical or health advice*" (Haynes *et al.* 1979). Compliance therefore refers to the patient's behaviour in relation to their medicines (Blenkinsopp *et al.* 1999) and it has been dejected, because it conveys the meaning that the health professionals have paternalistic attitude toward the patient who should just follow their recommendations (Donovan 1995, Kyngas *et al.* 2000). Research has focused on the reasons for non-compliant behaviour (WHO 2003, Osterberg and Blaschke 2005). There are two categories of non-compliance: primary and secondary (Marinker 1998, Aslani and Du Pasquier 2002, WHO 2003). Primary non-compliance refers to patients' failure to have their prescription dispensed. Secondary non-compliance refers to cases when patients collected their medication, but failed to take their medications as intended by the prescriber.

The concept of compliance has been regarded as paternalistic (Marinker 1997, Marinker 1998, Lutfey and Mishner 1999, Aslani and Du Pasquier 2002, WHO 2003). For example in patient counselling situations the "compliance approach" does not recognise the patient as an active participant in managing his or her own condition. Instead, this approach involves patients being considered objects of decisions made by health care professionals. In the "compliance approach", patient counselling is seen as the process of information transmission from an authoritative health care professional to a passive subject. As such it is based on the traditional learning concept of behaviourism. At a pharmacy level, the "compliance approach" involves the pharmacist being perceived as an expert, with little attention being paid to the beliefs and behaviours of the patient.

Recent recognition of the importance of patients' attitudes and beliefs has led to the use of the term adherence. Use of the term adherence to define medication taking behaviour is less judgemental than the use of the term

compliance, and implies more active patient involvement in therapeutic decision-making (Cameron 1996, Marinker 1998, Myers and Midence 1998, WHO 2003). According to the World Health Organisation (WHO), the following definition of adherence was adopted: "*the extent to which a person's medication-taking behaviour, following diets or executing other lifestyle changes, corresponds with agreed recommendations from a health care provider*" (WHO 2003). The term adherence suggests that patients have adhered to informed decisions about their own health care. It has been suggested that the conceptual shift from compliance to adherence is an important first step in moving towards models of patient counselling, emphasising the independence and self-regulatory activity of the patient (Leventhal 1993, Mullen 1997, Marinker 1998, WHO 2003).

6.2 The concordance model

The newest model describing the interaction between health professionals and patients is referred to as concordance. It was proposed in 1997 by the Royal Pharmaceutical Society of Great Britain, published in "*From compliance to concordance: achieving shared goals in medicine taking*" (Royal Pharmaceutical Society of Great Britain /Merck Sharp and Dohme 1997). Concordance is based on the notion that the pharmacist and patient interact as equals, thus allowing the formation of a therapeutic alliance between them (Marinker 1997). Concordance is not synonymous with compliance or adherence; concordance is about involving the patient as a decision-maker about their own health care (Blenkinsopp *et al.* 1999). Concordance is based on a new concept of information transmission between the pharmacist and the patient. In the "concordance approach" the role of the pharmacist is to support the patient in constructing his or her own knowledge and attitudes towards the use of his/her medications. The patient is perceived as an expert on his or her own disease and medication use. This was studied by Raynor *et al.* (2000) and the study concluded, that pharmacists need to acquire a new role. This does not undermine the role of the pharmacist as an expert in the use of medications, but instead facilitates a meaningful interaction between the pharmacist and patient that is necessary to promote and support optimal disease management. However, according to studies, patients' willingness to take part in decision-making concerning their medications is not very clear (Stevenson *et al.* 2002)

Thus, the term concordance has been used to define a process of prescribing and medicine-taking based on partnership (Cox *et al.* 2002). The "concordance approach" challenges pharmacists to rethink their own attitudes to

patient counselling. Pharmacists, as health professionals, could help people to maintain optimal health and to gain maximum benefit from their medicines (Hepler and Strand 1990, Airaksinen 1996, Bond 2001, Närhi 2001, Anderson 2002). To perform these tasks, pharmacists require a new type of professional competence in concordance and patient-centered counselling. Due to this, pharmacists' professional roles should change. Pharmacists should move away from drug-focused, paternalistic approaches to patient counselling and provide customized information according to patients' needs, with the aim of achieving better outcomes from drug therapies (De Young 1996, Marinker 1997, Morrow and Hargie 2001).

6.3 The operationalisation of the concordance model

Few studies have so far attempted to operationalize the concept of concordance. In the University of Leeds, England, Raynor *et al.* (2001) have developed the Leeds Attitude to Concordance (LATCon) scale in order to assess the attitudes of health care professionals (nurses, doctors and pharmacists) toward concordance model (Table 1). The original LATCon scale consists of 12 statements using a Likert scale format from 1 (Strongly Disagree) to 4 (Strongly Agree). All the statements in the LATCon scale are positively worded. The LATCon scale was derived from a larger pool of items and has been evaluated in newly qualified doctors, nurses and pharmacists, as well in patients (Raynor *et al.* 2001).

Table 1. Statements in the Leeds Attitude to Concordance Scale (LATCon). Derived from: Raynor *et al.* 2001.

Statement
1. The consultation between the prescriber and patient should be viewed as a negotiation between equals
2. Prescribers should respect the validity of their patients' personal beliefs and coping strategies
3. The best use of medicines is that which is compatible with what the patient wants and is capable of achieving
4. Just as prescribing is an experiment carried out by the prescriber, so too is medication taking an experiment carried out by the patient
5. Prescribers should give patients the opportunity to communicate their thoughts about their illness and negotiate how it is treated
6. Enhanced health outcomes would follow from mutual and co-operative interaction between prescribers and patients
7. A high priority in the consultation between prescriber and patient is to establish a "therapeutic alliance"
8. Prescribers should be sensitive to patient desires, needs and capabilities
9. Prescribers should try to assist patients to make as informed choice as is possible about benefits and risks of alternative treatments
10. During the prescriber-patient consultation, it is the patient's process of deciding that is most important
11. I believe that prescribers should be more sensitive to how patients react to the information they give
12. I believe that prescribers should try to learn about the beliefs their patients hold about their medicines

In the study conducted in Leeds, England, which assessed the health care professionals' (doctors, nurses and pharmacists) attitudes toward concordance, the results showed that pharmacists (n= 25) showed the least favourable attitudes, although a typical respondent had a positive attitude toward concordance (Raynor *et al.* 2001). Stokes *et al.* (2005) have assessed patients' attitudes toward concordance by using the LATCon scale. The results showed that patients (n=150) had a range of attitudes to concordance, across the spectrum. There was a significant difference in attitudes toward concordance between males and females ($p=0,026$), with females having more positive attitudes than males.

However, further studies are required to assess the reliability of the scale and it needs to be modified over time. The LATCon scale could be used in pharmacy education to illustrate the concept of concordance and make it more concrete and understandable. It is important that the profession continue to further develop the scale and have more experiences with its use in other countries.

7 CHANGE IN COMMUNICATION CULTURE OF PHARMACY

Working society can be considered as a learning society (Hart and Rotem 1995). In this dissertation working society means health care professionals, and pharmacists who work in community pharmacies. Figure 4 describes the dimensions that have influence on the working society so that it can become a learning society (Argyris 1977, Senge 1990, Huber 1991, Woolner 1992, Garvin 1993, Hart and Rotem 1995). Professional development is dependent on management style, development possibilities in the work place and the support from the colleagues (Figure 4). The purpose of management is to guide individual persons, various work groups and teams to work towards a desired direction in a particular organisation (Järvinen 2001). Management also aims to allow people and groups to autonomously direct themselves towards set targets and to take increased responsibility for the development of their work and activities (Schein 1992). This requires changes in the attitudes of pharmacy owners and staff pharmacists as well as willingness to commit oneself to the objectives of the organisation (Argyris 1985).

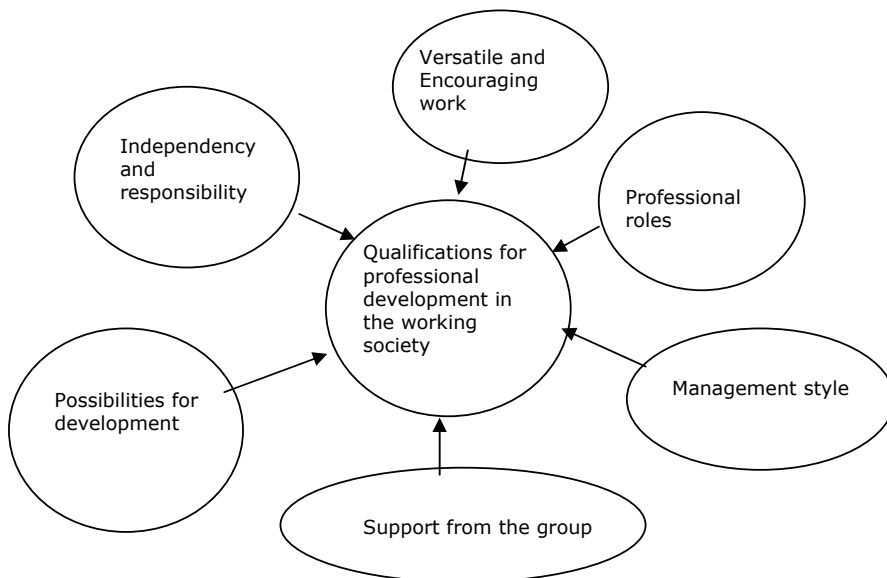


Figure 4. Dimensions that affect that a working society can become a learning society (Hart and Rotem 1995).

The development of the pharmacy as an organisation requires that the pharmacy owner, as an employer and a leader, is familiar with the principles of behaviour of people and work communities (Hersey and Blanchard 1991, Hunt 1991, Schein 1992). The pharmacy owner should show interest towards the staff pharmacists and their development, which means that the development of organisation must always start from the highest level of the organisation (Järvinen 2001). Long-term development projects, such as promoting patient counselling services, can be successful if the highest level of the organisation (e.g. pharmacy owner) considers them important or regards them as central tasks included in their own management work (Argyris 1990, Järvinen 2002, Lehtonen 2003).

The job description of pharmacists practicing in pharmacies has become much closer to that of a professional (Savela 2003). Earlier the work in pharmacies demanded different skills to those required nowadays. In the past medicines were extemporaneously prepared in pharmacies much more than they are today and counselling about medicines has only been permitted since 1982. Thus a pharmacist's professional work in compounding medicines required a level of competence beyond that of their subordinates (Juuti 1999). The work in pharmacies still requires in many respects professional specialisation and skills (Närhi 2001, Savela 2003, Vainio 2004, Katajavuori 2005a).

7.1 Development projects in pharmacies

When starting to plan innovations at the work place, such as the development of patient counselling in pharmacies, it should be understood that change is a very contradictory phenomenon in people's mental images. According to Järvinen (2002), on one hand, people want change and innovation, but on the other hand, they would like everything to remain unchanged. Change can occur for many different reasons: it is hoped that it can bring improvement to everyday life or it can provide new challenges and opportunities for personal development (Argyris 1985). The reason why changes may not be wanted is because it can bring about uncertainty, insecurity, anxiety and fear towards coping with change (Järvinen 2001). The complete opposite wishes and feelings towards change are to a great extent exclusive of each other. It is simply not possible to simultaneously change and yet remain the same; in other words, change always requires partially giving up the old and entering into the new. Change always involves some kind of risk-taking, which requires acceptance of uncertainty (Argyris 1985).

Change situations at the work place are difficult for its members, because it upsets the person's own basic structures, which lay the foundation for the person's mental balance and sense of well-being. Changes test a person's understanding of their own meaning or purpose, which is a very central principle guiding an individual's action. Human beings always want to understand the meaning and significance of things and events in order to rationally perceive what is going on in various situations (Fisher *et al.* 2001).

The position of the pharmacy owner in the change situation might be difficult, because the pharmacy owner as the director of change is also a target of the change (Järvinen 2001, Järvinen 2002). In development projects, it is not sufficient that the pharmacy owners just makes the staff pharmacists participate in the implementation of change, and at the same time they do not change their own behaviour. The consequence of this is that pharmacy owners need to elaborate the meaning or purpose of change and also personally adapt their own behaviour accordingly (Järvinen 2002).

In addition to the experience of individual meaningfulness, the right of self-determination, regulating the behaviour of individuals and communities, is put to the test in change situation (Järvinen 2001). This is because human behaviour is directed by the endeavour to determine for oneself and for one's relationship to work and life in general. In a change situation, the members of the work community become worried about a possible narrowing of their independence and influence or they are wondering if changes are made without asking their opinions (Argyris 1990). Commitment to the implementation of change requires, in addition to the experience of meaningfulness, that the pharmacists feel that they have a possibility to participate and have influence on its content (Hirschhorn 1988).

7.2 Professional development projects in different countries

Development projects are needed at pharmacies in order to maintain good quality in professional services. Projects can be used to start innovations and reforms related to a particular work community or the entire business. The starting points, targets, implementation methods and duration of development projects might vary. A common feature of all development projects is the necessity to involve entire business (Järvinen 2002). The starting point for professional development projects is that the pharmacists and the pharmacy owner should know the developmental needs and prob-

lems as well as the solutions in order to fulfil these needs and remove the barriers (Savela 2003). For the pharmacy, however, the problem might be that it does not have a sufficiently clear vision of what the barriers are and how they can be removed.

In the world there have been attempts to improve pharmacy service by introducing and implementing the philosophy of pharmaceutical care (Helper and Strand 1990, Helper 1997, Herborg *et al.* 1996, Van Mil 1999, Närhi 2001, Pronk 2002).

Here are presented some development projects, which have been implemented in the world in order to improve pharmacy service.

TOM (The Therapeutic Outcomes Monitoring Project) was developed in the USA and it can be considered as a tool of pharmaceutical care (Hepler and Strand 1990, Hepler 1997). It is a disease-based system and there are modules available for asthma and diabetes mellitus (Segal 1997). This idea was adapted to Europe in order to improve pharmacy services. WHO EuroPharm Forum established the TOM Project in Europe and multiple countries were involved including Ireland and Great Britain. The TOM Project has also been conducted in Finland, The Netherlands, Malta and in Denmark in the mid 1990's (Van Mil 1999, Herborg *et al.* 1996, Närhi 2001, Cordina *et al.* 2001). The projects were designed to help patients, with asthma, become better managers of their own chronic condition. The program consisted of practical guidelines for identifying therapeutic objectives, monitoring patients' progress, identifying potential problems and resolving them (Närhi *et al.* 2000). Evaluation of the projects included knowledge, attitudes and satisfaction measures toward the service. In Finland the study was conducted in four community pharmacies, with 28 asthma patients taking part in one-year intervention. Results showed that it was possible to improve outcomes of asthma patients by enhanced monitoring and counselling by community pharmacists (Närhi 2001).

Project ImPACT (Improve Persistence And Compliance with Therapy) commenced in 1996 and was an ongoing two-year, community pharmacy-based demonstration project being conducted by the American Pharmaceutical Association Foundation. The project documented that the pharmacists can help patients with lipid disorders improve their health and quality of life (Bluml *et al.* 1998). The aim of Project ImPACT was to improve compliance with lipid-lowering therapy, to increase communication and the flow of

clinical information among patients, pharmacists and doctors, and improve the cholesterol levels of individual patients over time.

An observational study was conducted in 12 states in United States of America during 1998. In this study demonstrated that pharmacists, working collaboratively with patients and doctors, promoted compliance with prescribed dyslipidemic therapy that enables patients to achieve their National Cholesterol Education Program (NCEP) goals (Bluml *et al.* 2000). Working collaboratively with patients and doctors, the health care provider, pharmacists who have necessary knowledge, skills and resources, can provide an advanced level of care that results in successful management of dyslipidemia.

OBRA`90 (Omnibus Budget Reconciliation Act of 1990). Patient counselling can bring the pharmacist personal, professional and economic benefits, and many new opportunities. The Omnibus Budget Reconciliation Act of 1990 (OBRA`90) required all pharmacists in USA to provide patient counselling for patients (Pugh 1995). The purpose of OBRA`90 DUR programs was to ensure that prescription orders for outpatient drugs are medically appropriate necessary and not likely to cause adverse medical reactions. To assess the impact of OBRA'90, in practice studies have been conducted in different states of the United States (Meade 1995, Perri *et al.* 1995, Pugh 1995, Rumore *et al.* 1995, Barnes *et al.* 1996, Erickson *et al.* 1998, Schatz *et al.* 2003). In general, results indicated that pharmacists spent more time counselling patients after the law was enacted, but falls short of complete compliance (Rumore *et al.* 1995, Erickson *et al.* 1998, Schatz *et al.* 2003). Barriers for compliance of the law have been assessed. Those barriers identified included a lack of time, lack of personnel and privacy, and expense constraints (Pugh 1995, Rumore *et al.* 1995, Barnes *et al.* 1996). Some of the study pharmacists have also indicated a lack of upper management support for patient counselling (Rumore *et al.* 1995). Ten years after the law took effect, most study pharmacies (69%) offered to provide prescription counselling fulfilling the minimum requirement of legislation (Schatz *et al.* 2003).

