

# Reflections on Guidelines and Theories for Pharmacist-Patient Interactions

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**ABSTRACT.** Various authorities in the past 25 years have encouraged pharmacists to communicate with patients about their drug therapy. This paper describes and evaluates various guidelines and models that authors have recommended that pharmacists use in their interactions with patients. While there are many guidelines for pharmacist-patient interactions, there are relatively few comprehensively described models or theories in the pharmacy literature. A challenge for pharmacy educators is to identify psychosocial and behavior principles that practitioners can use to improve their patients' well-being. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: [getinfo@haworth.com](mailto:getinfo@haworth.com)]

Education is our passport to the future. Tomorrow belongs to those who prepare for it today.

—Malcolm X

## INTRODUCTION

The Pew Health Professions Commission recently recommended that all health professional schools place more emphasis on the psychosocial-behavioral sciences (1). Pharmacy researchers and scholars should strive to identify and develop psychosocial and behavioral conceptual frameworks that pharmacists can use to improve patient outcomes. Svarstad,

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after assessing the status of behavioral science curricula in pharmacy, recommended that "empirical approaches to patient counseling and compliance management must be replaced by more rational, systematic approaches that are based on scientific principles" (2). A critical challenge for pharmacy educators who wish to help both future and current practitioners flourish in a patient-focused health-care system is to teach theoretically driven, clinically relevant, patient-care practices. The purpose of this paper is to review guidelines and theories that researchers and scholars have encouraged pharmacists to adopt in their interactions with patients. It is not the intent of this text to argue that a single communication model, theory, guideline, or approach for pharmacist-patient interactions has survived the test of time in the pharmacy literature. However, it is hoped that an overview of the profession's past guidelines and theories for pharmacist-patient communication will help to catalyze additional thoughts and insights about the future directions of pharmacist-patient communication education.

### **PATIENT-COMMUNICATION GUIDELINES FOR PHARMACISTS**

Many perspectives of pharmacists' patient-communication responsibilities have appeared in the pharmacy literature since the 1960s. While the American Pharmaceutical Association's Code of Ethics until 1969 discouraged pharmacists to talk to their patients about prescription medications, various authors in the 1960s strongly urged pharmacists to advise patients about prescription drugs. Gibson called for pharmacists to discuss every new prescription with the patient in a private consulting room (3). Brands, one of the first pharmacists to publish detailed guidelines in the pharmacy literature, outlined what patients should know about their medicines and suggested that pharmacists fulfill twelve communication obligations (Table 1) when providing patients with prescription medications (4). Knapp et al. recommended that pharmacists become "drug advisors" who made sure that patients: (1) understood their medications, (2) knew how to take their medications, (3) knew when to take their medications, and (4) could identify and protect themselves against contraindications (5).

Some evidence suggests that the pharmacy literature in the 1970s attempted to present pharmacists as patient counselors rather than as drug advisors. An admittedly cursory review of various publications during the 1970s suggests that the phrase "patient counseling" (6-14) appeared slightly more often in articles than other terms such as "drug advisor" (7,11,15-19), "drug consultation" (20), "medication consultation" (21), "patient communication" or "patient interaction" (22,23), "patient education" (24,25), and "patient instruction" or "patient information" (26-28). Authors dur-

TABLE 1. Recommended topics for the pharmacist-patient interaction.

Prescription Drug Information	Brands 1967 <sup>4</sup>	Knapp, Wolf, Knapp, and Rudy 1969 <sup>5</sup>	Cole and Emmanuel 1971 <sup>20</sup>	Covington and Pfeiffer 1972 <sup>29</sup>
Drug Name	X			X
Drug Purpose	X			X
How to Administer Drug	X	X		X
When to Take Drug	X	X	X	X
Maximum Daily Dose	X			X
Duration of Therapy	X			X
How to Manage Side Effects	X	X	X	X
Drugs, Food, and Activities to Avoid	X	X	X	X
Proper Storage	X			X
Importance of Compliance			X	
Special Directions				
How to Self-Monitor				
What to Do if Dose is Missed				
Refill Information				

TABLE 1 (continued)

