CPPE

CENTRE FOR PHARMACY
POSTGRADUATE EDUCATION

Consultation skills for pharmacy practice: taking a patient-centred approach

A CPPE distance learning programme
for pharmacy professionals

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NHS
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MANCHESTER 1824
The University of Manchester

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A core learning programme for:

Consultation Skills
for Pharmacy Practice

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Educational solutions for the NHS pharmacy workforce

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About CPPE

The Centre for Pharmacy Postgraduate Education (CPPE) offers a wide range of learning opportunities in a variety of formats for pharmacy professionals from all sectors of practice. We are funded through the NHS Multi-professional Education and Training Fund from Health Education England to offer continuing professional development for all pharmacists and pharmacy technicians providing NHS services in England. For further information about our learning portfolio, visit: **www.cppe.ac.uk**

CPPE 1 2 3

We recognise that people have different learning needs and not every CPPE learning programme is suitable for every pharmacist or pharmacy technician. Some of our programmes contain core learning, while others deliver more complex learning that is only required to support certain roles. So we have created three categories of learning – CPPE 1 2 3 – and allocated each programme to an appropriate category.

CPPE 1 Core learning (limited expectation of prior knowledge)

CPPE 2 Application of knowledge (assumes prior learning)

CPPE 3 Supporting specialisms (CPPE may not be the provider and will signpost you to other appropriate learning providers).

This is a CPPE 1 learning programme; however, some of the learning does involve the application of knowledge.

Revalidation

You can use this programme to support revalidation and your continuing professional development (CPD). Consider what your learning needs are in this area. For more information about revalidation and to record your entries, visit: **www.mygphc.org**

Activities

Exercises

We include exercises throughout this programme as a form of self-assessment. Use them to test your knowledge and understanding of key learning points.

Practice points

Practice points are an opportunity for you to consider your practical approach to the effective care of patients or the provision of a service. They are discrete activities designed to help you to identify good practice, to think through the steps required to implement new practice, and to consider the specific needs of your local population.

We have designed the practice points in this programme to help you and your team to make links between the learning and your daily practice and to co-ordinate with other healthcare professionals.

Case studies

We base case studies on actual or simulated events. They are included to help you to interpret protocols, deal with uncertainties and weigh up the balance of judgements needed to arrive at a conclusion. We design the case studies to prepare you for similar or related cases that you may face in your own practice.

Reflective questions

These questions are included to give you an opportunity to pause and reflect on your current practice and skills throughout the programme. Thinking about these questions will help you to meet the objectives of the programme and will extend and reinforce your learning.

Assessment

Associated assessments have been developed as part of the toolkit for developing consultation skills. You can access the assessments at:
www.consultationskillsforpharmacy.com

References and further reading

You can find references for all the books, articles, reports and websites mentioned in the text, together with a list of further reading to support your learning at the end of the programme. References are indicated in the text by a superscript number (like this[3]).

Programme guardians

CPPE has adopted a quality assurance process called 'programme guardians'. A programme guardian is a recognised expert in an area relevant to the content of a learning programme who will review the programme every six months. We will post any corrections, additions, deletions or further supporting materials that are needed, as an update to the programme on the CPPE website. We recommend that you refer to these updates if you are using this (or any other) learning programme significantly after its initial publication date. A full list of programme guardians is available on our website. You can email your comments about this programme to them at: **info@cppe.ac.uk**

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Feedback

We hope you find this learning programme useful for your practice. Please help us to assess its value and effectiveness by completing the online feedback form available on our website. Visit: **www.cppe.ac.uk/mycppe** and then select *My CPPE record* from the menu and log in; scroll down to find the learning programme title, and click on the *Tell us what you think* icon. CPPE may email you a reminder to do this. You can also email us direct if you think your comments are urgent using the email address: **feedback@cppe.ac.uk**

About this learning programme

Welcome to the CPPE distance learning programme *Consultation skills for pharmacy practice: taking a patient-centred approach*, which forms the first step in the learning pathway for developing the consultation skills of pharmacists and pharmacy technicians in all sectors of pharmacy.