However, it seems that changes in patient counselling practices due to legislation can be slow. A study by Svartstad *et al.* (2004) indicated that counselling practices in different states in USA varied significantly according to the intensity of a state's counselling regulation. It seems that it takes time to teach pharmacy practitioners and pharmacy students new counselling

strategies. Other approaches and strategies along the legislation to improve counselling practices are required to promote a change in behaviour (Nichol and Michael 1992, Svarstad *et al.* 2004). Furthermore, laws and statutes should also be accompanied by implementation and enforcement systems (Nichol and Michael 1992).

8 CONCLUSIONS

Developing patient counselling in pharmacies requires knowledge and understanding of the concepts and meaning of medication counselling stages and health counselling stages. Patient counselling is a reflective, unique and interactive process. In order to counsel patients at the pharmacy, pharmacists must have professional competence. It consists of pharmaceutical knowledge, communication skills and understanding of reflectivity, meaning of the professional roles, and the principles of concordant style counselling. In order to develop patient counselling in pharmacies, there is a need for permanent change in community pharmacy communication culture. In order to study this kind of process, understanding the meaning of counselling, reflection in professional development and concordance in patient counselling needs to be taken account (Figure 5).

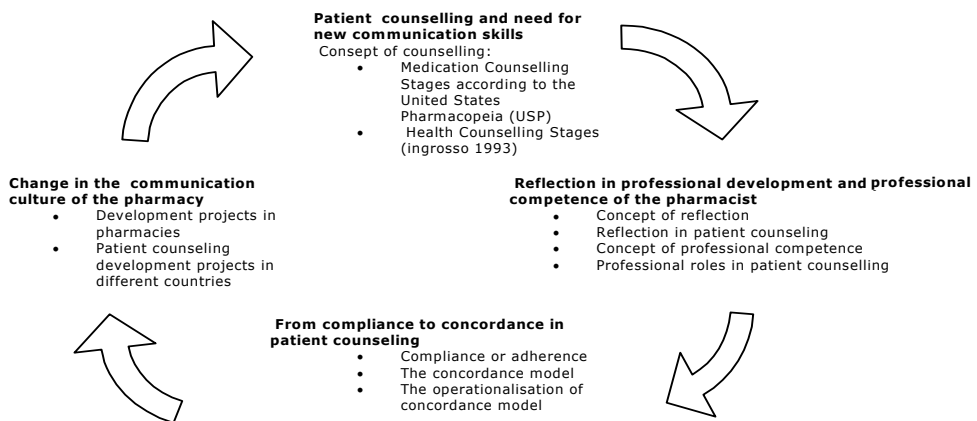


Figure 5. Developing process of patient counselling and dimensions that affect on it.

9 AIMS OF THIS STUDY

The aim of this study was to assess how the principles of patient counselling have been implemented in Finnish community pharmacies during a period of two and half years from the start of the TIPPA project (2000-2002). The specific objectives of this study were:

1. To study the levels of patient counselling skills of practicing pharmacists in the context of reflectivity.
2. To study community pharmacists' attitudes toward the impact of a long-term continuing education course on their patient counselling skills.
3. To study implementation of a national 4-year project to promote patient counselling in community pharmacies during the two and half years of program's action (2000-2002).
4. To study community pharmacists' attitudes toward concordance.

10 MATERIALS AND METHODS

10.1 The TIPPA Project

In order to be able to implement the strategy and to meet the challenge of counselling patients, pharmacists need to develop their professional skills. The first systematic attempt in Finland to improve patient counselling from community pharmacies was the WHO Europharm Forum "Questions to Ask about Your Medicines" campaign in 1993-1996. However, the desired change in patient counselling was not achieved (Airaksinen 1996). In 1998, the Association of Finnish Pharmacies conducted a pseudo customer study to assess counselling performances and to assess the implementation of the professional strategy (The Association of Finnish Pharmacies 1998, unpublished). The results indicated room for improvement.

As a consequence, a 4-year national program, TIPPA, was launched in 2000 in order to promote long-term professional development in community pharmacies (See also Introduction, page 15). The TIPPA Project was endorsed by all the important national stakeholders in the field of pharmacy, ensuring broad representation and commitment (Table 2, page 49). This was the first time that the Ministry of Social Affairs and Health and the major third-party payer (Social Insurance Institute) were involved in a project related to developing community pharmacy services.

The Project consisted of various, planned and co-ordinated activities supporting a long-term professional development process at the pharmacy level (Table 2, page 49). The activities took place at a national and local level. The main operational goal was to implement a new patient counselling model based on concordance and two-way communication. This was promoted by encouraging pharmacies to process long-term development plans by applying methods of strategic planning, including self-evaluation of current practices. In basic education, patient counselling and communication skills courses were modified to better meet the needs of customer-oriented counselling practices. In continuing education different kind of new long-term patient counselling courses (e.g. courses related to pharmacotherapy, pharmacology, communication and self-medication) were developed and used as tools to promote the aims of the project.

Based on previous studies (Airaksinen *et al.* 1998, Puumalainen 2005a), it was understood that pharmacists need concrete tools and instrument to

evaluate and improve their counselling performance. During the project, several practical and concrete instruments were provided, e.g. patient counselling and communication skills book and manual on good patient counselling (Table 2. page 49). The United States Pharmacopeia (USP) Medication Counselling Behaviour Guidelines (Appendix 1) were chosen as a main instrument to promote two-way communication and customer-oriented patient counselling. During the project, the Guidelines were applied in several ways: in basic education in teaching pharmacy students the principles of patient counselling, and in continuing education to promote self-evaluation of counselling practices. They were also integrated into patient counselling and communication skills study books and quality manual. Also, at the beginning of the TIPPA project the Guidelines were sent to all pharmacists working in community pharmacies by the Finnish Pharmacists' Association. The use of guidelines was evaluated during the TIPPA project (Puumalainen *et al.* 2005b).

The progress of patient counselling practices was evaluated during the project by using a pseudo customer method (Puumalainen *et al.* 2005b). In the study conducted by Puumalainen *et al.* (2005b) results indicated that positive changes took place in the medication counselling behaviours in Finnish community pharmacists. Other research projects were launched during the project to provide evidence of the changes occurring in patient counselling practices, actions taken in community pharmacies and the implementation of the tools provided (Varunki 2003, Puumalainen 2005a, TIPPA Project 2002). This doctoral dissertation is part of the evaluation of the TIPPA Project.

Table 2. Outline of the TIPPA Project

TIPPA (2000–2003)

TIPPA was a 4-year national joint project to promote the implementation of a professional strategy by enhancing patient counselling in Finnish community pharmacies (www.tippa.net).

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 of Kuopio, the Pharmaceutical Learning Centre, and the University of Kuopio Centre for Training and Development.

Drug policy goals

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

Operational goals

Phase 1 (2000–2001): Introducing practitioners to new counselling behaviors (raising awareness), developing resources and tools specifically for patient counselling (e.g. easy-to-use electronic prescription drugs database, handbooks on self-medication, manual on quality assurance of counselling practices, handbook on patient counselling and communication and long-term CE-courses.

Phase 2 (2001–2002): Facilitating self-assessment of counselling practices and processing long-term development plans.

Phase 3 (2002–2003): Implementing and promoting the use of patient-counselling resources; assessment of the implementation of TIPPA resources and tools.

Phase 4 (2003): Evaluation and reporting. Constructing a new action plan based on the evaluation

10.2 Study design (I–IV)

During the TIPPA Project a long-term continuing education course was developed for practicing community pharmacists in order to improve their patient counselling skills (See also Table 2, page 49). The study was initiated by assessing patient counselling skills among practicing pharmacists in the context of reflectivity. This was done in 2000 and 2001 by analyzing narratives of 40 practitioners who participated in the long-term continuing education course (I). The impact of the long-term CE course on practicing pharmacists' patient counselling skills was assessed when the course was completed (II).

A pharmacist survey was conducted in 2002 in order to assess the implementation of the TIPPA Project in Finnish community pharmacies (III) and assess practicing pharmacists' attitudes toward concordance (IV) during a period of two and half years from the TIPPA project's start (Figure 6).

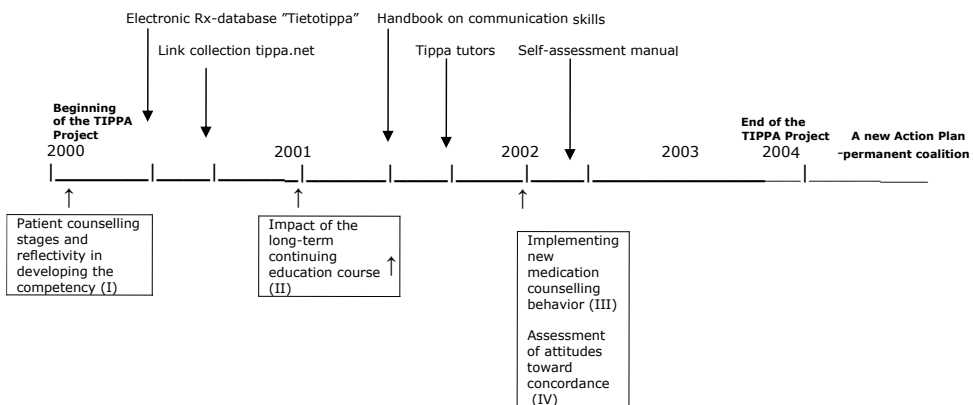


Figure 6. Outline of the study in relation to the actions of the TIPPA Project in 2000–2004

Summary of materials and methods used in the original publications (I-IV) are shown in Table 3 on the page 51.

Table 3. Methods used in original publications (I-IV)

Study	Study Target	The aim of the study was to assess	Method	Analysis
I	<ul style="list-style-type: none"> - Reflectivity - Stages of patient counselling according to USP Medication Counselling Behaviour Guidelines 	<ul style="list-style-type: none"> -The level of practicing pharmacists' patient counselling skills in the context of reflectivity, before attending a long-term CE-course 	Written essays (n=40)	Qualitative content analysis based on essays' thematic content
II	<ul style="list-style-type: none"> -Impact of the long-term continuing education course on patient counselling skills 	<ul style="list-style-type: none"> - Community pharmacists' perceptions of the impact of a long-term continuing education (CE) course on their patient counselling skills 	Focus group discussion (FGD) (n=17)	Qualitative analysis based on grounded theory with an inductive approach
III	<ul style="list-style-type: none"> -Implementing new medication counselling behaviour 	<ul style="list-style-type: none"> -Implementation of the TIPPA Project in Finnish community pharmacies during the two and half years of program's action from 2000-2002. 	Postal Survey (n=376)	<ul style="list-style-type: none"> -Quantitative analysis -SPSS 10.1 program - The constructed sum scale of implementation rate - χ^2-test of the implementation rate - Descriptive statistics on the sample characteristics, background variables, means, standard deviations (SDs) and frequency distributions.
IV	<ul style="list-style-type: none"> - Attitudes toward concordance and its perceived impact on pharmacist-patient consultations 	<ul style="list-style-type: none"> -Community pharmacists' attitudes toward concordance and its influence on patient counselling practices during the TIPPA Project 	<ul style="list-style-type: none"> - 2 open-ended questions Postal Survey (n=376) - Modified LATCon scale (Raynor et al. 2001) including 14 statements about concordance - 2 open-ended questions 	<ul style="list-style-type: none"> - Two open-ended questions were analyzed qualitatively based on their thematic content -Quantitative analysis -SPSS 10.1 program - The construct validity of the modified scale was evaluated using a factor analysis, (the Principal Axis Factor method with a Direct Oblimin rotation). - Descriptive statistics on the sample characteristics, background variables, including means, standard deviations, and frequency distributions. -Two open-ended questions were analyzed qualitatively based on their thematic content

10.3 Methodological background of this study

Studies can be divided, based on the methodology used, into quantitative and qualitative studies (Hirsijärvi *et al.* 1997, Smith 2002). Quantitative study is still the dominating research strategy in social sciences, even though its roots are in the natural sciences. This paradigm emphasizes the universally applicable laws of cause and its impact on the phenomenon. The background is formed by realistic ontology, according to which the reality is built up by objectively verifiable facts (Hirsijärvi *et al.* 1997, Raunio 1999). Quantitative studies include surveys, observation studies and experimental studies. Quantitative studies require sufficiently extensive material for the generalization of results. In social pharmacy a quantitative survey methodology is often used, in which information is gathered using interviews, mail questionnaires or by telephone (Hirsijärvi *et al.* 1997, Raunio 1999, Smith 2002). The survey method refers more generally to data collection by means of questionnaires or interview forms that have been structured in advance (Alkula *et al.* 1994, Raunio 1999). In this case the data collection is standardized and the target persons form a sample from a large population (Raunio 1999). In a standardized method questions are asked from all persons studied in exactly the same way (Hirsijärvi *et al.* 1997).

The starting point in qualitative study is to describe real life and the objective is to explore the object as comprehensively as possible. The purpose of qualitative study is not to look for average relationships or statistical regularities, nor to draw conclusions as regards generalization; thus the scope of the material is not defined by these. The target of the qualitative study is to understand the research object with the underlying thought that the general is emphasized in the individual. By studying an individual case with a sufficient accuracy, it is also possible to identify what the significant aspects of the phenomenon are and what is often repeated when analyzing the phenomenon on a more general level (Hirsijärvi *et al.* 1997, Alasuu-tari 1999, Raunio 1999). There are several types of qualitative studies, for example discourse analysis, participant observation, and group interviews (Hirsijärvi *et al.* 1997).

Quantitative and qualitative research methods have different philosophic starting points and objectives. Quantitative research methods emphasize the scientific values of positivism, such as objectivity, accuracy and unambiguity (Raunio 1999) and they are based on measuring, which aims at producing grounded, reliable and generalizable information on clearly defined material. Quantitative research methods are suitable for studying subject areas for which a certain amount of researched information already exists.

The qualitative approach usually aims at understanding the phenomenon as a whole, it emphasizes the interpretation of the persons studied of the events and conditions, it does not use formal or structured meters and it analyzes narrative information systematically, yet intuitively (Pope and Mays 1995, Pope *et al.* 2000). Qualitative research methods can provide more profound and comprehensive information on a phenomenon and they are well adaptable for studying subject areas for which there is not much existing information. Thus qualitative and quantitative research approaches complement each other (Hirsijärvi *et al.* 1997). Qualitative and quantitative analyses can be separated from each other, but they can be applied in the same study and they can be considered a continuum, not the opposites (Alasuutari 1999). Combining qualitative and quantitative research in the same study helps to provide a more profound and versatile general view of the phenomenon studied (Raunio 1999).

Reliability and validity

All studies and methods have their own strengths and limitations. Therefore it is important to analyze each study as a whole (Hirsijärvi *et al.* 1997). The first requirement for a study is that the study has been carried out in accordance with the criteria set for scientific research. Reliability of research can be reduced by various errors, such as measurement errors, processing errors, loss errors, covering errors and sampling errors (Smith 2002). A sampling study always involves random error or sampling error due to sampling and often also distortion caused by loss (Heikkilä 1999). Covering error is generated if the research object population is not from an updated register.

Validity of quantitative research means the capability of the study to measure exactly what is intended (Hirsijärvi *et al.* 1997, Heikkilä 1999, Smith 2002). The validity conveys how well the measurement method used in the study measures exactly that property of the studied phenomenon, which is intended to be measured (Heikkilä 1999). Survey studies can estimate the appropriateness (face validity) of the questionnaire and whether the questions cover the content that is essential as regards the target phenomenon (content validity) (Smith 2002). Weak points in quantitative study with regards to validity can be inappropriate material (scope and sampling), poor consistency of measuring equipment and unsuitable statistical methods (Heikkilä 1999). For ensuring validity, versatile information collection and appropriate statistical methods should be used. In validity, a distinction can be made between external validity, which means that other researchers

also interprets the concerned research results equally, and internal validity, which refers to whether the measurements in the theoretical section of the study correspond to the concepts presented (Heikkilä 1999).

The reliability of the quantitative study refers to the capability to repeat the measurement or to perform the study again later (Heikkilä 1999). In the survey study the questionnaire is reliable, if the questions are presented unambiguously such that the respondent understands the questions and is able to answer them consistently in the same way (Hirsijärvi *et al.* 1997, Heikkilä 1999). Reliability can be assessed by examining Cronbach Alfa derived from factor analysis (Heikkilä 1999).

For the qualitative study, different interpretations have been given to validity and reliability (Hirsijärvi *et al.* 1997, Eskola and Suoranta 1998, Alasuutari 1999, Silverman 2001). Reliability of the qualitative study is increased by the researcher's detailed description of the implementation of the study; the accuracy applies to all the stages of the study. When assessing reliability, it is estimated how well the research result corresponds to the research object and whether the conclusions conform to the study intention (Eskola and Suoranta 1998, Silverman 2001). Repeatability is generally not possible in the qualitative study; the researcher's own view of the object studied is always concerned. Reliability can be ensured for example by using sound and video recording in interviews and by writing down the recorded text on paper as soon as possible after performing the study.