Prescription Drug Information	Grissinger, Wolf, and Cohen 1973 <sup>30</sup>	Boyd, Covington, Stanaszek, and Coussons 1974 <sup>31</sup>	Gurwich and Emmanuel 1974 <sup>32</sup>
Drug Name	X	X	
Drug Purpose	X	X	
How to Administer Drug	X	X	X
When to Take Drug	X	X	X
Maximum Daily Dose	X	X	
Duration of Therapy	X		X
How to Manage Side Effects	X		X
Drugs, Food, and Activities to Avoid	X		
Proper Storage	X		X
Importance of Compliance			X
Special Directions			
How to Self-Monitor			
What to Do if Dose is Missed			
Refill Information			

Prescription Drug Information	American Society of Hospital Pharmacists 1976 <sup>6</sup>	Clinite and Kabat 1976 <sup>22</sup>	Crichton, Smith and Demanuele 1978 <sup>8</sup>
Drug Name	X		X
Drug Purpose	X		X
How to Administer Drug	X	X	X
When to Take Drug	X		X
Maximum Daily Dose			X
Duration of Therapy	X		X
How to Manage Side Effects	X	X	X
Drugs, Food, and Activities to Avoid	X		X
Proper Storage	X	X	X
Importance of Compliance		X	
Special Directions	X		
How to Self-Monitor	X		
What to Do if Dose is Missed	X		
Refill Information	X		X

ing this period rarely explicitly defined terms such as "patient counseling" or other related phrases. Puckett et al. offered a rather broad definition of "patient counseling": "any oral or written communication (including auxiliary labels) from the practitioner relating to the drug product and its use" (12). In contrast, Slama and Gurwich's description of a "medication consultation" was relatively more specific and consisted of the pharmacist telling the patient (1) the medication's name and purpose (including the disease state for which the drug was prescribed), (2) instructions for use, (3) instructions for proper self-administration, and (4) the importance of obtaining any prescription refills (21).

Many organizations, researchers, and scholars in the 1960s and 1970s published guidelines regarding what practitioners should talk about during a pharmacist-patient interaction (Table 1) (4-6,8,20,22,29-32). It appears that many publications in the 1960s and 1970s agreed that, at a minimum, pharmacists should tell patients (1) how to administer the medication, (2) the time of medication administration, and (3) how to recognize and manage side effects.

Numerous authors and organizations in the 1980s and 1990s discussed the objectives of and standards for pharmacist-patient interactions. For example, Director of the Food and Drug Administration Kessler observed that pharmacists had an obligation to counsel patients and that "pharmacists should reinforce the instructions of physicians" (33). Reeder, quoting Smith, noted that there were four major objectives of patient counseling: (1) collect information about the patient's medication history and condition, (2) establish a good pharmacist-patient relationship, (3) educate the patient about proper medication use, and (4) support and direct patients in their therapy (34). The American Pharmaceutical Association's and the American Association of Colleges of Pharmacy's standards of practice for pharmacist-patient communication included:

- Confirming and clarifying [the] patient's understanding of medication dosage, dosage frequency, and method of administration; and
- Advising the patient of potential drug-related or health-related conditions that may develop from use of the medication for which the patient should seek other medical care. (35, p. 51)

Guidelines for pharmacist-patient interactions continued to appear in the 1980s and 1990s pharmacy literature (Table 2) (34,36-38). Guidelines in the last fifteen years, in general, appear to be slightly more comprehensive than those published in the 1960s and 1970s. The data in Table 2 suggest that various scholars and organizations in the 1980s and 1990s agreed that pharmacists should tell patients (1) the name of the medication

TABLE 2. Recommended topics for the pharmacist-patient interaction.

Prescription Drug Information	American Society of Hospital Pharmacists 1984 <sup>36</sup>	Reeder 1989 <sup>34</sup>	Omnibus Budget Reconciliation Act of 1990 <sup>37</sup>	American Society of Hospital Pharmacists 1993 <sup>38</sup>
Medication Name, Description, and/or Purpose	X	X	X	X
Route, Dosage, Dosage Form, and Administration Schedule	X	X	X	X
Directions for Preparation and Administration	X		X	X
Precautions to be Observed	X			X
How to Identify and Manage Adverse Effects	X	X	X	X
Techniques for Self-Monitoring	X		X	X
Proper Storage	X	X	X	X
Potential Drug-Drug, Drug-Food Interactions	X	X	X	X
Radiologic and Laboratory Procedure Issues				X
Prescription Refill Information	X	X	X	X
Action to be Taken in the Event of a Missed Dose	X	X	X	X

and its purpose, (2) the drug dosage form, its route of administration, and the proper dose and administration schedule, (3) how to identify and manage side effects, (4) how to properly store the medication, (5) any potential drug-drug or drug-food interactions, (6) prescription refill information, and (7) what patients should do if they miss a dose.