Enhancing the communication and consultation skills of pharmacy professionals was identified as a key priority and has led to the development of a set of practice standards for consultation skills.

In 2012, proposals were issued as part of the Modernising Pharmacy Careers (MPC) programme to help strengthen and develop the careers of post-registration pharmacists and pharmacy technicians. The proposals included the need to enhance the skills of pharmacy professionals in working with patients, other healthcare professionals and members of the public to improve the safety, value and effectiveness of medicines through medicines optimisation, and to enhance their skills in the delivery of public health interventions. Enhancing the communication and consultation skills of pharmacy professionals was identified as a key priority and has led to the development of a set of practice standards for consultation skills which set out the standard of knowledge, skills and behaviours expected of all pharmacy professionals in order for them to carry out effective patient-centred consultations. This is supported by a national learning and development programme, which is hosted on a new website (**www.consultationskillsforpharmacy.com**). The website outlines the different steps a pharmacy professional should take in developing their practice to ensure that they are the best they can be when speaking with and consulting with patients.

Oversight of work being taken forward as part of the MPC legacy, including the *Consultation skills for pharmacy practice* learning and development programme, has now transferred to Health Education England (HEE) and forms part of HEE's national programmes.

The *Consultation skills for pharmacy practice* learning pathway is outlined below and poses the following questions in relation to your consultation skills education and training needs.

How do I know what standard is expected of me?

A set of national practice standards for consultation skills has been developed. As a pharmacy professional, it is your responsibility to take steps to meet these standards. This learning programme will support you in meeting some of the national practice standards, but due to the nature of the topic, you will need to complement your learning by putting it into practice with face-to-face training and peer review.

How do I know how effective my consultation skills are now?

There are a range of options available for you to establish how effective your current practice is when conducting medicines and public health consultations. The *Consultation skills for pharmacy practice* website provides guidance and evidence-based tools on how to self-assess and suggestions about how to work together with your team and peers to improve practice, take feedback from patients and critique others. These steps will contribute to your own personal development portfolio and are essential in improving your performance.

How do I improve my performance?

People learn in different ways, and with that in mind, we recommend a set of learning steps to help you achieve your development goal. There are many learning options (set out in detail on the *Consultation skills for pharmacy practice* website), as we recognise that people will be at different stages of their development journey. Completing a learning programme or attending a consultation skills workshop should not be the end of your learning journey.

How can I check my learning and development?

Developing effective consultation skills should be part of everyday practice. There is always the opportunity to improve and learn new skills and techniques and your learning should be ongoing. Working through the online assessment process will provide you with reassurance that you can recognise good practice versus poor practice or practice which can be improved. The assessment runs via the CPPE website and is available to all pharmacy professionals.

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How do I continue to develop my performance?

As a healthcare professional, you have a responsibility to continually revisit your personal development. We are all fallible and bad habits can soon creep into routine practice.

Maintaining a portfolio of your professional development in relation to the consultations you conduct will provide evidence to others of the steps you have taken to improve your practice and highlight the areas in which you need to develop further. This can include completing and revisiting the self-assessment, feedback from colleagues, patients and other healthcare professionals and reflecting on individual consultations.

At this stage of the process there are options for you to regularly reassess your performance and identify opportunities to further improve your approach to consultations.

To find out more about the *Consultation skills for pharmacy practice* learning and development programme, visit: **www.consultationskillsforpharmacy.com**

Aim

The overall aim of this programme is to support you in developing your consultation skills in order to conduct effective consultations which integrate a patient-centred approach to everyday practice. By improving your consultation skills you will make a positive contribution to the lives of your patients, work towards improving patient outcomes and ensure that you are the best you can be when speaking with patients.

Learning objectives

When you have completed this programme you should be able to:

- explain the concept of patient-centred care
- describe the key communication and consultation skills and techniques required to conduct patient-centred care
- apply methods to assess your own practice and identify areas of improvement
- incorporate patient-centred care into your everyday practice
- adapt your consultation style to individual patients and the context of practice within which you work
- explore patient knowledge, understanding and concerns during the consultation
- support patients, by using a patient-centred approach, to help them get the best from their medicines and/or in making healthy lifestyle choices
- offer patients the opportunity to be involved in decisions around their own healthcare
- take your practice one step further by exploring tools and techniques, such as health coaching
- continually review your practice relating to consultation skills and identify areas for development.