This study entails descriptive study assessing the implementation of patient counselling into the pharmacy practice. The objects of interest are Finnish practicing pharmacists. Descriptive research aims at acquiring more information on the characteristic features of the phenomenon studied, and the purpose is to describe the phenomenon such as it occurs, without trying to look for any causal relationships between the matters. The target of the study was to provide new information on how the tools and principles produced in the TIPPA project were implemented during the period of two and half years from the start of the project. The study also includes features from applied research, as to how new information can be applied in the practical pharmacy work for improving the interaction between the patient and pharmacist and for implementing a professional pharmacy strategy.

In this study, an overall assessment of the implementation of counselling is made using triangulation. The purpose of using triangulation is to achieve reliability of research results and the use of triangulation enriches the re-

researcher's perspective over the phenomenon studied (Raunio 1999). In addition, triangulation can be used to support the information obtained from the phenomenon and to acquire more profound information on the phenomenon studied (Tashakkori and Teddlie 1998). This study uses triangulation related to methodology, which involves the use of methods originating from different research traditions for studying the same problem (patient counselling). The qualitative research methods used were: narratives, focus group interviews and open-ended questions (studies I, II, III and IV) while the quantitative research method was a survey (studies III and IV).

There are two qualitative studies in this doctoral thesis. The first one is based on narratives written by pharmacists, and the nature of their patient counselling skills in the context of reflectivity. The narratives were written in free form, which gives the pharmacists studied a possibility to express his/her own views and thoughts as desired (compare for open-ended questions).

The second partial study (II) consists of focus group discussions. The aim was to find out practicing pharmacists' perceptions of the impact of a long-term continuing education course. The possibility to study issues of which only little is known is considered to be the specific strength of the focus group (Pyörälä 1994). Flexibility is regarded as another advantage of the method; the discussion can concentrate on the subject matters, which the debaters themselves consider important (Pope and Mays 1995). During the discussion people open up and share their views with one another in a way which is not possible e.g. in an individual interview (Hirsijärvi *et al.* 1997). The research subjects address mainly each other, not the researcher. When using this method, its limited generalizability should be born in mind (Pyörälä 1994); however, the purpose of a focus group interview is not to provide statistical generalizability, but to increase the depth of understanding.

There are two quantitative studies in this doctoral thesis (studies III and IV). In this study, structured reply alternatives of a structured questionnaire provided information on the pharmacists' attitudes towards concordance and on how the tools produced in the Tippa Project were implemented in the pharmacy. The questionnaire also included open-ended questions for analyzing how the TIPPA project has influenced the pharmacists' work; and what the benefits of the project have been. With open-ended questions the persons studied have the possibility to express themselves in their own way, not merely as structured by the researcher in advance (Patton 1990,

Polit and Hungler 1995). This allows highlighting the pharmacist's point of view in the study, while the quantitative study generally manifests the object of interest of the researcher by giving an answer to the questions asked (Polit and Hungler 1995).

10.4 Assessment of patient counselling stages among practicing pharmacists using a qualitative content analysis (I)

The aim of this study was to describe the levels of patient counselling skills of 40 Finnish community pharmacists in the context of reflectivity. Theories used as a framework of the analysis are based on patient counselling according to USP Medication Counselling Stages (www.usp.org, Appendix 1) and Mezirow's theoretical underpinning (1981, 1991). The theoretical underpinning of Mezirow is explained in more detailed in chapter 4.

The study was carried out at the beginning of the TIPPA Project (Figure 6. page 50). The data for this study consisted of narratives written by a convenience sample of 40 practicing pharmacists (M.Sc.Pharm. and B.Sc. Pharm) who had registered in the long-term training course on patient counselling skills. The detailed explanation of the long-term CE course is given in article II. Before the course started, the participants were asked to write a free-form narrative about themselves as patient counsellors. All participants wrote a narrative willingly. The participants were also asked to fill in a structured questionnaire about demographic data (gender, age, working experience). The participants were not given any information and education concerning patient counselling, USP Medication Counselling Stages or reflectivity before they were asked to write a narrative. The narratives were written in Finnish.

The narratives were qualitatively content analysed by categorising the content of narratives into different themes, which were based on two theoretical frameworks: (The USP Medication Counselling Stages and Mezirow's theoretical underpinning). The analysis involved two levels of evaluation. First, the researchers developed a coding scheme on the basis of the USP Medication Counselling Behaviour Guidelines (Appendix 1) and the Mezirow's conception of reflectivity (Mezirow 1991). Two researches coded the data independently, after which the results were compared. Then the narratives were reviewed again and discussed until the consensus agreement was reached.

10.5 Assessing learning objectives by focus group discussion among practicing pharmacists (II)

The impact of the long-term continuing education (CE) course on community pharmacists' patient counselling skills was assessed in order to find out whether the learning objectives set for the course were met.

As a part of the TIPPA Project, the Pharmaceutical Learning Centre developed a long-term continuing education course focusing on patient counselling skills. The course was organized twice, in 2000 and 2001. The learning objectives of the course were to introduce the principles of two-way communication and self-evaluation of the pharmacist's performance, to set goals for personal development, and to create a development plan for pharmacists by applying principles of strategic planning (II: Table 1).

In order to investigate the impact of the CE course, the participants (n=17) attended a focus group discussion during the last module of their training in September 2001. Attendance was voluntary that being the reason why not all participated the focus group discussion. Participants were divided into three groups of 5-6 people in each to ensure maximum discussion by each of the participants (Silverman 2001). The three moderators and three scribes were instructed to facilitate the discussion in the same way, using a topic guide, so that the same issues were raised with each group. The focus group discussions were semi-structured and they covered three main topics:

- Feedback of the CE course and the learning objectives achieved,
- Personal development in patient counselling skills during the course,
- Impact of the training on practice.

The key questions were how the participants perceived themselves as providers of drug information, how the CE course had helped them in promoting changes in patient counselling practice in their pharmacy, how they had developed their self-evaluation skills, and how they would further develop their skills after the course.

The data from the interviews were qualitatively analysed, using a grounded theory approach, which advocates an inductive approach with no preconceived hypothesis (www.metodix.com). The qualitative data analysis software ATALS.ti The Knowledge Workbench –program version 4.1. was used as a tool to develop and apply coding (II: Figure I).

10.6 Assessment of implementation of new patient counselling by a pharmacist survey (III–IV)

This pharmacist survey was carried out by a mail survey in June 2002 and it was a part of a larger evaluation study of the TIPPA project (See Appendix II, Varunki 2003). The target population in study III and study IV included all registered staff pharmacists in Finland working in community pharmacies. A sample was selected with every fifth pharmacist selected from an alphabetical listing of professional membership of those pharmacists with a Bachelor's Degree (the Finnish Pharmacists' Association) and those with a Master's Degree (the Finnish Pharmacists' Association and the Society of Pharmacists) (n= 734). The response rate was 51 % (n=376). Comparison of the respondent's characteristics to the target population on the basis of mean age, academic degree and geographic location of the pharmacy indicated that the study population was representative of the target population (III: Table 1 and IV: Table I).

The survey was pilot tested among ten pharmacists. After piloting the survey, the structured statements were modified by adjusting alternative answers. The final questionnaire consisted of the six different sectors (Appendix II):

- 1) Awareness of the TIPPA project,
- 2) Patient counselling practices,
- 3) Assessment of strengths and weaknesses of the working society in patient counselling,
- 4) Attitudes toward concordance,
- 5) Background information of the respondents,
- 6) Feedback and future expectations from the respondents concerning the TIPPA Project

In this present study, three from six different sectors mentioned above were used (1,3,4), because they were found to measure the study target most comprehensively.

The research instrument used in the study III was a self-completed questionnaire measuring an implementation scale of the TIPPA Project's actions (Appendix II, sector 1, item 6) and two open-ended questions ("*What are the strengths concerning patient counselling at your working place?*" and "*What are the development areas concerning patient counselling at your working place?*") to evaluate the development areas and strengths in patient counselling at the working community (Appendix II, sector 3, items 18

and 19). The section assessing actions taken in pharmacies to implement TIPPA project, consisted of 16 statements rated using a Likert scale format, varied from 1 (Well implemented) to 5 (Not implemented). The statements were derived from "The Action Plan for the TIPPA Project in 2000-2003" and operationalised in "The Manual on Good Patient Counselling Practice" (Figure 6. page 47, Puumalainen *et al.* 2005d). The items measuring the implementation rates were recoded so that the statements, which reflected the orthodox approach was reversed coded. Thus high scores on the scale indicated a greater implementation rate. Items were scored using the following point scale: "well implemented" (3), "implemented quite well" (2), "I cannot say" (0), and "not implemented at all" (0). Item-reminder correlation analyses were undertaken to reduce the scale to more manageable dimensions, using the responses to the 16-item scale (III: Table 3). The sum scales of the implementation rates were calculated and ranged between 0 and 48. A low implementation rate was operationally defined as a score between 0 and 15 points, a moderate implementation rate between 16 and 31 points and a high implementation rate between 32 and 48 points.

The data were analyzed using the SPSS version 10.1 (Windows 1998). Descriptive statistics on the sample characteristics, background variables, and questionnaire items were computed, including means, standard deviations, and frequency distributions. Correlations were assessed using Spearman correlations, and $p < 0.001$ was considered to be statistically significant. The open-ended questions were analyzed based on their thematic content (www.metodix.com).

The survey instrument used in the study IV consisted of a modified version of The Leeds Attitude Toward Concordance (LATCon) scale (Appendix II, sector 4, item 24) and two open-ended questions ("*What is the impact of the TIPPA project concerning the patient counselling*" and "*How has your work changed since the TIPPA project started*") to evaluate the perceived impact of the TIPPA Project on counselling practices (Appendix, sector 1, items 4-5).

The Leeds Attitude Toward Concordance (LATCon) scale has been developed and validated in the University of Leeds, England, in order to measure health care professionals' attitudes to concordance and it consisted of 12 statements rated using a Likert scale format (Raynor *et al.* 2001).

The scale was translated into Finnish, and two statements were added to adjust it to Finnish conditions. The added statements concerned barriers to patient counselling and the pharmacists' role in helping patients make

informed choices about prescription and nonprescription medicines. In this doctoral dissertation, the Likert scale varied from 1 (strongly agree) to 5 (strongly disagree), including the neutral alternative choice (3). In the original LATCon scale, the neutral alternative choice was missing (Raynor *et al.* 2001). All statements in the Finnish version and in the original LATCon scale were positively worded. The Finnish scale was pilot tested among pharmacy students and practitioners, and by a scientist specialized in pharmacy ethics, particularly in paternalism and autonomy of the patient from the philosophical point of view. The construct validity of the modified LATCon scale was evaluated using a factor analysis, specifically using the Principal Axis Factor method with a Direct Oblimin rotation. The internal consistency of the scale was measured by Cronbach's alpha. Mean summative factor scores (MSS) and 95% confidence intervals were calculated for each factor. The data were analyzed using the SPSS version 10.1 (Windows 1998). Descriptive statistics on the sample characteristics, background variables, and questionnaire items were computed, including means, standard deviations, and frequency distributions. Correlations were assessed using Spearman correlations, and $p < 0.001$ was considered to be statistically significant. The open-ended questions were analyzed based on their thematic content (www.metodix.com).

11 RESULTS

1.1 Assessment of patient counselling stages (I)

All the study pharmacists (n=40) self-reported that they were aware that the patient counselling situation between the pharmacist and the patient should be a discussion according to the United States Pharmacopeia Medication Counselling Stages. In that, the level of information between the pharmacist and the patient can be viewed as detailed discussion and guidance. Ten of the study pharmacists (5 pharmacists with Bachelor's degrees and 5 pharmacists with Master's degrees) were categorized as having patient counselling competency at the lowest stage (monologue), reaching the level of non-reflection (Table 4, page 63). They self-reported to be poor drug information providers, but they were fast in serving their patients. They self-reported to have poor understanding of the interactive role of a patient (concordance). Ten study pharmacists self-reported that they would be willing to develop their competency from the monologue stage to the dialogue stage but they did not know how to do that. The study pharmacists were not able to reflect on the counselling experience, because when describing the counselling sessions in their narratives they did not connect empirical knowledge with analysing their actions in relation to their knowledge. They described their counselling briefly and the meaning scheme of practice was constructed directly without evaluating what was counselled during the session.

Most of the participants (22 study pharmacists, 15 with Bachelor's degrees and 7 with Master's degrees) were categorized to have their competency at the dialogue level (Table 4, page 63). These study pharmacists self-reported that they needed long-term continuing education courses in pharmacology, disease management and therapeutic guidelines. The study pharmacists described themselves to be technical and medicine-centred, without personal or affective involvement. They described that their counselling was focused on the instructions of the use of medicines and how to store them.

Seven pharmacists (5 pharmacists with Bachelor's degrees and 2 pharmacists with Master's degrees) demonstrated competency at the conversation stage and were categorized to reach the higher level of critical consciousness (Table 4, page 63). The study pharmacists self-reported that providing drug information was the most important work in pharmacies. They

also self-reported that a pharmacy could be more than a place to buy medicines; it could be a comprehensive source of health information. The pharmacists thought that life-long learning is essential to develop their professional competence and saw themselves as approved professionals capable of providing legitimate patient counselling.

One study pharmacist, who had a Master's degree, achieved the highest level of patient counselling stage and the level of critical reflectivity (Table 4, page 63). It was typical of the critical reflector to have an open, affective and personal style of reflecting and to explicate any earlier assumptions regarding the self and counselling. According to this pharmacist, patient counselling is based on: listening, asking questions, discussing, concretising, and repeating. In order to be a good drug information provider and maintain communication skills, continuing education and good support from management are required. By activating his/her own self-reflection, the pharmacist is able to help the patients reflect on their thoughts concerning their medication.

Table 4. Medication Counselling Stages (Appendix I) and Level of reflectivity (Mezirow 1981, 1991) of the study pharmacists according to content analysis of the narratives (n=40). (I: Table IV).

	Medication information Transfer (n=10)	Medication Information Exchange (n=22)	Medication Education (n=7)	Medication Counselling (n=1)
Level of information	Basic, brief, non-individualized	Detailed, individualized	Comprehensive, group or individualized	Detailed discussion and guidance
Level of counselling	Most often spontaneous in response to the medication prescription	Spontaneous or planned	Planned	Planned
Objective of process	Essential information related to taking prescribed medication as directed (MONOLOGUE)	Provider responds to and asks questions related to prescribed medication (DIALOGUE)	Collaborative learning regarding prescribed medication (CONVERSATION) Increases knowledge regarding proper use and safe use of medication for specific condition	Guidance that assists in fulfilling needs in managing medical condition and prescribed medication (DISCUSSION) Enhanced problem solving skills and assists with proper management of medical condition and effective use of medication
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		
Nature of relationship	Passive individual receives instruction given by the healthcare 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
Level of Reflectivity	Non reflector (level 0)	Reflector (consciousness at levels 1-4)	Critical reflectors (critical consciousness at levels 5-7)	Critical reflectors (critical consciousness at levels 5-7)

11.2 Learning new patient counselling skills (II)

The focus group discussion (FGD) was conducted between 17 participants after the first long-term continuing education (CE) course was completed in 2001, in order to assess the participants' perceptions of the impact of CE-course on patient counselling skills. The participants' accounts showed that the most important learning during the course related to the principles of patient counselling and how to analyse their own performance. The participants reported to have understood that they needed to offer counselling to all patients throughout the working day in the pharmacy, not only to selected patients. The study pharmacists reported that they had learnt to use therapeutic guidelines as a basis for understanding drug therapies. The participants reported during the FGD that they found therapeutic guidelines useful in patient counselling. Some of them reported applying an idea from the CE course where each pharmacist in the pharmacy took one therapeutic guideline to study in detail and then summarised the main points to colleagues. Some participants said they had suggested to their pharmacy owner that they could review and rearrange the self-medication department according to therapeutic guidelines.

Other important issues the pharmacists said they had learnt were the principles of making a long-term development plan for patient counselling at the pharmacy level. The participants reported that they had learnt how to apply principles of strategic planning into practice.

According to the FGDs, the course appeared to have encouraged participating pharmacists to assess their own and their colleagues' performance. Study pharmacists reported that they had previously dispensed medicines without paying attention to communication skills. Some pharmacists reported telling patients everything they knew about the medicine without taking into account the patient's information needs. Participants reported that they had also learnt more about non-verbal communication, and the importance of facial expressions, eye contact, and tone of voice, body posture and movement. The participants reported that their attitude towards patient counselling had changed in a positive way and they reported to be more patient focused than before. The participants perceived that they could now understand patients as individuals, rather than as people presenting prescriptions in a system of reimbursement restrictions. According to the participants, the attitudes of other pharmacy staff to patient counselling had changed in some pharmacies and it was now seen as an important service. Counselling on prescription drugs had improved and there was more active use of computerised drug information database (Tietotippa).