The pharmacy literature in approximately the last fifteen to twenty years also urges pharmacists to collect particular types of information from patients. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) recommends that pharmacists make a "reasonable effort" to obtain an "individual history where significant, including disease state or states, known allergies and drug reactions and a comprehensive list of medications and relevant devices" (37). Additionally, pharmacists have been encouraged to use strategies developed for pharmacists practicing in the Indian Health Service (IHS). Pharmacists adopting the IHS approach ask patients these questions:

1. What did the doctor tell you the medicine is for?
2. How did the doctor tell you to take the medicine?
3. What did the doctor tell you to expect?
4. Just to make sure I didn't leave anything out, please tell me how you are going to take your medicine.
5. What kind of problems have you had with medications in the past? (optional). (39, p. 43)

Some scholars have also developed relatively comprehensive "check-lists" that pharmacists and/or pharmacy managers could use to evaluate a practitioner's patient counseling skills. Appendix A briefly outlines two frameworks that an evaluator could use to help assess the quality of a pharmacist-patient interaction (40,41).

Various publications through the years have provided pharmacists with a diversity of advice on how to communicate with patients. For example, authors have encouraged pharmacists to ask open-ended questions, listen to and understand their patients, be empathetic, avoid jargon, and identify and address patients' needs (41-48). Additionally, scholars have given pharmacists tips on how to improve their patient-communication skills. Leibowitz suggested that pharmacists:

1. Try to become more aware of the process of patient communication.
2. Work on building individual communication skills, one at a time.
3. Try to develop a repertoire of communication skills for use in different situations.
4. Begin a program for developing new skills through successive improvements.
5. Be able to recognize success. (40)



Smith outlined ten steps that pharmacists could follow to implement a successful patient counseling program in their practices (Appendix B) (49).

While the literature suggests that pharmacists should become more involved in patient care, there continues to be disparate views of the pharmacist's responsibilities when he or she counsels a patient. Raynor held that most pharmacists' misunderstood the fundamental principles of true counseling (50). Pedersen and Schulz, after reviewing literature from the 1980s, noted the widely differing perspectives in pharmacy about patient counseling:

The counseling professions literature describes counseling as helping the patient make sense out of the information he possesses, not solely as the providing of information. The professional pharmacy literature sees the term counseling as being interchangeable with many other words, with no clear definition being proposed. The professional pharmacy associations view counseling as the provision of information and advice. The state practice acts tell us why information should be provided, but do not use the word counseling consistently, and often interchange the term counseling with other terms. The court cases state, if you are to counsel, you had better do it well. (51, p. 66)

#### ***Limitations of Traditional Communication Guidelines/Orientations?***

There are doubts about some of the communication guidelines and orientations in the pharmacy literature. Various authors have expressed reservations that guidelines in literature are drug, rather than patient, focused. Specifically, some scholars question guidelines that fail to emphasize that it is important for pharmacists to understand the patient's perspective. For example, The American Society of Hospital Pharmacists' Guidelines on Pharmacist-Conducted Patient Counseling were criticized for neglecting to mention that the pharmacist should elicit the patient's views (52). Horne argued that pharmacists should do more than just provide patients with information about their drugs and that pharmacists had a responsibility "to elicit patients' views about their treatment, provide clear information about the rationale for its use and to collaborate with the patient to design a treatment schedule which fits into their lives" (53, p. 152).