Working through this programme

Many pharmacy undergraduate courses include an element of communication and consultation skills training, but this has not always been the case and some pharmacists may have had little or no training in consultation skills.

As a pharmacy professional you will be taking an increasingly patient-facing role as part of your everyday practice. Your current knowledge of the patient-centred consultation will depend on your previous learning on this topic and your existing experience of talking with patients in practice. Many pharmacy undergraduate courses include an element of communication and consultation skills training, but this has not always been the case and some pharmacists may have had little or no training in consultation skills. Similarly, pharmacy technicians may have a varying range of experience in consultation skills training.

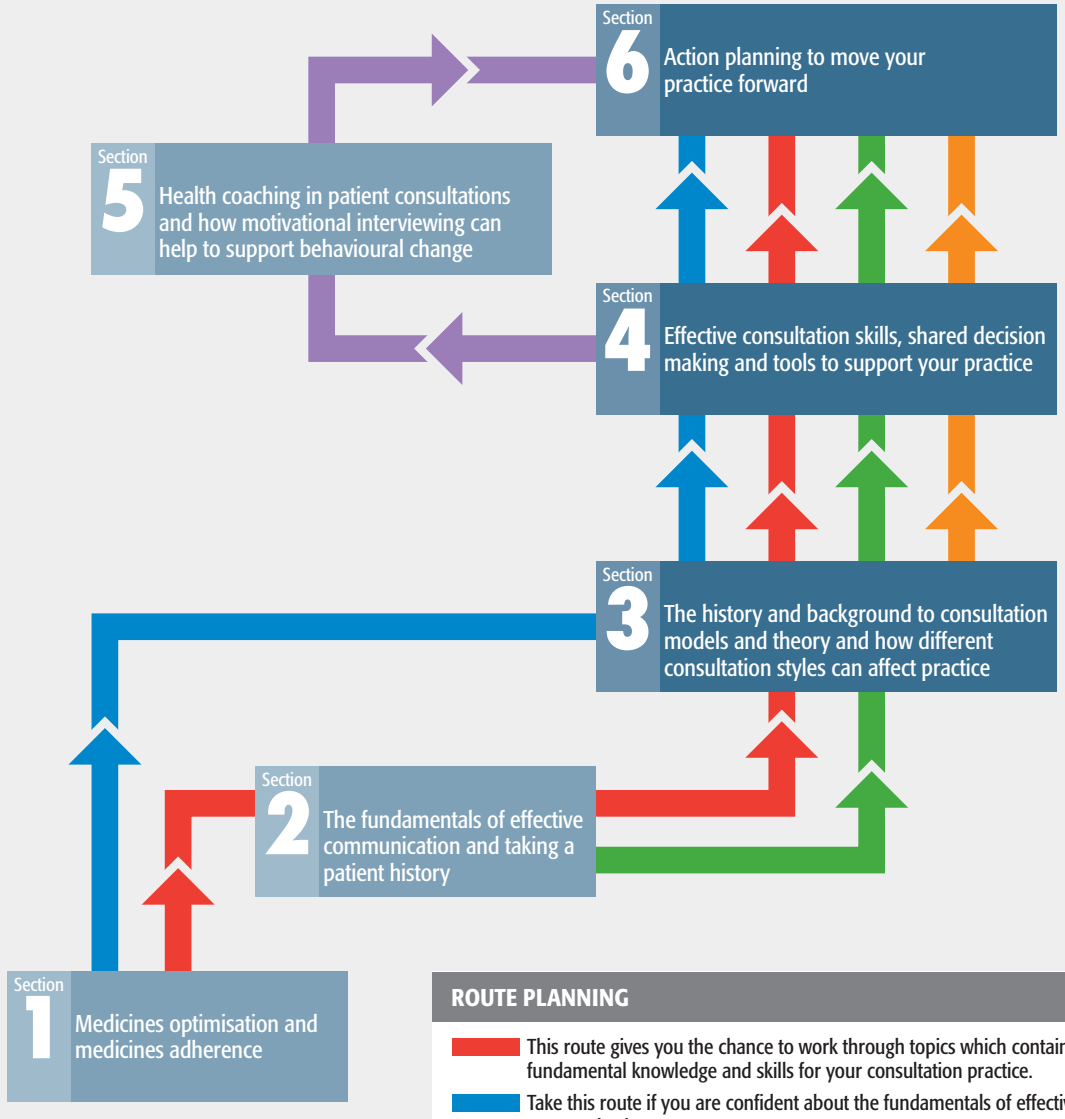
With this in mind, we have developed this programme as a flexible resource. We have set out a 'road map' overleaf showing the six sections and indicating different learning routes you can take, depending on your existing level of knowledge, skills and experience in consultation skills. Each section includes exercises to support you in translating your knowledge into practice; helpful for all learners even if you are working through a particular section as a revision exercise.