The participants reported that the negative points of the course were completing the home assignments without peer support, lack of time and the amount of homework. Another issue was that not all colleagues in the pharmacies were fully involved in the CE course, even if they wanted to promote the changes in the counselling process. Implementing change in pharmacies was not based on the long-term professional development plan, because the study pharmacists reported having insufficient support in the work place. The main problem that came out in FGD was that one pharmacist alone could not change the communication culture of the pharmacy without active involvement of the pharmacy owner and colleagues.

11.3 Impact of the TIPPA Project on patient counselling (III–IV)

11.3.1 Actions taken in pharmacies to implement the TIPPA Project into practice

According to the constructed sum scale, a low or moderate implementation rate of the TIPPA Project was indicated Finnish pharmacies to be polarized: there are pharmacies that are committed to the long-term professional development and those who are not. In the majority of cases, 70% of the respondents were working in pharmacies with a low implementation rate and 25% with a moderate implementation rate. Only 5% worked in a pharmacy with a high implementation rate, the highest scoring being 44 points out of the maximum 48. Of the respondents, 13 (4%) showed no points at all. The cross-tabulation (χ^2 -test) of the implementation rate with the pharmacy-related factors (location, business concept, size) did not show any statistical differences.

Drug information sources were clearly the tools most often implemented of those provided by the TIPPA Project (III: Table 3). Of the respondents, 88% (n=330) reported improvements in the availability of drug information sources. Two thirds (66%) (n=248) of the respondents reported improvements in privacy of facilities for patient counselling. Almost as many (64%) reported having regular in-house training for patient counselling in their pharmacy. The lowest implementation rates were related to systematic development of drug information service, e.g., only 29 and 30% of the respondents reported that they had nominated a responsible pharmacist for developing drug information services on prescription and non-prescription medicines, respectively. Only 36% of the respondents reported using sys-

tematic personal development in their pharmacies. Most of the respondents reported having regular in-house training; only 34% of them had personal educational plans. Almost half of the respondents reported their pharmacies cooperating with other local health care professionals concerning patient counselling (Table 5, page 67).

Table 5. Implementations of actions related to the TIPPA Project after 2.5 years starting the project (n = 376) (III: Table 3).

Actions	¹ Very well to quite well implemented (%)	Implemented to some extent (%)	² Not implemented or do not know (%)
Information sources concerning drug information are easily available in our pharmacy	88	4	8
Our pharmacy provide complete privacy for patient counselling	66	27	7
Our pharmacy arranges regular in-house training for patient counselling	64	29	7
Our pharmacy has made sure that the process of writing prescriptions with the computers is now more effective to leave more time for patient counselling	50	40	10
The general contracts and action plans concerning drug information on prescription drugs have been drawn up in our pharmacy	44	45	11
The general contracts and action plans concerning drug information on OTC- drugs have been drawn up in our pharmacy	42	46	12
Our pharmacy's education plan is made once a year	41	45	14
Our pharmacy co-operates in patient counselling with other local health care professionals	41	45	14
Our pharmaceutical staff has the possibility to take part in developing patient counselling	40	45	15
Our pharmacy has a counselling development plan	39	47	14
Development discussions concerning patient counselling are held regularly in our pharmacy	36	53	11
Our pharmaceutical staff has their own personal education plan	34	57	9
Our pharmacy has made sure that our staff has the ability to use the Internet as a tool in patient counselling in our pharmacy.	33	60	7
Feedback from the customers concerning counselling will be recorded and discussed among the staff.	30	63	7
Our pharmacists is authorized to be responsible for developing drug information about OTC-drugs.	30	59	11
Our pharmacist is authorized to be responsible for developing drug information about the prescription drugs.	29	61	10

¹ The percentage results were calculated by combining responses "Very well implemented" and "Quite well implemented"

² Responses with "No opinion" and "Not Implemented" were left as they were.

The themes emerging from the first open-ended question "*what are the development areas among the working community concerning patient counselling*", were related to management skills of pharmacy owners and lack of feedback, systematic education and co-operation with other health care professionals. Altogether 249 study pharmacists responded to that question. The respondents reported that more time to continuing education during the working day and also during leisure time was needed. The respondents reported that the owner of the pharmacy should pay more attention to the education of the staff. According to the respondents, the most difficult issues were the lack of commitment and feedback from the pharmacy owner concerning patient counselling.

Respondents reported that privacy for patient counselling was implemented well and the electronic information sources were easily available. But the lack of systematic education on how to use different kind of information sources made it difficult to take full advantage of the information sources whilst counselling patient. Respondents reported that co-operation with the local healthcare system was lacking in some pharmacies. Co-operating about asthma and diabetes in professional programmes were the issues that were indicated for more systematic planning.

The themes emerging from the second open-ended question "*what are strengths of the working community concerning patient counselling*" were related to privacy, increased motivation to counselling and customers. Altogether 259 study pharmacists responded to that question. Most of the respondents reported that they had easy-to-use computer-based programme (called "Tietotippa") in their pharmacies, and it helped them while counselling patients. According to the respondents, the privacy in customer service facilities was fine; the pharmacists had designated private spaces to counsel patients. The facilities in the pharmacy and the organisation of the customer flow with separate service booths seemed to be the biggest strengths at the pharmacies.

11.3.2 Attitudes toward concordance and the TIPPA Project's influence on patient counselling practices

The modified LATCon scale showed the highest agreement with the statement related to establishing a therapeutic alliance in the consultation between the pharmacist and the patient (IV: Table 2). From the respondents 78% (288) strongly agreed with this statement. Almost as many (76%, 278) strongly agreed that enhanced health outcomes would follow from

mutual and cooperative interaction between pharmacists and patients. In addition, 74% (272) strongly agreed that pharmacists should be sensitive to patients' desires, needs, and capabilities. The lowest agreement rate was related to the statement concerning the pharmacist's own attitudes and beliefs as barriers to patient counselling, with only 10% (40) of the respondents indicating strong agreement. Also, the statement related to the pharmacist's task of helping the patient make as informed a choice as possible about benefits and risks of alternative treatments with prescription medicines yielded a low agreement rate. When the background variables of the respondents were compared with the 14 statements in the attitudinal scale, positive attitudes toward concordance were directly correlated with pharmacist's age, years since graduation, and years of practice in community pharmacy (IV: Table 3).

Factor analysis of the attitudinal scale showed that the Finnish version of the LATCon scale was valid, yielding 3 factors explaining 37.6% of the overall variance (Table 6, page 70). The factors were interpreted as: respecting the patient's beliefs and coping strategies ($\alpha=0.60$; MSS=1.90; CI=1.83–1.96), establishing a therapeutic alliance ($\alpha=0.65$; MSS=1.36; CI=1.31–1.40), and sensitivity to the patient's reactions ($\alpha=0.66$; MSS=2.33; CI=2.25–2.40). The first factor suggests that pharmacists felt that providing information based on concordance would help them respect the validity of their patients' personal beliefs and coping strategies. In turn, this would yield better outcomes for drug therapy. Moreover, the second factor indicates that pharmacists felt they have a responsibility to provide information based on a therapeutic alliance with the patient and they should be sensitive to patients' desires, needs, and capabilities. This approach would enhance health outcomes. According to the third factor, the respondents believed that they should be more sensitive to the patients' reactions to the information they are provided to support the patients' own decision-making process.

Table 6. Factor Loadings of the Items in the Finnish Version of the LATCon Scale (IV: Table 4).

Item number and statement	Factor number	Item N	Mean	95% CI	Corrected item-total correlation	Alpha if item deleted	N of cases	Alpha
	1	2	3					
Factor 1. Respecting patient's beliefs and coping strategies								
3. Pharmacists should respect the validity of their patients personal beliefs and coping strategies.	.671		4	2.33	2.25 - 2.40		357	0.60
4. The best use of medicines is when it is compatible with what the patient wants and is capable of achieving	.581							
2. Any consultation between the pharmacist and patient should be viewed as negotiation between equals.	.418							
5. Just as ordering medicines is an experiment carried out by the doctor,so too is medication taking an experiment carried out by the patient.	.371							
Factor 2. Establishing therapeutic alliance								
7. A high priority in the consultation between pharmacist and patient is to establish a "therapeutic alliance."	.878		4	1.36	1.31 - 1.40	.5906	362	0.65
8. Pharmacists should be sensitive to patients' desires, needs and capabilities.	.666					.5318		
6. Enhanced health outcomes will follow from mutual and co-operative interaction between pharmacists and patients.	.586					.4310		
1. A pharmacist should give patients the opportunity to communicate their thoughts about their illness and negotiate how it is treated.	.325					.3010		.7440
Factor 3. Sensitiveness to patient's reaction								
11. Pharmacists should be more sensitive to how patients react to the information they give	.749		4	1.90	1.83 - 1.96	.5311	362	0.66
12. Pharmacists should try to learn about the beliefs their patients hold about their medicines.	.609					.4667		.5814
10. During the pharmacist-patient consultation, it is the patient's process of deciding that is most important	.527					.4314		.6057
13. Barriers to patient counselling are the own attitudes and beliefs of the pharmacist.	.500					.4056		.6397

The themes emerging from the open-ended question, "*What is the impact of the TIPPA Project concerning the patient counselling?*" were related to improved drug knowledge and communication skills and increased motivation to counselling. Altogether 336 study pharmacists responded to that question. Most of the respondents reported that the TIPPA Project had a positive impact on their counselling skills. They also reported that the TIPPA Project had motivated them to facilitate achievement of the patients' needs. The respondents reported that their attitudes toward patient counselling had changed from a paternalistic to a concordant approach. Some reported that the TIPPA Project had not had any influence on their counselling practices. The reasons provided were lack of staff and time and poor access to drug information sources. This was especially true of access to electronic drug information because of inadequate access to computers in the pharmacy.

The themes emerging from the second open-ended question, "*How has your work changed since the TIPPA Project started?*" were related to the influence of the TIPPA Project on community pharmacy and the importance of a long-term development process. Altogether 237 study pharmacists responded to that question. More than half of the respondents reported that the TIPPA Project had made them increase their interactive role with the patient. Furthermore, their counselling had become more systematically planned and based on two-way communication. The respondents stated that, because of the TIPPA Project, they now had a desire to be involved with the patients' medical treatment. The respondents also realized the importance of a long-term development process in changing their performance, and they indicated the need for more continuing education to develop their counselling skills. According to the respondents, the TIPPA Project had improved and increased the quality and quantity of counselling. About one-third of the respondents reported that their work at the pharmacy had not changed. Few reported that the TIPPA Project had produced a negative influence; the time allotted for customer service had been doubled, thus resulting in increased work and stress, but the communication with patients had not improved. The reasons provided for these negative responses were the pharmacy staff was not well acquainted with the TIPPA Project or the pharmacy had its own development projects.

11.4 Conclusion of the results

The aim of this study was to assess the implementation of patient counselling into pharmacy practice. Conclusion of the results of this study is presented in Figure 7, on page 70. In order to implement principles of patient counselling into pharmacy practice, practicing pharmacists need to have professional competence. This requires an understanding of the meaning of reflectivity and concordance in patient counselling, and developing basic education for pharmacy students, continuing education courses for practicing pharmacists and pharmacy owners. This all leads to change in the communication culture of pharmacy. But in order to have a permanent change in the communication culture at the pharmacy the whole working community needs to be involved with the long-term professional development. The role of the pharmacy owners is especially important when developing the whole working community in patient counselling. This study demonstrated that pharmacists' work requires strong pharmaceutical knowledge, communication skills, and ability to implement theoretical knowledge into pharmacy practice in order to reach a concordant-style in patient counselling.

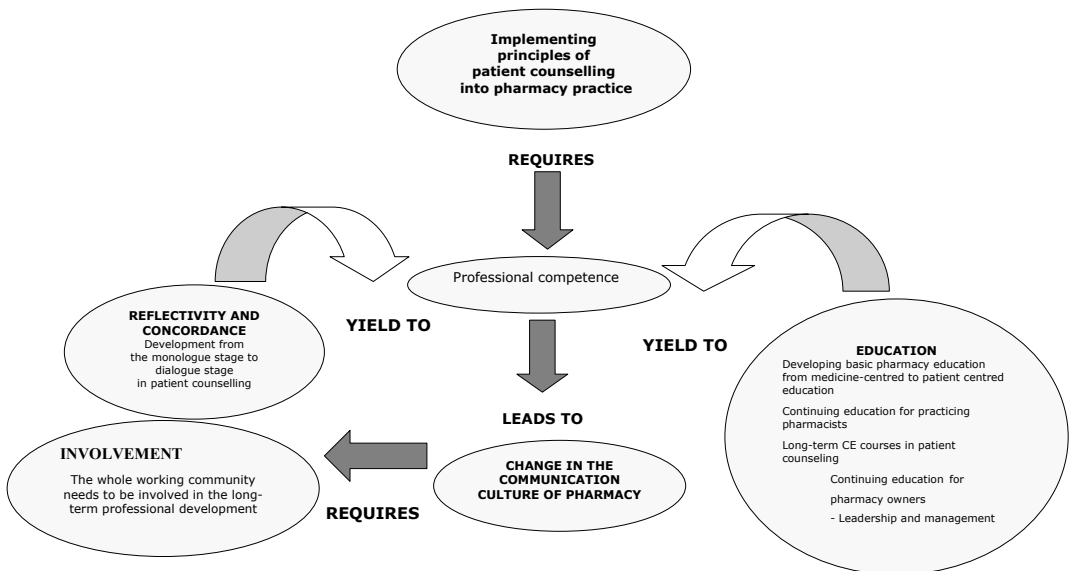


Figure 7. Conclusion of the results of this study

12 DISCUSSION

The data for this study were collected during 2000–2002 when the long-term development program TIPPA was going on. The TIPPA-Project was the leading professional program among the pharmacy profession in Finland since its beginning in 2000. It was also a quality improvement programme targeted at community pharmacies. In the action plan for TIPPA, these aspects were taken into account by e.g., involving the pharmacy owners to the project, providing pharmacists with concrete tools and instrument to enhance counselling and by providing continuing education (Tippa Project 2002). As this and previous Finnish studies (Puumalainen 2005a, Saario 2005) have indicated that in change programmes the use of several strategies are required, all the important stakeholders in the field of pharmacy were asked to participate.

The TIPPA Project provided a unique possibility to study the implementation of principles of patient counselling into pharmacy practice at Finnish community pharmacies. The TIPPA Project focused on long-term development processes in patient counselling and that has been studied in this doctoral thesis from different points of view.

This doctoral thesis has been based on the practical needs of community pharmacists for the implementation of patient counselling. This doctoral thesis has produced new information about patient counselling competence among practicing pharmacists, and what are the professional roles of the pharmacist and the patient in interactive patient counselling situation, and how the long-term continuing education courses could support the professional development work at pharmacies. This doctoral thesis also indicated that practicing pharmacists are not familiar with the concept of reflectivity as a part of their own professional development; with most of the study pharmacists were categories as reflectors at levels 1 to 4 (Table 4, page 63). Even if study pharmacists had positive attitudes toward concordance, there is a need to educate pharmacists in order to implement a concordance-based counselling practice. These findings are in line with other Finnish studies (Katajavuori 2005a, Puumalainen 2005a). In the study undertaken by Katajavuori (2005a), it was concluded that, it is important to enhance reflective action already during basic education. Community pharmacists are aware of the principles of the quality assurance e.g., through compounding, but it seems to be difficult to extend these principles into professional community pharmacy services (Lahdelma 2005, Puumalainen 2005a). These study re-

sults are important as professional community pharmacy services are further developed as part of the new action plan after TIPPA (Tippa Project 2002). Key stakeholders in the field of pharmacy have found nationally co-ordinated, long-term activities necessary to promote health policy goals through professional community pharmacy services also after the TIPPA Project (Tippa Project 2002). For this purpose, there exists a permanent, national co-ordination of activities with a special focus on integrating community pharmacists into local multidisciplinary health care team. The goals of the TIPPA Project and the new action plan are in line with the profession strategy for community pharmacies. The professional community pharmacy strategy was also supported by the National Pharmaceutical Drug Policy for 2010 established by the Ministry of Social Affairs and Health in 2003. According to this policy statement, information about medicines and their appropriate use given by pharmacy staff is necessary for good medical treatment.

12.1 Patient counselling stages among practicing pharmacists

Most of the study pharmacists perceived their competency at the dialogue stage according to USP Medication Counselling Stages (www.usp.org) while evaluating their narratives. In this field there are no previous studies and it needs to be studied more in the future. Pharmacists should be able to reflect on their communication skills and understand the role of patient counselling in order to reach the highest level of counselling (www.usp.org) and critical reflectivity (Mezirow 1991). Levels of reflectivity according to Mezirow (1981) are complicated, and Mezirow himself does not comment on which level of reflectivity is enough and which is reachable with respect to professional practice. In some cases, acting as the non-reflector is enough in practice. But reaching the consciousness reflection level, requires that each pharmacists need to think about their own principles carefully. All study pharmacists had awareness of dialogue and only ten of the study pharmacists were categorized as being at the level of monologue. All study pharmacists who wrote the narrative and attended the CE course on did so at their own initiative, but this does not mean that participants were conscious reflectors. In some cases pharmacy owners had encouraged pharmacists to attend the course. Pharmacists could be encouraged to practice reflective thinking by talking with their colleagues and writing about their thoughts. Pharmacists could also assess their own actions after they have counselled patients. This kind of action is described as "reflection-on action" and "reflection-in-action" according to Schön (1983, 1987) (see also the figure 1, page 25).