Some suggest that it is time for the profession to move in a new direction and urge pharmacists to adopt a biopsychosocial, rather than a biomedical, orientation when they interact with patients. Dole recommends that pharmacists should strive to become healers instead of clinicians (52). Hargie and Morrow emphasized the multidimensional nature of patient counseling in pharmacy practice:

Firstly, counselling should enable patients to enter into a relationship where they feel accepted and understood and are therefore prepared to talk openly and explore their problems. Secondly, it would encourage an increased understanding of themselves and their problems. Thirdly, it facilitates the consideration of alternative courses of action and decisions to pursue. Fourthly, it aids the development and execution of specific plans of action. Finally, counselling can produce a change of feeling or adjustment to a situation that is unlikely to change (e.g., chronic illness). (54, p. 257)

Morley, after criticizing the conventional clinical pharmacy movement for fostering a culture in which pharmacists virtually ignore the psychosocial aspects of patient care, demanded that pharmacists providing pharmaceutical care significantly change their orientation to the patient:

Of necessity, pharmacists must become more proactive patient-focused practitioners imbued with an ethical imperative to wed technical, scientific competence to a commitment to pursue the best interests of the patient, and wherever it is possible and practicable these interests must conform to the patient's values, preferences and perceptions of what is important to his/her well-being. The patient must be seen as an autonomous decision-maker, and not merely as a passive recipient of professionally arrogated fact and value. (55, p. 145)

#### **MODELS AND THEORIES FOR PHARMACIST-PATIENT INTERACTIONS**

While there are many publications that outline guidelines for pharmacist-patient interactions, there are relatively few that discuss models or theories that pharmacists could use in their interactions with patients. At least three publications in the pharmacy literature during the 1970s discussed communication principles, models, or theories (56-58). Covington and Whitney discussed interviewing techniques and important factors (i.e., social, cultural, educational, economic) affecting communication (56). Ivey, Tso, and Stamm presented an applied model which held that there were five objectives of the pharmacist-patient interaction: (1) identify the patient's information needs; (2) listen to and instruct the patient at appropriate times; (3) define the purposes and objectives of the communication; (4) develop methods of communication that will accomplish the communication purposes and objectives; and (5) follow-up to assess the effectiveness of the communication (57).

Lively encouraged pharmacists to adopt a meaning-centered rather than a message-centered approach to communication (58). He suggested that all communication was a transactional process which he explained thusly:

In general, however, a transaction is a psychological event, interaction, or overt manifestation of some type of social behavior or encounter between two or more persons actively participating to be understood or influence the other. These transactions are physical and social in nature, and we may assume that transactional communication is a continuous process of verbal and nonverbal stimuli. Participants in the process construct their own meanings of events they experience. (58, p. 82)

Pharmacists adopting the transactional framework of communication use the basic tools of speech communication, the prescription label, and auxiliary labels during the consultation to help meet an individual patient's needs.

There was additional discussion about explicit models or theories that pharmacists could use to improve patient outcomes in the 1990's. Hudmon and Berger described how pharmacists could use the *transtheoretical model* to help patients stop smoking (59). Prochaska et al. summarized the fundamental aspects of the model:

In this model, people move from *precontemplation*, not intending to change, to *contemplation*, intending to change within 6 months, to *preparation*, actively planning change, to *action*, overtly making changes, and into *maintenance*, taking steps to sustain change and resist temptation to relapse. However, progression through the stages is not usually linear. For most health behavior problems the majority of people relapse and return to the precontemplation or contemplation stage of change, before eventually succeeding in maintaining change. In this model, relapse is not extraordinary, but a natural part of the change cycle. (60, p. 473)

The model also incorporates other important factors that can influence change: decisional balance (where an individual evaluates the pros and cons of changing her/his behavior), and self-efficacy (the confidence an individual has in her/his ability to change). Practitioners using this approach recognize that they must identify the stage of change that a patient is in and then implement the intervention(s) that best fits that particular stage. For example, pharmacists assisting smokers in the *contemplation* stage could inform patients about the disadvantages of smoking, while

pharmacists would help patients who have advanced to the action stage by encouraging and reinforcing their efforts to quit smoking (59). While this model has been studied in a variety of areas, it is not clear if anyone has published the results of research in which pharmacists have used this approach in their practices (59).

Researchers in the 1990s began studying explicit models that pharmacists could use in their interactions with patients. The approach of Berger et al. (61) was derived from Meichenbaum and Turk's *Facilitating Treatment Adherence: A Practitioner's Guidebook* (62) and "other researchers." Pharmacists participating in the study received ten hours of instruction on how to improve their communication skills, understand the patient's perspective, foster collaborative relationships with patients, obtain and provide information more effectively, and customize the patient's treatment regimen. Practitioners also watched videotapes to help practice skills such as assessing patients' ideas and feelings about their therapy and medical condition, informing patients about their medication, identifying and solving problems, and how to do patient follow-up.