The findings of this study indicated that old traditions still dominate pharmacist-patient interaction, and that is in line with other previous Finnish studies (Katajavuori *et al.* 2002, Vainio 2004). This can be described by the "Active/Passive Model", in which the health care professional plays the active role and the patient is passive (Szasz and Hollander 1956). The results of this study could indicate that pharmacists seem to still have attitudes of selling medicines instead of selling treatments that is influencing their behaviour. Pharmacists' relationship to the patients has been paternalistic and asymmetrical, which means the pharmacist has been "in control", and pharmacists have not been encouraged to actively interact with the patients (Airaaksinen *et al.* 1994, De Young 1996, Itkonen 2000). Pharmacists have had a drug-centered way of thinking and the transfer of information has been monologue-based. This could possibly be a result of the basic education in pharmacy, as until 1996 pharmacy curricula have consisted of traditional natural sciences and education has been very medicine-centered. And also pharmacy students have had difficulties in combining theoretical knowledge into pharmacy practice (Sleath and Cambell 1998). Therefore pharmacists may have the knowledge but they don't know how to share it with patients in practice. This might imply that pharmacists have knowledge but they don't know how to share it with patients in practice (Katajavuori 2005a).

The role of the pharmacists should change from the paternalistic counsellor towards a counsellor who supports the patient emotionally and helps them to combine actions, knowledge and feelings. In order to support pharmacists' reflection, educators at the continuing education courses and pharmacy owners at the working place should be committed to reflective practice and be sensitive to pharmacists' learning. The role of educators and pharmacy owners is important in the creation of an open and supportive atmosphere (Wong *et al.* 1995, Katajavuori *et al.* 2005c, Katajavuori 2005a).

Learning counselling skills is challenging but not impossible. It requires life-long learning and combining theoretical knowledge into practice (Aspergen 1999). Learning new communication skills requires reflecting and changing earlier behaviour patterns. Kolb (1984) has developed the model of experiential learning (see also figure 2, page 26) in which the focus is on the ability of the individual to reflect and conceptualise personal experiences. This is a theory, but it may not optimally work in practice. Professional development in the health care field requires conscious and practical knowledge (Jarvis 1992, Tynjälä *et al.* 1997). Using these skills, pharmacists are able to pay more attention to the patient. Customised patient counselling situations are constructed when the patient is an active partner and his/her

needs and wishes are taken into account. In order to develop professionally, pharmacists have to combine knowledge, action and feelings. Practicing critical reflection, e.g. by writing and talking with other colleagues, the pharmacist can redefine his/her own work and improve his/her performance. This is demanding because nowadays there are patients who have obvious gaps in their knowledge and in these cases pharmacists' instructions support patients' own reflections. The patients who do not suffer from insufficient knowledge but do not know how to connect the fragments of knowledge to their own lives, present a challenge for pharmacists.

In addition to counselling about medicines, pharmacists are in a position to offer emotional support and activate patients' reflective skills. To improve the effectiveness and productiveness of patient counselling, pharmacists should apply counselling methods that recognize the gaps in patients' knowledge and above all, activate patients to assess their own knowledge and activities in order to improve and maintain their health. Carnevale *et al.* (1990) and Rush and Evers (1986) have studied professional competence and the results of these studies could be applied to the practice of pharmacy. Competence required by pharmacists, when they graduate from University, includes skills in learning how to learn, communication skills, adaptation, creative thinking and problem solving. In order to develop their professional competence, pharmacist need to have skills to combine relevant information and ability to ingrate the information within a professional work environment (Evers and Rush 1996, Sleath and Cambell 2001).

In Finnish pharmacy, there are no studies, which had evaluated reflectivity among practicing pharmacists. In this study the amount of study pharmacists who wrote the narratives was small (n=40) and assessing the level of reflectivity was related to writing the narratives. It was very special situation because development as a reflector during the whole long-term continuing education course was not studied and the study pharmacists wrote their narratives without any teaching and guiding about reflectivity. On the other hand, reflectivity has been studied between nurses and patients in Finland and other countries (Tomm 1987, Tomm 1988, Poskiparta 1997). Tomm (1987) and Poskiparta (1997) studied how nurses used reflective questions while counselling the patients in clinics. Results indicated that nurses used only few reflective questions. This could be a worthwhile study to conduct among pharmacists in the future. Ora-Hyytiäinen (2004) has studied the professional growth and development of a polytechnic student and has concluded that the ability to deal with one's feelings, especially in the beginning and at the end of studies, is significant for the professional

growth and development of a polytechnic student. This conclusion could be extrapolated to pharmacy students.

12.2 Perceptions of the impact of the long-term CE course on patient counselling

This study indicated that long-term continuing education courses are needed when the aim is to develop patient counselling skills and this study is in line with other studies (De Almeida Neto *et al.* 2000, De Almeida Neto *et al.* 2001, Savela 2003). Participants reported that it was not easy to change established behaviour patterns, social interactions and working routines, and that has also been found in previous studies (Hilden 1999). Change requires a person to reflect on and evaluate their own interactions and practical exercises to practice and develop new styles (Moon 1999, De Almeida Neto *et al.* 2000, De Almeida Neto *et al.* 2001). One concept that is causing problems in this respect is that practicing pharmacists who have been qualified for several years may not be familiar with new learning and teaching methods, and it may be new for them to learn that teaching is not transferring knowledge but also involves students to construct knowledge (Moon 1999).

The TIPPA Project has developed several resources to facilitate the intended changes. A crucial component was training to enable pharmacists to acquire new skills and a new approach to patient information. A long-term continuing education course on patient counselling skills was developed for practicing pharmacists. In this CE training, teaching methods were based on problem-based learning, and the pharmacists practiced reflective skills by writing and discussion with each other. In order to have interactive CE course, 20 practicing pharmacists attended to the course at the time (altogether 40 practicing pharmacists attended to the courses), even though it is not enough from all Finnish pharmacists. According to the study pharmacists, they would like to have more long-term CE courses in the near future. However, the amount of study pharmacists is small (n=17) and the results cannot be generalized to all Finnish pharmacists, and the pharmacists who participated in the long-term CE course might already have had very positive attitudes toward continuing education courses.

The findings of this study indicated that the participating pharmacists might have low pharmacotherapeutic skills. Some of the study pharmacists reported that they didn't have enough knowledge about pharmacotherapy e.g. the therapeutic guidelines were not familiar for them. This doctoral

thesis is in line with another Finnish study (Savela 2003). According to that study most of the pharmacists felt that they have a lack of knowledge about side effects and interactions. It seems that pharmacists are unsure about their own skills; they seem to lack some self-awareness (Katajavuori *et al.* 2002). This doctoral thesis indicates that study pharmacists are willing to educate themselves in order to develop their professional competence if they have a chance to do that. In the study made by Savela (2003), only 20% of Finnish community pharmacists do not participate in continuing education. According to Savela (2003), reasons for that might be that training may be too expensive and pharmacies do not necessarily have sufficient personnel to substitute for the shortage created by the person attending training, the pharmacy owner is not motivated to undertake additional training. Besides the lack of interest, unwillingness towards training can be influenced by stressing work, exhaustion or family reasons (Hilden 1999). Long distances are not necessarily a hindering factor for training, since according to Savela's research (2003) pharmacists from Northern Finland educated themselves more than those living in Southern Finland.

Training (e.g. in-house training at pharmacies and CE-courses) is one way to keep up to date with the latest developments (Holland 1992). Learning and development of both the individual and the community must be persistent to make the ideology of pharmaceutical care come true in the pharmacy work setting (Närhi 2001, Lehtonen 2003). But how will it be possible for the pharmacists to provide patient counselling eight hours a day, and what is the alternative for patient counselling? Themed weeks and campaigns are good alternatives requiring both knowledge and skills from the pharmacist in the preparative arrangements. At the same time, such activities can communicate to the patients that the pharmacy could be a comprehensive source of health information. This requires that the pharmacy owners have also understood the concept of professionalism and know how to implement that idea in practice. Development of professional competence requires training and it is the pharmacy owner, as an employer, who can make it possible to implement into practice. The importance of the role of the employer has been proved also in another Finnish study (Viitala 2004). Increased knowledge and skills also increase interest and raise motivation towards one's own work, as was shown in this study. The pharmacist's work in a pharmacy is professional work and training has a significant effect on how expertise develops. If the pharmacist does not perceive him/herself as a professional, the work easily becomes routine, which is directly proportional to a professional career change (Loponen and Savela 2003).

In the future, continuing education for pharmacists as health care professionals should be focused even more at the practice level. Dynamic verbal- and non-verbal communication situations could be videotaped for further theoretical, consciousness and developmental feedback and self-assessment. In order to activate self-reflection, pharmacists need to practice communication skills (Van Manen 1977, Mezirow 1981, 1991, Smyth 1992, Wong *et al.* 1995, Katajavuori *et al.* 2005b).

12.3 Challenging concordance-style patient counselling

As this study showed, a long-term continuing education course in the principles of patient counseling has been successfully introduced. According to data from the focus group discussions pharmacists reported they learnt to pay more attention to their own and others' verbal and non-verbal communication. While assessing their own performance they became more aware of patient-centred counselling. Even though the study pharmacists reported learning to understand patients as individuals, they also reported that they still tended to make decisions on behalf of patients. Earlier Finnish studies showed that pharmacists' attitudes towards counselling were still more paternalistic than based on respecting the patients' autonomy (Airaksinen *et al.* 1994, Itkonen 2000). Also in the study undertaken in the UK, health care professionals had negative attitudes toward concordance, especially the pharmacists (Raynor *et al.* 2001). However, according to this doctoral thesis, Finnish pharmacists have generally positive attitudes toward concordance-style patient counselling, especially toward establishing a therapeutic alliance between themselves and the patient.

This study has indicated that the TIPPA Project might have had some effect on pharmacists in order to help them to understand the meaning of concordance-style patient counselling. This conclusion could be drawn from each of the 4 open-ended questions, with the results of each supporting the other, although it is noteworthy that the response rate was 51%. Still, other studies in Finland and in Australia have indicated that pharmacists are not automatically able to implement new programmes into pharmacy practice (Airaksinen 1996, De Almeida Neto *et al.* 2000, De Almeida Neto *et al.* 2001, Vainio *et al.* 2001, Puumalainen *et al.* 2005b). These findings could indicate that concordant-style counselling seems to be challenging for practicing pharmacists, but not impossible. It indicates that even if pharmacists have positive attitudes toward concordant-style counselling, it is not enough; they need concrete tools and CE-education on how to implement principles of concordance into practice. Furthermore, pharma-

cists have been found to spend more time on counter activities and less on talking to patients about their medicines and health (Cox *et al.* 2002). The problem might be in basic education for pharmacists, which is too medicine-centered. This could be supported by another Finnish study, which indicated that pharmacy students have knowledge but they have difficulties with sufficient communication style (Katajavuori *et al.* 2005b). According to the systematic review of concordance, pharmacists tend to initiate and dominate discussion with patients, only some pharmacists check patient's understanding (Cox *et al.* 2002). This might be problematic for concordance if patients feel intimidated and unable to express their own feelings. Thus, according to the study made by Du Pasquier (2005), patients were positive about concordance, because they valued two-way communication and increased consideration for their needs and ideas by health professionals.

However, it was surprising that Finnish study pharmacists' attitudes toward patient counselling were more positive the older they were, the longer since they had graduated and the longer they had worked in community pharmacies compared with younger respondents. Still, younger pharmacists should have better knowledge and skills than their senior colleagues, as they have been taught the principles of concordance and two-way communication in their basic pharmacy education (Katajavuori *et al.* 2003).

There is a need for developing tools for educating practicing pharmacists and pharmacy students about communication skills. For example the LAT-Con scale (Raynor *et al.* 2001) and USP Medication Counselling Behaviour Guideline (www.usp.org) could be useful tools while implementing the principles of concordant-style patient counselling into pharmacy practice. The modified LATon scale can be used in Finland in basic and continuing education for pharmacists, pharmacy students and also pharmacy owners to illustrate the concept of concordance-style counselling and make it more understandable. In this doctoral thesis as well as another Finnish study (Puumalainen 2005a), the USP Medication Behaviour Guidelines proved to be a practical tool in developing counselling skills in long-term CE-courses. The USP Medication Behaviour Guidelines is not the only tool by which to develop patient counselling, but it is one of the fundamental tools. It has been systematically applied for introducing practitioners the principles of two-way communication and self-assessment of performance. The USP Medication Behaviour Guidelines have already been used in basic education in Finland and its' suitability and validity to Finnish context has been tested (Puumalainen *et al.* 2005c). Morrow and Hargie (1992, 1993a,b) have also developed their own model for practicing patient counselling and it is main-

ly focused on communication, and it has been widely used in UK. Recently International Students' Federation (IPSF) has developed a patient counselling booklet (Counselling, Concordance and Communication- Innovative Education for Pharmacists 2005) (Wuliji and Airaksinen 2005) in co-operation with International Pharmaceutical Federation (FIP). This booklet provides a tool to develop patient counselling skills through proactive efforts towards engaging patients in partnerships.

12.4 Implementing the change in the communication culture of pharmacy

The findings of this study have shown the importance of involving all pharmacy staff in the long-term professional development in order to promote change at the pharmacy level. Even though the course participants' colleagues were positively oriented towards being involved, it was difficult to implement change in the communication culture of the pharmacy through only one person. According to another Finnish study, the successful implementation of change requires that all staff are involved with change (Niskanen 1998) and the pharmacy owner is the facilitator of the change (Holland and Nimmo 1999). Professional development is dependent on management style, development possibilities in the work place and support from colleagues. With these dimensions, working society can be described as a learning society (Hart and Rotem 1995, see also the chapter 7, figure 4, page 39) and in turn that can facilitate change in the communication culture of a pharmacy. Within the work communities in the health care sector, pharmacies are not, however, the only places in which personnel do not feel committed for long term professional development projects. Studies have also been carried out among nurses, and one such study revealed that the work community included nurses who did not feel sufficiently committed to the long-term professional development projects and had difficulties in adapting to change (Hilden 1999).

In the future, it will be important to use innovative training methods that require involvement of all pharmacy staff. The Australian training model based on pseudo customers with immediate feedback seems to be promising in this respect (De Almeida Neto *et al.* 2000, De Almeida Neto *et al.* 2001). A pseudo customer method means that pharmacists are being assessed by the "patient" but the pharmacist is not aware of the simulated patient's identity or purpose. A pseudo customer is requesting a specific product or general advice and the pseudo customer is trained to follow a standard script (De Almeida Neto *et al.* 2000, De Almeida Neto *et al.* 2001,

Puumalainen *et al.* 2005b). A similar training process has been developed also in Finland (Tippa Report 2002). Long-term development projects in patient counselling requires the whole pharmacy staff to be involved, and projects are most likely to be successful if the highest level of organization (pharmacy owner) considers them important (Argyris 1990, Järvinen 2002, Lehtonen 2003).

According to previous studies, change in communication culture cannot be achieved by participating in short-term courses (Bowden and Marton 1998, De Almeida Neto *et al.* 2000, De Almeida Neto *et al.* 2001). The goal of future continuing education should be to facilitate a permanent change in practice. Previous studies have shown that each pharmacy has an individual organizational culture that will determine for example quality of pharmacist-patient interaction (Savela 2003, Vainio 2004). Without educational interventions, behaviour patterns and interactions with patients may be based on perceptions, beliefs and paternalistic attitudes (Itkonen 2000, Katajavuori *et al.* 2002, Vainio *et al.* 2002). More studies are needed to understand the factors related to managing change in professional community pharmacy and influencing the change process by training and developing new management skills. Still, there are plenty of studies, which have concentrated on studying the changes in organizational culture.

One very important factor in spreading the change throughout pharmacy is the pharmacy owner (Roberts *et al.* 2003). The vision and the strategy of the pharmacy in patient counselling formed a core of the developed instrument, indicating the important role of the pharmacy owner in the development process (Puumalainen 2005a). The constructive sum scale in this doctoral dissertation showed in most cases (70%) the implementation of the TIPPA Project was low. The whole development process in pharmacies should be managed and led by the pharmacy owner. One person only cannot implement new practices even if the pharmacy owner is involved with the development project. It requires the whole working community to be involved with the change.