The research of Kimberlin et al. (63,64) was guided by Arnold Lazarus's *Multimodal Behavior Therapy* (65) and Bonnie Svarstad's "Patient-Practitioner Relationships and Compliance with Prescribed Medical Regimens" chapter in *Applications of Social Science to Clinical Medicine and Health Policy* (66). The researchers taught the pharmacists in the study to see problems as "multifaceted, requiring interventions of patient education, use of behavior management strategies, and/or modification of health beliefs, depending on the nature of the specific problem and the underlying cause of the problem" (63,64). Pharmacists also learned patient education techniques derived from a health communication model described by Svarstad. This health communication model holds that "there are at least seven ways of enhancing patient comprehension and recall of the regimen: providing more explicit directions, explaining the purpose or importance of therapy, supplementing oral counseling with written instructions, presenting information in categorical form, repeating important points, simplifying instructions, and providing consistent advice" (66).

The procedure for preparing the pharmacists in this study involved having the practitioners review a training manual at home and then completing a day-long workshop. The workshops included having pharmacists participate in exercises in which they analyzed medication profiles; identified when they should obtain additional patient information from either patients, physicians, or other sources; planned interventions; and role-played assessments and interventions.

Opdycke et al. (67) adopted the PRECEDE (Predisposing, Reinforcing, Enabling, Causes in Educational Diagnosis and Evaluation) model of patient education to guide their research. The PRECEDE model draws upon the fields of behavioral science, education, and epidemiology. Pharmacists using the PRECEDE model first assess and prioritize the patient's educational needs, and then identify interventions that will enhance predisposing (e.g., patient knowledge of drug therapy), reinforcing (e.g., access to pharmaceutical services), and/or enabling (e.g., attitudes and behavior of caregivers) factors in a patient's life (67).

### ***Discussion of Research Results***

The results of the research did not indicate that any one particular model was vastly superior to other conceptual or empirical approaches. While the pharmacists in the experimental group of Berger et al. were rated by patients as more supportive than pharmacists in the control group on a single-item measure ( $p < 0.05$ ), there were no significant differences between experimental and control group pharmacists on a four-item measure of provider support (61). The researchers did not find significant differences between experimental and control groups with regards to patient knowledge of or adherence to patient medication regimens. Additionally, there were no significant differences in blood pressure between experimental and control group patients. However, the lack of significant differences between experimental and control groups does not necessarily imply that the strategies used by the experimental group pharmacists to improve patient outcomes were ineffective. The investigators suggested that other variables may have diminished the ability of the research measures to detect significant differences between experimental and control groups. For example, the researchers noted that patients in the study may have received care from physicians who were also using strategies to increase medication adherence (61).

A study by Kimberlin et al. indicated that pharmacists in the experimental group engaged in more patient education activities, but that their patients did not have significantly better outcomes than patients in the control group. The results of a survey conducted approximately one month after patients were in the pharmacy suggested that, compared to control, experimental group pharmacists were more likely to: discuss new medications with patients ( $p = 0.003$ ), ask patients if they were having any problems when they obtained a refill ( $p = 0.003$ ), spend enough time with patients ( $p = 0.005$ ), help patients understand their medications ( $p = 0.006$ ), and provide written information ( $p = 0.002$ ). A follow-up survey three months later found that experimental group pharmacists were more likely

to speak with patients about their medications since the initial interview ( $p = 0.0055$ ), ask if the patients were having any problems with their medications ( $p = 0.0001$ ), recommend a compliance aid ( $p = 0.0001$ ), and spend more time with patients ( $p = 0.0039$ ) (64). However, patients receiving services from pharmacists in the experimental group were not significantly different from control group patients with regards to patient knowledge (as measured by the patient's recall of name, purpose, number, and timing of doses per day), compliance (as measured by patient self-report and pill count), hospital admissions, and patient reports of problems with their medications (63,64).

It is difficult to use the results of the study by Kimberlin et al. to judge the effectiveness of the conceptual frameworks that the pharmacists were taught to use in their practices. There are many potential reasons why research measures did not find significant differences with regards to patient outcomes such as hospitalization. For example, one explanation is that the experimental group pharmacists had not mastered the models/theories described by Lazarus and Svarstad. The researchers suggested that additional training may have helped to improve the skills of the pharmacists in the experimental group (64). Additionally, the practice environments of the pharmacists in the experimental groups may have been too busy to allow the practitioners to apply the models appropriately (63, 64).