Many of the actions related to the TIPPA project were not optimally implemented. This may be because this doctoral study was conducted only 2,5 years after the TIPPA project started. Still, it was evident that long-term development plans in patient counselling practice and co-operation with other health care professionals need developing at pharmacies. This was indicated by the fact that the tools related to strategic planning and long-term development had the lowest implementation rate although they were

prioritized as the most important ones to be taken by the national expert panel designing the intervention protocol (Tippa Report 2002, Puumalainen *et al.* 2005d). The strength of the project has been in the various activities conducted at different levels, including basic and continuing education. As the factors related to the pharmacy outlet e.g., geographic location, facilities, number of prescriptions dispensed, did not influence the implementation of the TIPPA Project, the attitude of the pharmacy owner, his/her business orientation and leadership skills might be the most essential factors affecting the actions taken in the pharmacy. Thus, people (e.g. pharmacists) want change and innovation, but on the other hand they would like everything to remain unchanged (Järvinen 2002). The position of the pharmacy owner in change situations might be difficult, because the pharmacy owner as the director of change is also the target of the change. So, it is not enough that pharmacy owner tries to staff pharmacists to participate in the implementation of change, and at the same time the pharmacy owner does not change their own way of actions. Schein (1996) has defined two crucial criteria for leaders; first the leader should be mentally very strong to deal with strain and conflicts, and secondly the leader should understand the working society from all possible points of view. Furthermore, the leader should be the leader of change in the future. These things could be extrapolated to Finnish pharmacy owners.

Even if the actions related to the TIPPA project were not optimally implemented, at least some individual actions had been taken in many pharmacies. Two and half years is too short a time to induce permanent change. The current status of the outcomes of the TIPPA project, are the same as they were 2 years after the project was initiated. But the TIPPA project is still on-going in 2005 and there have been progress on the implementation rates during 3 years (Saario 2005). The study conducted by Saario (2005) was done five years after the TIPPA Project started. The results showed that 55 % from the respondents are working in pharmacies with low implementation rate and 35 % from the respondents are working in pharmacies with moderate implementation rate and 10 % from the respondents are working in pharmacies with a high implementation rate. The results also indicated that there has been a real progress in improving access to drug information sources and privacy for patient counselling is often better organized through outlet arrangements. Still, the long-term development process has not yet been established in many pharmacies. According to the study made by Saario (2005) implementation of customized patient counselling is still needed, along with education on strategic planning and quality assurance.

Good quality in patient counselling and professional pharmaceutical staff should be seen as an added value to the pharmacy and as an element, which enhances competitiveness. By providing possibilities for the development of the pharmaceutical staff in the field of patient counselling and communication, the pharmacy owners improve their business. This could give the pharmacy owners an opportunity to redefine their business and thus a pharmacy could be a comprehensive source of health information (Normann and Ramirez 1993).

12.5 Methodological considerations

This study focused on assessing the implementation of customer-oriented principles to pharmacy. The study was done two and half years after the TIPPA Project was started. In this study, various methods were used to explore the study design (see also chapter 10). This chapter describes a common methodology and the strengths and limits of this study.

Qualitative part of the study; studies I and II

Content analysis was used to assess the level of practicing pharmacists' patient counselling skills in the context of reflectivity (study I). The data consisted of narratives (n=40). Even though content analysis is originally a quantitative method, the purpose of using this method is to describe the division of data into classes and categories, and thereby express the essence of the content. Content analysis is also an important method for qualitative analyses (www.metodix.com, Pietilä 1976). Content analysis is a research method, which makes it possible to draw repeatable and valid conclusions about the relation between the research data and its context and contents. Content analysis provides an inductive or deductive approach for the research (Kynğäs and Vanhanen 1999). In this study the content analysis was based on the deductive approach, which means that the study data was analyzed through the theoretical framework, which was based on USP Medication Counselling Stages and Mezirow's critical reflection. Combining these two aspects as a harmonious theory was very challenging and demanding. USP Medication Counselling Stages cannot be considered as a real theoretical framework, rather a tool, which helps to promote two-way communication and customer-oriented patient counselling. It might have been almost impossible for practicing pharmacists to be able to reflect critically without any teaching and guidance to the topic. It must be remembered that the results of 40 practicing study pharmacists cannot be generalized to all Finnish pharmacists. It would be interesting to conduct a similar study, learning organization as the theoretical framework.

The challenge associated with the use of content analysis as a method of evaluation concerns the difficulty in finding distinct classes and categories. The categories might be very close or even overlapping to each other (www.metodix.com). This might be a problem in this study too. In order to avoid bias, two authors analysed the data. The analysis was first done independently and then compared, and in the case of interpretation discrepancy, the essays were reviewed again and discussed until the consensus was reached. The results of the study reflect the subjective experiences of the study pharmacists in the beginning of the course and cannot be generalised more widely. It would be useful to repeat the study among larger number of pharmacists during CE-courses in order to follow the development of reflectivity in the area of patient counselling.

Focus group interviews proved to be an effective method for assessing pharmacists' perceptions of the impact of a long-term continuing education course (study II). Focus group interview provides one-to-one interaction between the examinees, and an opportunity for researcher to provide clarification if the question and/or answer is equivocal (Tashakkori and Teddlie 1998, Smith 2002). By using focus group interviews as a study method, the findings cannot be generalized to the wider population (Smith 2002). The aim of the focus group- method is to enhance the meaning of deeper understanding of the study findings, not to achieve statistical generalisability (Pyörälä 1994). The reliability was assured by having all three focus groups at the same time, and each group had an interviewer and a scribe with the audiotape and the video camera, and by transcribing the data verbatim immediately after the discussions. One of the major disadvantages of the focus group discussions (FGD) is the risk of interviewer effects on responses of the interviewees (Tashakkori and Teddlie 1998). This might have happened in this study, because one of the scribes was a course leader during the CE-course. The most important criterion regarding the numbers of participants should be effective functioning of the group. The study pharmacists were divided to three groups of five to six people to ensure maximum discussion by each of the participants (Holstein and Gubrium 1997, Smith 2002).

There were three moderators for FGDs and they were instructed to facilitate the FGDS in the same way. The FGDS were semi-structured and the moderators used a topic guide in order to raise the same issues. The findings of the transcribed data were similar. The data from each FGDs could have been analysed separately and compared to each other, and if there had been any aberrant results between the groups, the researcher could have

examined the reasons for differences. The evaluation of the intervention process could have been included in this study. The data could have been collected during the long-term CE course and one year after the course, in order to measure long-term impact of the course on patient counselling practices of the participants or their peers in the pharmacy. The amount of study pharmacists is not enough in order to generalize the results to all Finnish practicing pharmacists.

Quantitative part of this study; studies III and IV

Pharmacy surveys were carried out by mail survey in 2002. The response rate was 51% (n=376), which is moderate, according to the literature; the response rates varied among health care professionals (e.g. doctors, nurses and pharmacists) from 24% to 85% (Smith 2002). Comparison of the respondent's characteristics to the target population on the basis of mean age, academic degree and geographic location of the pharmacy indicated that the study population was representative of the target population.

This study was part of a larger evaluation study of the TIPPA project (Varunki 2003) and this study consisted of two sectors of the evaluation study, which were the modified LATCon scale and the implementation scale with four open-ended questions (study III and IV, Appendix II).

The research instrument used in this study consisted of modified version of the LATCon scale (See study III). The original LATCon scale consisted of 12 statements rated using a Likert scale format (Raynor *et al.* 2001). The scale was translated into Finnish and two statements were added to increase its focus on Finnish conditions. Translating the scale was very challenging, it is important to modify the scale into one's own language and ensure its validity. The Finnish scale was pilot tested among pharmacy students and practitioners, and a Finnish scientist specialized in pharmacy ethics also evaluated the scale. All the statements in the Finnish version and in the original version were positively worded and that may have led to bias (DeVellis 1991, Bowling 1997). In a comprehensive attitude scale, half of the statements should be negative and half of the statements should be positive (Steiner and Norman 1995). The construct validity of the modified Finnish scale was evaluated using a factor analysis. Principal Axis factoring, which was used in this study, is commonly used method of factor analysis and an oblique rotation (Oblim) was selected as a rotation step to increase the interpretability of the data. The internal consistency of the scale was measured using Cronbach's Alpha. These showed that the Finnish version of the LATCon scale was construct valid and demonstrated internal consistency reliability.

Methods used in this study were both qualitative and quantitative, and the use of them proved to be quite challenging but fruitful. Content analysis, which was used in analysing the narratives proved to be successful. Focus group discussions (in the study II) could have been analysed also by using content analyses, because the used method, Grounded Theory, was too complicated, and there was no meaning to develop a new theory from the material. Methods used in quantitative studies proved to be useful and convenient. Theoretical concepts used in this study supported the research questions and helped while analysing the data, even though Mezirow's critical reflection might have been too complicated as a theoretical framework in the study I. Theoretical framework as a whole could have been based on reflection by Dewey's and Habermas'. Their work could be described as the backbone of the study of reflection.

12.6 Ethical aspects of research

The person who conducts scientific research on people must always consider, besides the requirements of the sciences, the exclusive rights of the persons studied as well as the rights of the individual subjects of the study or subjects of application of the results. The high quality of the study, correct interpretation and reliability of results are considered to be the most important ethical principles of scientific research (Alkula *et al.* 1994, Hirsjärvi *et al.* 1997, Raunio 1999,). Ethical principles related to researching also include respect for individual, obligation not to harm an individual, and being correct. The researcher is responsible for not allowing the research material to be accessed by any third parties in any of the stages of the study. In addition, the research results must be expressed in such a form that the test persons cannot be identified. In this study, each person selected for inclusion in the study had a right to choose whether he/she wanted to participate in the study. Each participant of the long-term course wrote a narrative and the participants were informed about the narratives being used for a research purpose. If someone did not want his/her narrative to be used for the study, this opinion was allowed and it was respected. No one prohibited the use of the narrative in this study. Refusing to take part in the focus group interview was also possible. The results obtained with the narratives and interviews are published in such a way that no pharmacist can be identified based on them. Citations are used with consideration to avoid identification of the participants of the study based on them. It was possible not to reply to the questionnaire and the replies were given anonymously to avoid revealing the identity of respondents. The questionnaires, narratives and interview materials, have been with the researchers at all times.

12.7 Further research

This study had some limitations, e.g. the relatively small number of participants in studies I and II, $n=17$ and $n=40$, respectively; and the challenges associated with combining the USP's Medication Counselling Stages and Mezirow's critical theory in, studies III and IV were done only 2,5 years after the TIPPA Project started. Nevertheless, it has provided information about a field of pharmacy that has not been studied earlier. Using different research methods it has been possible to examine how the principles of patient counselling have been implemented into pharmacy practice and how the development can be influenced on the individual and work community level. The development of a pharmacy as a work community is not self-evident. If the development work is not sufficiently emphasised in the workplace, there is a risk of gradual freezing of ways of action and thinking, and the pharmacy owner and the pharmaceutical staff start becoming lulled into a false sense of well-being with safe customs and routines. With sustainable and well planned development work, it is possible to achieve remarkable advances and improvements in the quality of the pharmacies' patient counselling. This is due to the fact that a development process with a focus on customer-orientation never originates from a zero base, but instead the existing knowledge and experience of the pharmacists are used as far as possible. The basis of the pharmacy operation in a professional pharmacy is expertise, which develops through training and experience in work and can be examined on different levels (Turpeinen 1998, Tiuraniemi 2002). Further research could be made on the process stages of the dialogue between pharmacists and patient, such as the relevance or lack of them in a counselling situation. Also, it would be interesting to analyse the strategy, which the pharmacist could use to find out whether the patient has contemplated the matter him/herself, or what the meaning of patient counselling is for the patient.

The development of interaction skills and professional competence should be analysed with long-term studies. The narratives written at the start of the course and the final interview only provide information about the current events and reflect work activities in the short term. The impact of long-term training in patient counselling changes in one's own ways of action and those of the entire work community should be followed up over a reasonably long period of time to obtain a reliable view. Training interventions for developing one's own skills in patient counselling should be increased and their impact should be examined.

Attitudes toward patient counselling have a major role as to how counselling is implemented in pharmacy practice. It has become evident in this doctoral thesis, that pharmacists have positive attitudes toward concordance style counselling. This study also indicates that the TIPPA Project has had some influence on attitudes. In order to reach patient oriented service at the pharmacy level, one important step is to assess pharmacists' attitudes toward patient counselling and concordance-style counselling. By knowing pharmacists' attitudes toward concordance, it will be possible to influence behavioural intention and possibly behaviour itself, in implementing a concordance-based counselling service. This doctoral thesis study included only pharmacy staff as a target population while assessing the attitudes toward concordance. It would be interesting to extend this study to pharmacy owners, in order to find out how motivated they are toward professional goals and strategies in their business. Also this assessment was conducted two and half years after TIPPA Project was initiated, it would be useful to repeat the survey after the Project is completed. A repeat survey could help assess the TIPPA Project's longer-term impact on attitudes toward concordance-style counselling.

In this study a modified version of LATCon scale was used assessing the attitudes toward concordance. One interesting research opportunity in the future is to further develop the LATCon scale. This could be done by qualitative research, e.g. interviewing pharmacists about the statements of the LATCon scale. By interviewing pharmacists, more in-depth knowledge about pharmacists' attitudes toward concordance and factors that are facilitators and barriers to concordant-style counselling, could be obtained. Also it would be interesting to find out how divided decision-making is fulfilled in the dialogue between the pharmacist and the patient.

This doctoral thesis has been a real learning process for me. The use of triangulation as a research method, combining quantitative and qualitative methods, has been shown to be an effective way for evaluating pharmacist involvement in patient counselling. Furthermore, the use of a qualitative approach is relatively rare in Finnish studies of the practice of pharmacy. Hence this research has required a turning around of my way of thinking, especially because my background is to a extent in mathematics and science. Studying and applying qualitative methods in pharmaceutical research is important and is necessary. When looking at the conclusions, attention should be paid to the methods used, the relatively small sizes in the qualitative studies, and the applicability of this work to community pharmacy practice. As regards generalisability and transferability of the re-

sults to the Finnish pharmacy context, the reader is encouraged to rely on his/her own interpretations. However, it is noteworthy that no previous studies have specifically been conducted in this important area of social pharmacy practice research. I wish that this study could have an impact on the on-going development of professional competence of pharmacists in the Finnish health care sector.

13 CONCLUSIONS

Based on the results of this study, the following conclusions can be drawn:

1. In order to develop professional competences, such as patient counselling skills, new teaching methods and evaluation tools applicable to continuing education and in-house training are needed.
2. The challenge in both basic and continuing pharmacy education is to support community pharmacists in constructing their thinking toward patient counselling. In order to achieve this, pharmacists are supported to undertake long-term continuing education courses.
3. The effective learning process should focus on the principles of two-way communication, patient-orientation, concordance and reflectivity.
4. In order to have a permanent change in communication culture in pharmacies, more than one pharmacist from each pharmacy must attend to long-term CE courses on patient counselling.
5. Pharmacist education through programs such as TIPPA can aid in the implementation of a concordance-based counselling practice although the implementation rate vary between pharmacies indicating polarization.
6. The Finnish pharmacists highly agree to establish a therapeutic alliance in the consultation with the patient, but the pharmacists do not consider that their own attitudes and beliefs as barriers to patient counselling.
7. The Finnish version of LATCon scale proved to be valid and reliable tool for assessing practicing pharmacists' attitudes toward concordance
8. Pharmacies have been polarised, i.e. there are pharmacies that are committed to the long-term professional development and those who are not.

9. Results at 2.5 years after starting TIPPA Project indicate that a progress towards value services is slow but achievable. Regular follow-ups will be needed to assess the progress in implementation of actions and sustainability of changes.

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APPENDICES

UNITED STATES PHARMACOPEIA (USP)

Medication Counseling Behavior Guidelines

Accessed: <http://www.usp.org>, June 4, 2001

The information that follows is the work of the USP's Ad Hoc Advisory Panel on Medication Counseling Behaviors. The document describes appropriate situations in which medication counseling should occur and provides recommendations for effective counseling.

UNITED STATES PHARMACOPEIA

Medication Counseling Behavior Guidelines

Accessed: <http://www.usp.org>, June 4, 2001

General Introduction

The Ad Hoc Panel on Medication Counseling Behavior Guidelines was established in 1994 as a subgroup of the USP Consumer Interest/Health Education Advisory Panel. It was charged with the mission of determining appropriate situations in which medication counseling should occur and developing guidelines for the behaviors applicable to these interactions.

The Ad Hoc Panel explored the following counseling parameters: definitions, patient outcomes, skill evaluation, curriculum, current practices, content, incentives, barriers, patient perceptions and needs, and special groups.

The work of the Ad Hoc Panel establishes a base for continuing study, and from which further explorations may be launched. This document provides the raw materials for the development of a number of important applications, and serves as a database for health care providers in every discipline. With concern for the patient's welfare as the motivating force behind the initiative, it is the panel's intent that the final thrust of these applications be one of patient advocacy, rather than merely a framework on which guidelines for professional conduct can be built.

The publication of an authoritative analysis of medication counseling behaviors is an important motivator for additional research. This initial effort forms a framework for additional information and promotes the employment of efficacious, valid patient education techniques.



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Panel Members

Frank Ascione, Ph.D. (Chair), University of Michigan, College of Pharmacy, Ann Arbor, MI

John E. Arradondo, MD, Meharry Medical College, Nashville, TN

Karin Bolte, National Consumers League, Washington, DC

Allan H. Bruckheim, MD, Anything Medical, Harrison, NY

Mark Clasen, Wright State University, School of Medicine, Dayton, OH

Frederick A. Curro, DMD, Ph.D., Block Drug Company, Inc., Jersey City, NJ

Robin DiMatteo, Ph.D., University of California, Department of Psychology, Riverside, CA

Diane B. Ginsburg, The University of Texas at Austin, College of Pharmacy, Austin, TX

Denise Grimes, Jackson, MI

Richard Herrier, Pharm.D., University of Arizona, College of Pharmacy, Tucson, AZ

Barry Kass, R.Ph., Northeastern University, Bouvé College of Pharmacy, Boston, MA

Thomas Kellenberger, Pharm.D., Merck-Medco Managed Care, Inc., Montvale, NJ

Alice Kimball, Darnestown, MD

Pat Kramer, Bismarck, ND

Patti Kummeth, RN, St. Mary's Hospital, Rochester, MN

Ken Leibowitz, Philadelphia College of Pharmacy and Science, Philadelphia, PA

Colleen Lum Lung, RN, National Jewish Center, Denver, CO

Louise Matte, University of Montreal, School of Pharmacy, Montreal, Quebec, Canada

Amy Outlaw, Pharm.D., Egleston Children's Hospital, Atlanta, GA

Constance C. Pavlides, RN, D.N.Sc., Walter Reed Army Medical Center, Washington, DC

Scotti Russell, Virginia Board of Pharmacy, Richmond, VA

Lisa Tedesco, Ph.D., University of Michigan, School of Dentistry, Ann Arbor, MI

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Medication Counseling Behavior Guidelines

Definitions/Outcomes

This material has been formulated to serve as the foundation upon which the discussions and outcome results of the Ad Hoc Panel: Medication Counseling Behavior Guidelines could be predicated. It provides definitions of key terms, a graphic structured format detailing the interactions which take place during various stages of counseling, and a final listing of anticipated outcomes of patient counseling stated in objective-based terminology.

Medication Counseling Behavior Guidelines encompass strategies for healthcare professionals to enhance communications with patients when providing information about the safe and proper use of medications. This section offers key definitions related to medication counseling. The term "patient" is used to identify client, consumer, or the individual being served.

Definitions of key terms

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 audiovisually. 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 audiovisually 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 focuses 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 counseling: 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.

Medication Counseling Stages

Medication counseling is viewed as a continuum of interaction between the healthcare professional and the patient. This table integrates key definitions related to medication counseling behavior and is designed to assist the healthcare professional in determining the stage of medication counseling. These are stages in the continuum, starting from limited interaction to involved interaction. Major emphasis has been placed on empowerment of the patient in these interactions. The interactions are considered to be generic and unrelated to the professional orientation of the information/counseling provider.

	Medication Information Transfer	Medication Information Exchange	Medication Education	Medication Counseling
Level of Information	Basic, brief, non-individualized	Detailed, individualized	Comprehensive, group or individualized	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 prescribed medication as directed (Monolog)	Provider responds to and asks questions related to prescribed medication (Dialog)	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 healthcare 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

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Outcomes of Patient Counseling

To assist in the use of this material in academic or teaching environments, outcome expectations are stated to reflect the anticipated consequences of properly conducted counseling interactions.

1. The patient will recognize why a prescribed medication is helpful for maintaining or promoting well-being.
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 compliance or adherence to his/her prescribed medication regimen.
4. The patient will improve coping strategies to deal with medication side effects and drug 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 or her health status.

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Medication Counseling Behavior Guidelines

Introduction to Counseling Assessment Inventory

The panel worked to develop a comprehensive medication counseling assessment inventory, that could be used by members of all health professions, for purposes of learning and self improvement. The intent was to construct an evaluation tool that contains items having potential application to a variety of medication counseling contexts.

The panel solicited medication counseling instruments from health care institutions, schools, and practice settings. A review of these forms yielded an initial listing of 174 items. After eliminating redundancies, the remaining items were grouped into four sections to highlight the basic components of a medication counseling session: (1) the introduction of the session, (2) the content of the session, (3) the process followed, and (4) the conclusion of the session. The result of this process is a form comprised of 35 items that is designed to measure behaviors associated with the four medication counseling components.

It is important to recognize that the goal was to be as thorough and systematic as possible, at the same time realizing that if one decided to utilize all 35 items on the inventory, use of the tool could result in a tedious evaluation process.

Optimal use of the medication counseling assessment form is affected by several factors. First and foremost is the intended purpose of conducting the assessment. The assessment form should be used for educational purposes not for work-related personnel decisions.

Second, use of this form is influenced by the context in which medication counseling occurs. The objective was to derive a core group of medication counseling evaluation items that would be relevant to most counseling encounters. Panelists representing pharmacy, medicine, nursing, and academia reviewed the items to insure that the counseling behaviors included on the inventory were professionally inclusive. There may be items contained on the form, however, that are inappropriate for specific situations. Similarly, 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. The N/A response option has been included on the inventory to enable users to preselect those items they feel are inappropriate for their evaluation needs. Since the form is intended to be used by members of all health professions in a variety of settings, the items are general in nature. Users may need to add items to meet their specific needs.

Finally, use of the form is affected by the accuracy and efficiency of those individuals functioning as raters. There are two issues of concern in this regard. Raters will need to determine in advance if they want to engage in a checklist or rating scale evaluation. The former will tell ratees which behaviors they used; the latter will provide a judgment regarding how well they performed these behaviors. Both formats have been provided to allow for maximum implementation flexibility. The second rater issue involves item clarity. A descriptive statement has been prepared for each assessment item. The intent is to clarify each item not only for the benefit of the raters but also for use by individuals who will be evaluated. The 35 items included on the rating scale have not been weighted in terms of importance. The panel recognizes that the items have differing importance, but research needs to be conducted to determine the relative significance of the individual counseling behaviors

comprising the assessment inventory.

Medication counseling instruments were submitted from the following: Auburn University, Drake University, Midwestern University - Chicago College of Pharmacy, University of Missouri Kansas City, State University of New York at Buffalo, North Dakota State University, Purdue University, University of Texas at Austin, the USP National Patient Counseling Competition.

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Medication Counseling Behavior Guidelines Counseling Assessment Inventory

CATEGORY 1: COUNSELING INTRODUCTION ITEMS

CHECKLIST

RATING

Y	N	N/A	N/A	Not Done	Poor	Unsatisfactory			Satisfactory		Excellent			
						0	1	2	3	4	5	6	7	8
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			1.	Conducts appropriate counseling introduction by identifying self and the patient or patient's agent.										
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			2.	Explains the purpose of the counseling session.										
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			3.	Reviews patient record prior to counseling.										
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			4.	Obtains pertinent initial drug related information (e.g., allergies, other medications, age, etc.).										
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			5.	Warns patient about taking other medications, including OTCs, herbals/botanicals, and alcohol, which could inhibit or interact with the prescribed medication.										
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			6.	Determines if the patient has any other medical conditions which could influence the effects of this drug or influence the likelihood of an adverse reaction.										
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			7.	Assesses the patient's understanding of the reason(s) for the therapy.										
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
			8.	Assesses any actual and/or potential concerns or problems of importance to the patient.										

CATEGORY 2: COUNSELING CONTENT ITEMS

Y	N	N/A	N/A	Not Done	Poor	Unsatisfactory	Satisfactory	Excellent						
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	9.	Discusses the name and indication of the medication.	—	—	—	—	—	—	—	—	—	—
—	—	—	10.	Explains the dosage regimen, including scheduling and duration of therapy when appropriate.	0	1	2	3	4	5	6	7	8	9
—	—	—	11.	Assists the patient in developing a plan to incorporate the medication regimen into his/her daily routine.	0	1	2	3	4	5	6	7	8	9
—	—	—	12.	Explains how long it will take for the drug to show an effect.	0	1	2	3	4	5	6	7	8	9
—	—	—	13.	Discusses storage recommendations, ancillary instructions (e.g., shake well, refrigerate, etc.).	0	1	2	3	4	5	6	7	8	9
—	—	—	14.	Tells patient when he/she is due back for a re-fill.	0	1	2	3	4	5	6	7	8	9
—	—	—	15.	Emphasizes the benefits of completing the medication as prescribed.	0	1	2	3	4	5	6	7	8	9
—	—	—	16.	Discusses potential (significant) side effects.	0	1	2	3	4	5	6	7	8	9
—	—	—	17.	Discusses how to prevent or manage the side effects of the drug if they do occur.	0	1	2	3	4	5	6	7	8	9
—	—	—	18.	Discusses precautions (activities to avoid, etc.).	0	1	2	3	4	5	6	7	8	9
—	—	—	19.	Discusses significant drug-drug, drug-food, and drug-disease interactions.	0	1	2	3	4	5	6	7	8	9

—	—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	—	0	1	2	3	4	5	6	7	8	9	10

CATEGORY 3: COUNSELING PROCESS ITEMS

Y	N	N/A	N/A	Not Done	Poor	Unsatisfactory	Satisfactory	Excellent						
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10

—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

CATEGORY 4: COUNSELING CONCLUSION ITEMS

Y	N	N/A	N/A	Not Done	Poor	Unsatisfactory	Satisfactory	Excellent						
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10
—	—	—	—	0	1	2	3	4	5	6	7	8	9	10



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Definitions of Core Counseling Items

- 1. Conducts appropriate counseling 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 for the patient.

- 2. Explains the purpose of the counseling 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 counseling session is important from their perspective.

- 3. Reviews patient records prior to counseling.**

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 counseling 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 (drug-drug, drug-disease interactions).

- 5. Warns patient about taking 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 drug or enhance the likelihood of an adverse reaction.**

See item 5.

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

It is extremely useful to find out what the patient already knows. Doing this has the potential for saving time in the counseling sessions 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 health care 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. 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.

14. Tells patient when he/she is due back for a re-fill.

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

15. 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.

16. Discusses potential (significant) side effects.

Patients need to be aware of side effects so they do not unnecessarily seek medical attention if they occur. It is erroneous to think that telling

patients of side 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.

17. Discusses how to prevent or manage the side effects of the drug if they do occur.

Patients should be told whether the side 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 side effects and what they should do if they do not go away.

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. Discusses significant drug-drug, drug-food, and drug-disease interactions.

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.

20. 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've missed a dose five hours later should they take the dose or not, or should they ever double-dose.

21. 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.

22. Helps patient generate solutions to potential problems.

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

23. Provides accurate information.

Self explanatory.

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

Health care professionals should avoid technical jargon when counseling 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.

25. Uses appropriate counseling aids to support counseling.

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've heard the practitioner say. The use of videos, graphics, and other tools could also be used to support counseling.

26. Responds with understanding/empathic responses.

This skill is absolutely essential to an effective counseling session. If the patient sees the health care professional as competent, trustworthy, and someone who cares about what happens to them, it increases their compliance. Health care professionals need to hear what patients have to say without judgment or attempting to minimize their concerns.

27. 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 counseling session. It has been shown that people retain information longer when information is presented this way.

28. Maintains control and direction of the counseling session.

While the emotional needs of the patient relative to drug therapy should be addressed, the counseling 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.

29. 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.

30. Uses open-ended questions.

The use of open-ended questions (e.g., "What did your health care provider tell you this medication is for?") rather than close-ended questions (e.g., "Did your health care provider tell you what this medication 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.

31. Displays effective nonverbal behaviors.

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.)

32. 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 side 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.

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

The health care provider should summarize key points of the

counseling 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 haven't left anything out, let me summarize."

34. Provides an opportunity for final concerns or questions.

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

35. Helps 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.

Contact

infomonographs@usp.org

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Vastausohje: Alla oleva kysely on jaettu kuuteen eri osa-alueeseen. Toivomme, että vastaat jokaiseen kysymykseen huolella, jotta saatu tieto on mahdollisimman hyvin hyödynnettävissä. Ympyröi vastausvaihtoehto, joka vastaa parhaiten omaa mielipidettäsi. Avoimiin kysymyksiin on vastauksille varattu oma tilansa.

1. TIPPA-PROJEKTI APTEEKISSAMME

1. Kuinka hyvin tunnet TIPPA-projektin?

- 1 Erittäin hyvin
- 2 Melko hyvin
- 3 Jonkin verran
- 4 Huonosti
- 5 En lainkaan

2. Mistä olet saanut tietoa TIPPA-projektista?

Vastausvaihtoehdot:

1 = Erittäin paljon, 2 = Melko paljon, 3 = Vähän, 4 = Erittäin vähän, 5 = En lainkaan

Semina	1	2	3	4	5
Apteekkarilehti	1	2	3	4	5
Apteekkariliiton farmaseuttiset tiedotteet	1	2	3	4	5
Koulutustilaisuudet	1	2	3	4	5
Järjestötilaisuudet	1	2	3	4	5
Apteekkari	1	2	3	4	5
Työkaverit	1	2	3	4	5
Jostain muualta, mistä?					

3. Miten TIPPA-projekti näkyy apteekkisi toiminnassa?

4. Mitä hyötyä TIPPA-projektista on omassa työssäsi?

5. Miten työsi apteekissa on muuttunut TIPPA-projektin myötä?

6. Miten seuraavat asiat ovat toteutuneet omassa apteekissasi?

Vastausvaihtoehdot:

1 = Toteutuu hyvin, **2** = Toteutuu melko hyvin, **3** = En osaa sanoa,
4 = Toteutuu jossain määrin, **5** = Ei toteudu lainkaan

	Toteutuu					Ei toteudu				
Apteekissamme on nimetty reseptilääkkeiden lääkeneuvonnan kehittämisestä vastuussa oleva henkilö.	1	2	3	4	5					
Apteekissamme on nimetty itsehoitolääkkeiden lääkeneuvonnan kehittämisestä vastuussa oleva henkilö.	1	2	3	4	5					
Apteekissamme on lääkeneuvonnan kehittämissuunnitelma.	1	2	3	4	5					
Apteekissamme on laadittu yhteiset reseptilääkkeiden lääkeneuvontaa koskevat toimintaohjeet tai sopimukset.	1	2	3	4	5					
Apteekissamme on laadittu yhteiset itsehoitolääkkeiden lääkeneuvontaa koskevat toimintaohjeet tai sopimukset.	1	2	3	4	5					
Asiakkailta tuleva palaute lääkeneuvonnasta kirjataan ylös ja käydään henkilökunnan kanssa yhdessä läpi.	1	2	3	4	5					
Apteekissamme on kiinnitetty huomiota reseptinkäsittelyn työvaiheiden tehostamiseen ajan löytämiseksi lääkeneuvonnalle.	1	2	3	4	5					
Apteekissamme on varmistettu, että lääkeneuvontaa tukevat tietolähteet ovat helposti saatavilla.	1	2	3	4	5					
Apteekissamme on varmistettu, että henkilökuntamme osaa käyttää internetiä lääkeneuvonnan apuvälineenä.	1	2	3	4	5					
Apteekissamme on pyritty varmistamaan lääkeneuvontatilojen intymiteettisuoja.	1	2	3	4	5					
Apteekillamme on lääkeneuvontaa tukevaa yhteistyötä paikallisen terveydenhuollon kanssa.	1	2	3	4	5					
Lääkeneuvontaa tukevaa toimipaikkakoulutusta järjestetään apteekissamme säännöllisesti.	1	2	3	4	5					
Apteekissamme tehdään vuosittain koulutussuunnitelma.	1	2	3	4	5					
Apteekissamme on farmaseuttisella henkilökunnalla henkilökohtaiset koulutussuunnitelmat.	1	2	3	4	5					
Apteekissamme koko farmaseuttiselle henkilökunnalle on annettu mahdollisuus osallistua apteekin lääkeneuvonnan suunnitteluun.	1	2	3	4	5					
Apteekissamme on säännöllisesti lääkeneuvontaa tukevia kehityskeskusteluja.	1	2	3	4	5					

7. Miten käytät seuraavia lääkeneuvonnan työkaluja?

Vastausvaihtoehdot:

1 = Päivittäin, **2** = Viikoittain, **3** = Kuukausittain, **4** = Muutaman kerran vuodessa,
5 = Olen tutustunut, mutta en käytä, **6** = En ole tutustunut

Tietotippa	1	2	3	4	5	6
Tippa.net-linkkikokoelma	1	2	3	4	5	6
Apteekin itsehoidon käsikirja (osa I ja/tai II)	1	2	3	4	5	6
www.itsehoito-opas.net	1	2	3	4	5	6
Pharmaca Fennica	1	2	3	4	5	6
Elektroninen Pharmaca Fennica (EPF)	1	2	3	4	5	6
Pakkausselosteet	1	2	3	4	5	6
Lääkeopas	1	2	3	4	5	6
Lääkäriin CD (LCD)	1	2	3	4	5	6
Jotain muuta, mitä?						