Patients' views of a research project by Opdycke et al. were "overwhelmingly positive" (67). Most of the patients (91%,  $n = 59$ ) responding to a survey about the program indicated that they would participate in the program again. However, it is difficult to assess the utility and value of the PRECEDE model because it was not compared to a control group or other approaches. Additionally, the researchers acknowledged that, due to the extensive and comprehensive services required by the model, it might be difficult for some pharmacists to use this framework in their practices (67).

### CONCLUSIONS

Many guidelines for pharmacist-patient interactions have been published in the pharmacy literature over the last twenty years. However, there are some concerns that these guidelines are drug, rather than patient, focused. It is difficult to recommend what psychosocial, behaviorally oriented models or theories pharmacy educators should teach at this time because relatively few conceptually driven approaches involving pharmacists have been described and evaluated by researchers and scholars. McBean-Cochran notes that:

Research based in community pharmacies is sparse. And as researchers themselves readily admit, the complex nature of compliance and knowledge makes it hard to draw firm conclusions about the effectiveness of any one counselling method. (68, p. 121)

It does not appear that pharmacist-patient communication research clearly or strongly favors any one particular communication model or theory at this point in the profession's history. Given this situation, what should pharmacy educators teach pharmacy students and/or practitioners about pharmacist-patient communication? In order to answer this question, one must be clear about the purpose of the pharmacist-patient interaction. Pendleton emphasized the importance of understanding the aims of the health-care provider-patient interaction:

Unless we have a clear idea of the purpose of any consultation it is impossible to know which behaviours or approaches are more or less helpful. If the purpose is only to get the patient out of the surgery in the shortest possible time, writing a prescription for an antibiotic before even looking at a painful ear is effective behaviour. (69, p. 40)

Educators must be explicit about what they believe to be the primary purpose of the pharmacist-patient interaction. The lack of clarity of such terms as "patient counseling" can potentially make it difficult for instructors to understand exactly what they should try to accomplish when they teach pharmacy students and practitioners. Should educators teach pharmacists to become biomedically oriented drug-information dispensers or holistically focused patient advocates? The answer to this question dramatically influences the nature and scope of pharmacist-patient communication education. Some might suggest that shifting from an "information dispensing" role to a "problem-solving, patient-advocate" role requires pharmacy educators, students, and practitioners to make a quantum leap in the way they view and approach the pharmacist-patient relationship.

It is tempting, after reviewing the pharmacist-patient communication literature, to give a simple thumbs up or thumbs down assessment and recommend an approach or a laundry list of approaches that instructors should incorporate into pharmacist-patient communication courses. Admittedly, this paper resists this temptation and deliberately begs the question "What specific material, content, theories, or educational strategies should instructors adopt to improve patient-communication courses?" because it is not an easy one to answer at this point in time. However, it must be emphasized that the lack of a clear answer to this question does not

justify a haphazard approach to pharmacist-patient communication education. The absence of a solid consensus in the pharmacy literature *does not* mean that pharmacist-patient communication education should be trivialized and subsequently reduced or eliminated from pharmacy education, that any or every communication model or theory is appropriate for pharmacists or pharmacy students, or that the pharmacist-patient communication literature is somehow grossly inadequate.

What the relative lack of conclusive empirical research results on the effectiveness of various communication models or theories in the pharmacist-patient communication literature *does mean* is that pharmacist-patient communication instructors must constantly challenge old assumptions, attitudes, and beliefs about how to best prepare pharmacy students and practitioners to interact with patients to help them make the best use of their medications. For example, the profession and pharmacy educators are striving to make pharmaceutical care the dominant practice model in pharmacy. Pharmacist-patient communication educators should critically assess current instructional materials and strategies to determine if they are consistent with the patient-focused orientation that is essential for the optimal provision of pharmaceutical care.