8. Miten olet kehittänyt taitojasi lääkeneuvojana viimeisen kahden vuoden aikana?

Vastausvaihtoehdot:

1 = Päivittäin, **2** = Viikoittain, **3** = Kuukausittain, **4** = Muutaman kerran vuodessa,
5 = En lainkaan

Itseopiskelulla	1	2	3	4	5
Apteekin itsehoidon käsikirjan avulla	1	2	3	4	5
Kuuri loppuun!- kirjan avulla	1	2	3	4	5
Osallistumalla toimipaikkakoulutukseen	1	2	3	4	5
Osallistumalla täydennyskoulutukseen	1	2	3	4	5
Osallistumalla farmasian perusopetukseen	1	2	3	4	5
Jollain muulla tavalla, millä?					

2. LÄÄKENEUVONTA

LÄÄKENEUVONNAN PROSESSIMALLI

USP (United States Pharmacopeia) on kehittänyt lääkeneuvonnan 35-kohtaisen prosessimallin. Prosessimalli jakaa lääkeneuvonnan neljään osa-alueeseen, jotka toistuvat kaikissa lääkeneuvonta-tilanteissa. Läkeneuvontatilanteet voidaan jakaa aloitukseen, sisältöön, viestinnän keinoihin ja neuvonnan päättämiseen. Prosessimallin tarkoituksena on avata asiakaslähtöisen lääkeneuvonnan periaatteet ja sitä voi käyttää lääkeneuvontakäytäntöjen arvioimiseen.

9. Miten hyvin tunnet USP:n lääkeneuvonnan prosessimallin?

- 1 Erittäin hyvin
- 2 Melko hyvin
- 3 Jonkin verran
- 4 Huonosti
- 5 En lainkaan → mikäli vastasit en lainkaan, siirry suoraan kysymykseen nro 15.

10. Mitä kautta olet tutustunut prosessimalliin?

Voit ympeöridä halutessasi useamman vaihtoehdon.

- 1 Farmasian perusopetus
 - 2 Täydennyskoulutus
 - 3 Toimipaikkakoulutus
 - 4 Kuuri loppuun! – kirja
 - 5 Muu, mikä?
-

11. Onko USP:n prosessimalli hyödynnettävissä lääkeneuvonnassa?

- 1 Erittäin hyvin → vastaa kysymykseen a)
- 2 Melko hyvin → vastaa kysymykseen a)
- 3 Melko huonosti → vastaa kysymykseen b)
- 4 Erittäin huonosti → vastaa kysymykseen b)
- 5 Ei lainkaan → vastaa kysymykseen b)

a) Miten olet käyttänyt USP:n prosessimallia?

b) Miksi USP:n prosessimalli ei ole mielestäsi hyödynnettävissä?

12. Miten USP:n prosessimalli on mielestäsi sovellettavissa oppimisen välineenä opiskeltaessa lääkeneuvontaa? Arvio asiaa lääkeneuvonnan periaatteisiin ja itsearviointiin tutustumisen näkökulmasta.

Vastausvaihtoehdot:

1 = Erittäin hyvin, **2** = Melko hyvin, **3** = En osaa sanoa, **4** = Melko huonosti, **5** = Erittäin huonosti

	Tutustuminen lääkeneuvonnan periaatteisiin					Tutustuminen lääkeneuvonnan itsearviointiin				
Perusopetuksessa	1	2	3	4	5	1	2	3	4	5
Täydennyskoulutuksessa	1	2	3	4	5	1	2	3	4	5
Itseopiskelussa	1	2	3	4	5	1	2	3	4	5

13. Miten USP:n prosessimallin soveltamista käytännön lääkeneuvonnassa voisi mielestäsi parantaa?

14. Miten USP:n prosessimallin soveltamista lääkeneuvonnan itsearvioinnissa voisi mielestäsi parantaa?

15. Mitä mielestäsi tarkoitetaan asiakaslähtöisellä lääkeneuvonnalla?

käännä!

3. OMAN OSAAMISEN ARVIOINTI LÄÄKENEUVOJANA

Seuraavien vastauksien ei tarvitse olla tärkeys- tai paremmuusjärjestyksessä.

16. Mitkä ovat mielestäsi omia vahvuuksiasi lääkeneuvojana? Mainitse 3 asiaa.

Vahvuus 1: _____

Vahvuus 2: _____

Vahvuus 3: _____

17. Mitkä ovat mielestäsi kehittämisaalueitasi lääkeneuvojana? Mainitse 3 asiaa.

Kehittämisaalue 1: _____

Kehittämisaalue 2: _____

Kehittämisaalue 3: _____

18. Mitkä ovat mielestäsi oman työyhteisösi vahvuudet lääkeneuvonnassa?

Mainitse 3 asiaa.

Vahvuus 1: _____

Vahvuus 2: _____

Vahvuus 3: _____

19. Mitkä ovat mielestäsi oman työyhteisösi kehittämisaalueet lääkeneuvonnassa?

Mainitse 3 asiaa.

Kehittämisaalue 1: _____

Kehittämisaalue 2: _____

Kehittämisaalue 3: _____

20. Mitkä tekijät haittaavat eniten lääkeneuvonnan antamista omassa työssäsi?

21. Mitkä asiat motivoivat parhaiten itseäsi lääkeneuvonnan antamisessa?

Vastausvaihtoehdot:

1 = Erittäin paljon, **2** = Melko paljon, **3** = En osaa sanoa, **4** = Vähän, **5** = Ei lainkaan

Työtoverien palaute	1	2	3	4	5
Asiakkaiden palaute	1	2	3	4	5
Työnantajan palaute	1	2	3	4	5
Palkka	1	2	3	4	5
Toimipaikkakoulutus	1	2	3	4	5
Täydennyskoulutus	1	2	3	4	5
Työpaikan ilmapiiri	1	2	3	4	5
Kehityskeskustelut	1	2	3	4	5
Lukutunnit	1	2	3	4	5
Riittävä intymiteettisuoja	1	2	3	4	5
Jokin muu, mikä?					

22. Minkälaista tukea tarvitsisit kehittyäksesi lääkeneuvojana?

23. Oletko tyytyväinen siihen, miten lääkeneuvontaa toteutetaan apteekissasi?

1 Kyllä **2** En **3** En osaa sanoa

Perustele:

käännä!

4. HOITOMYÖNTYVYYS JA HOITON SITOUTUMINEN

24. Ympyröi mielipidettäsi vastaava vaihtoehto seuraaviin väittämiin (farmaseutilla tarkoitetaan kaikkia farmaseuttisen koulutuksen saaneita, apteekissa lääkeneuvontaa antavia henkilöitä kuten farmaseutti/proviisori/apteekkari).

Vastausvaihtoehdot: **1** = Täysin samaa mieltä, **2** = Jokseenkin samaa mieltä, **3** = En osaa sanoa, **4** = Jokseenkin eri mieltä, **5** = Täysin eri mieltä

	Samaa mieltä			Eri mieltä	
Farmaseutin tulisi antaa asiakkaalle mahdollisuus keskustella sairautensa herättämistä ajatuksista ja siitä, kuinka sairautta hoidetaan.	1	2	3	4	5
Lääkeneuvottelutilanne farmaseutin ja asiakkaan välillä tulisi nähdä neuvotteluksi kahden tasavertaisen osapuolen välillä.	1	2	3	4	5
Farmaseutin tulisi kunnioittaa asiakkaan kykyä päättää lääkkeidensä käytöstä ja siihen liittyvistä käsityksistä.	1	2	3	4	5
Lääkkeiden käyttö onnistuu parhaiten silloin kun se on asiakkaan toiveiden ja kykyjen mukaista.	1	2	3	4	5
Lääkkeiden määrääminen ja käyttö on joka kerta ainutlaatuinen tilanne sekä lääkärille että potilaalle.	1	2	3	4	5
Yhteistyöhön perustuva vuorovaikutus farmaseutin ja asiakkaan välillä johtaa parantuneisiin hoitotuloksiin.	1	2	3	4	5
Lähtökohta farmaseutin ja asiakkaan välisessä neuvontatilanteessa on luoda tunne, että farmaseutilla ja asiakkaalla on yhteinen päämäärä.	1	2	3	4	5
Farmaseutin pitäisi olla herkkä ymmärtämään asiakkaan toiveita, tarpeita ja kykyjä selviytyä lääkeshoidosta.	1	2	3	4	5
Farmaseutin tulisi antaa asiakkaalle tietoja eri hoitovaihtoehtojen haitoista ja hyödyistä.					
A) Reseptilääkkeet	1	2	3	4	5
B) Itsehoitolääkkeet	1	2	3	4	5
Tärkeintä apteekin lääkeneuvonnassa on asiakkaan päätöksentekoprosessin tukeminen.	1	2	3	4	5
Farmaseuttien tulisi olla herkempiä käsittämään, miten asiakkaat reagoivat saamaansa tietoon.	1	2	3	4	5
Farmaseuttien tulisi oppia ymmärtämään asiakkaiden lääkkeisiin liittyviä uskomuksia.	1	2	3	4	5
Lääkeneuvonnan esteenä ovat farmaseutin omat uskomukset ja asenteet.	1	2	3	4	5

25. Seuraavassa esitellään kolme erilaista asiakastapausta. Tapauksien yhteydessä on esitetty erilaisia väittämiä. Ympäri jokaisen tapauksen kohdalta YKSI vaihtoehto, joka on lähinnä omaa näkemystäsi.

ASIAKAS 1.

56-vuotiaalla miehellä on todettu kolme viikkoa sitten sydäninfarkti ja hän on juuri päässyt kotiin sairaalasta, jossa hänelle määrättiin aspiriinia, kolesterolia alentavaa lääkettä ja pitkävaikutteista nitroa. Nyt hän on apteekissa, jossa hän valittaa väsymystä. Asiakas kertoo lopettaneensa tupakoinnin eikä haluaisi ottaa hänelle määrättyjä lääkkeitä, koska on varma, että lääkkeet pahentavat hänen oloaan. Hän kysyy farmaseutilta, mitkä lääkkeet hän voisi jättää ottamatta.

- A** Asiakas hyötyy kaikkien lääkkeidensä ottamisesta.
- B** Asiakkaan tulisi ottaa kaikki hänelle määrättyt lääkkeet.
- C** Sairaalan lääkäri ei ole selvittänyt asiakkaalle kunnolla, miksi lääkkeitä tulisi ottaa.
- D** Asiakkaalle tulisi kertoa mahdollisista sivuvaikutuksista.
- E** Jos asiakas lopettaa lääkkeiden käytön ja saa toisen infarktin, on syy asiakkaassa.
- F** Jos lääkäri on samaa mieltä, että jokin lääkkeistä tulisi jättää pois ja asiakas saa toisen infarktin, on syy lääkäriässä.
- G** Lääkärillä on vastuu kertoa asiakkaalle, kuinka lääkkeet tulisi ottaa.
- H** Asiakkaalla on vastuu kysyä kysymyksiä, jotta hän ymmärtää hoitonsa syyt.
- I** Lääkäriin, joka määräsi lääkkeet sairaalassa, olisi pitänyt kysyä asiakkaalta asiakkaan omia käsityksiä häntä koskevasta hoidostaan.
- J** Lääkäri tietää parhaiten ja asiakkaan tulisi noudattaa annettuja hoito-ohjeita.

ASIAKAS 2.

Äiti tulee apteekkiin hakemaan teini-ikäiselle lapselleen insuliinia. Farmaseutti ottaa reseptin ja laskee, voiko insuliinia vielä toimittaa. Hän selvittää asiaa myös muiden farmaseuttien kanssa. Farmaseutti ilmoittaa äidille, että laskelmien mukaan insuliinia pitäisi vielä olla jäljellä ja Kelan säädöksiin vedoten hän kieltäytyy toimittamasta insuliinia. Äiti kertoo annoksen vaihtelevan tilanteen mukaan. Koska reseptissä ei ole tästä merkintää, farmaseutti ei toimita insuliinia, ja äiti lähtee apteekista tuhtuneena.

- A** Farmaseutti toimi oikein, kun ei toimittanut insuliinia.
- B** Farmaseutin olisi pitänyt antaa lääkkeet asiakkaalle ilman korvausta ja kertoa asiakkaalle mahdollisuudesta hakea korvausta Kelalta jälkepäin.
- C** Kelan säädöksiä on noudatettava, eikä poikkeuksia voi tehdä.
- D** Farmaseutin olisi pitänyt huomioida äidin huoli ja joustaa säädöksissä.
- E** Farmaseutin tulisi selvittää yhdessä asiakkaan kanssa mahdollisia vaihtoehtoja asiakkaan tarpeet huomioiden.
- F** Farmaseutin tulisi turvata asiakkaan lääkityksen jatkuminen ja tehdä tarvittavat selvitykset Kelalle.

ASIAKAS 3.

Noin 50-vuotias miesasiakas tulee ostamaan apteekista "lasten aspiriinia" päänsärkyyn. Asiakkaan naapuri on kehottanut miestä käyttämään kyseistä lääkettä, koska lääke on miedompi kuin tavallinen aspiriini eikä ärsytä niin paljon vatsaa.

- A** Farmaseutti myy asiakkaalle kyseisen valmisteeseen kyselemättä.
- B** Asiakkaalla on vastuu varmistaa farmaseutilta, että lääke sopii hänen vaivaansa.
- C** Farmaseutin velvollisuus on selvittää, sopiiko lääke asiakkaan vaivaan.
- D** Farmaseutilla on vastuu kertoa asiakkaalle, kuinka lääke tulisi ottaa.
- E** Apteekissa tulisi selvittää, onko asiakas käyttänyt muita särkylääkkeitä aikaisemmin.
- F** Farmaseutti kertoo, ettei mieto aspiriini tehoa särkyyn eikä myy valmistetta asiakkaalle.
- G** Farmaseutti päättelee, että asiakas tarvitsee valmistetta myös verenkiertohäiriöihin ja kehottaa asiakasta kääntymään lääkärin puoleen myymättä valmistetta.
- H** Farmaseutti selvittää asiakkaan tuntemat oireet ja niiden keston ja suosittelee sen mukaan hoidon.
- I** Farmaseutin, joka toimitti itsehoitolääkkeen asiakkaalle, olisi pitänyt kysyä asiakkaalta asiakkaan omia käsityksiä hänen omasta hoidostaan.
- J** Jos asiakas käyttää väärää vahvuutta lääkkeestä, eikä saavuta toivottua hoitotulosta, on syy asiakkaassa.
- K** Jos farmaseutti ei varmista lääkkeen sopivuutta asiakkaan päänsärkyyn ja asiakas ei siksi saavuta toivottua hoitotulosta, on syy farmaseutissa.
- L** Asiakkaalle tulee kertoa lääkkeen käyttöohjeet ja annostus.
- M** Farmaseutti kartoittaa, kenelle lääke on tarkoitettu.
- N** Farmaseutti tietää parhaiten ja asiakkaan tulisi noudattaa annettuja hoito-ohjeita.

4. TAUSTATIEDOT

26. Ikä

- 1** Alle 30 vuotta
- 2** 30-39 vuotta
- 3** 40-49 vuotta
- 4** 50 vuotta ja yli

27. Koulutus

- 1** Farmaseutti **2** Proviisori **3** Muu, mikä? _____

28. Valmistumisvuosi nykyiseen ammattiin _____

29. Työvuodet avoapteekissa _____

30. Missä olet ollut pääosin töissä viimeisen kahden vuoden aikana?

- 1** Yksityisapteekissa
- 2** Yliopiston apteekissa
- 3** Jossain muualla, missä? _____

31. Apteekin tilat

- 1 Suoratoimitusapteekki
- 2 Tiskitoimitusapteekki
- 3 Jokin muu, mikä? _____

32. Apteekkisi reseptuuri (vuonna 2001)

- 1 Alle 30 000
- 2 30 000 – 60 000
- 3 60 001 - 100 000
- 4 Yli 100 000

33. Apteekin sijainti

- a)
 - 1 Pääkaupunkiseutu (Helsinki, Espoo, Vantaa, Kauniainen)
 - 2 Muu Etelä-Suomen lääni
 - 3 Itä-Suomen lääni
 - 4 Lapin lääni
 - 5 Länsi-Suomen lääni
 - 6 Oulun lääni

- b)
 - 1 Kaupungin keskusta
 - 2 Lähiö
 - 3 Kirkonkylä

Ruusuja ja risuja TIPPA-projektille.

**Mitä toiveita tai odotuksia sinulla on TIPPA-projektilta jatkossa?
Esimerkiksi mitä materiaalia/koulutusta TIPPA-projekti voisi tuottaa jatkossa?**

Tarvittaessa vastauksia voi jatkaa lomakkeen taakse.

KIITOS VASTAUKSISTANNE!