Finally, a "take-home message" of this paper is that additional discourse and research are required because it appears that, at the present time, research in the pharmacist-patient communication literature does not offer simple or clear answers to some profound pedagogical questions (e.g., what communication models should be taught or how they should be taught to students or practitioners). Guidelines, approaches, and perspectives on pharmacist-patient communication have changed, at times radically, since the 1960s. Pharmacy educators must be prepared to abandon traditional pharmacist-patient communication approaches and embrace change as the profession shifts from an information-dispensing to a patient-care role. Morley explains:

As pharmacy continues to acknowledge the importance of the pharmaceutical care "paradigm" it must also recognize the magnitude of change that this engenders. All health care professions are presently undergoing change: some more than others. To resist change and cling to outworn models and missions places pharmacy, as a profession, at risk . . . (55, p. 146)

Pharmacy educators, researchers, and scholars must continuously strive to engage in a constructive discussion about the psychosocial and behavioral principles that pharmacists should master and use to improve patient care.



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## APPENDIX A

## Patient Counseling Checklists

From: Leibowitz K. Improving your patient counseling skills. *Am Pharm.* 1993; NS33(4):65-9.

- Properly introduce themselves and identify the purpose of the counseling session.
- Express concern for and interest in the patient.
- Assess the patient's prior knowledge of the disease and treatment.
- Assess any real or anticipated concerns or problems the patient has.
- Display appropriate nonverbal behaviors.
- Use language the patient can understand.
- Maintain control and direction of the counseling session.
- Make appropriate use of the patient profile information.
- Present facts and concepts in a logical, sequential order.
- Convey complete and accurate information.
- Summarize the information presented.
- Check to determine the patient's understanding.

From: Berger BA, Felkey BG. Patient counseling and communication. In: *Effective pharmacy management: a comprehensive presentation of practical management techniques for pharmacists*. 7th ed. Alexandria, VA: NARD, 1994.

1. Pharmacist introduces self.
2. Identifies patient or the patient's agent.
3. Asks if patient has time to discuss medicine.
4. Explains the purpose/importance of the counseling session.
5. Asks the patient what the physician told him/her about the drug and what it is treating. What does the patient know or understand about the disease? Use any available patient profile.
6. Asks the patient if he/she has any concerns prior to information provision.
7. Responds with appropriate empathy, listening, attention to concerns. Uses these skills throughout the counseling session.
8. Tells the patient the name, indication, and route of administration of the medication.
9. Tells the patient the dosage regimen.

10. Asks patient if he/she will have a problem taking the medication as prescribed.
11. Tailors the medication regimen to the patient's daily routine.
12. Tells the patient how long it will take for the medication to show an effect.
13. Tells the patient how long he/she might be on the medication.
14. Tells the patient when he/she is due back for a refill (and number of refills).
15. Emphasizes the benefits of the medication and supports the drug *before* talking about side effects.
16. Discusses major side effects of the drug and whether they will go away in time. Discusses how to manage the side effect or what to do if the side effect does not go away and it becomes intolerable.
17. Points out that additional *rare* (emphasizes this to the patient) side effects are listed in the information sheet (to be given to the patient at the end of the counseling session). Encourages patient to call if he/she has any concerns about these.
18. Uses written information to support counseling where appropriate.
19. Discusses precautions (activities to avoid, etc.).
20. Discusses beneficial activities (e.g., exercise, decreased salt intake, diet, self-monitoring, etc.).
21. Discusses drug-drug, drug-food, drug-disease interactions.
22. Discusses storage recommendations, ancillary instructions (shake well, refrigerate, etc.).
23. Explains to patient in precise terms what to do if he/she misses a dose.
24. Checks for understanding by asking the patient to repeat back key information (drug name, side effects, missed doses, etc.).
25. Rechecks for any additional concerns or questions.
26. Advises patients to always check their medicine *before* they leave the pharmacy.
27. Uses appropriate language throughout the counseling session.
28. Maintains control of the counseling session.
29. Organizes the information in appropriate manner.
30. Follows up to determine how patient is doing.

## APPENDIX B

## Ten Steps to Develop a Patient Counseling Program

From: Smith DL. Patient counseling: your competitive edge. *Am Pharm.* 1991; NS31(7):53-56.

1. Determine the needs of your particular patient population.
2. Select a specific category of patients.
3. Keep physicians well informed and seek their input.
4. Develop your counseling skills.
5. Optimize your counseling with high-quality written instructions.
6. Explain the value of your new counseling service to patients the first time they are exposed to it.
7. Carefully evaluate the content, readability, and design of any written materials you give to patients.
8. Remember that no one is born a good communicator.
9. Evaluate the effectiveness of your counseling program.
10. Expand your counseling program.