The programme aims to provide a balance of background theory and practical tools that you can 'test drive' in practice. As you read through the programme consider the information and how it applies to you personally – how will it enable you to move forward and develop your practice?

Remember the aim of your hard work is to feel confident to meet the challenges facing you in your daily practice. Bear this in mind as you work through this programme – it will help you to decide if your approach to study is working.

Although we have designed the programme for self-study, as you progress through the sections it will be essential for you to talk through some of the issues with your colleagues and complement your learning with face-to-face training and peer review.

We acknowledge that people will have different levels of knowledge, skills and experience for each topic in this distance learning programme.
Follow the road map below to help you identify your learning needs.



Note: Once you have finished working through your chosen sections we recommend all pharmacy professionals complete *Section 6 – Moving your practice forward.*

We appreciate that consultations cover many different areas of practice, such as medicines optimisation, public health and self-care. The first section of this programme provides some background to the concepts of medicines optimisation and medicines adherence. A comprehensive understanding of medicines adherence is important in medicines consultations as it can help you to consider medicines-taking from a patient's perspective.

We then move on to the different skills and techniques you can apply to every consultation. First we look at basic communication skills, which are the cornerstone of good consultation skills. Section 3 provides the background and theory to the consultation process and includes useful models and frameworks which you can apply to practice. Section 4 of the programme encourages you to assess your current consultation and communication skills and suggests ways that you can adapt and develop your everyday practice. Once you feel more confident in applying the basic consultation skills you can explore methods of advancing your practice in health coaching in Section 5.

We recommend that everyone works through the final section of the programme, which will help you develop an action plan to support you in moving your practice forward.

The study time will depend on you and your personal learning requirements, but we estimate that completing the whole programme will take a total of **10 hours**.

Target audience

This programme is intended to support pharmacists, pre-registration pharmacists and pharmacy technicians working in all sectors of pharmacy practice.

Online resources

Some of the references in this programme are to material which is only available online, and we assume that you have access to a computer connected to the internet.

Where we think it will be helpful we have provided the URL to take you directly to an article or specific part of a website. However, we are also aware that web links can change (eg, the Department of Health links) so in some cases we have provided the URL for the organisation's home page only. If you have difficulty accessing any web links, please go to the organisation's home page and use appropriate key words to search for the relevant item.

Note on NICE guidance: To find any of the NICE guidelines or technology appraisals mentioned in this programme visit the NICE website at: **www.nice.org.uk** On their home page, click on 'Find guidance' and then enter the relevant topic in 'Search NICE guidance'.

Note on articles: If you have difficulty locating an article on the internet, search via: **www.google.co.uk** by typing in the title, author, date and name of the journal. It can also be helpful if you add in, at the end of the search criteria, the website where you think the information may be, eg, dh.gov.uk You may prefer to use the NHS Evidence website to search at:**www.evidence.nhs.uk/default.aspx**

All the web links in this programme were accessed on 5 August 2019.

Patient-centred care and pharmacy practice

This distance learning programme looks at the skills and techniques you can develop to support you in conducting an effective patient-centred consultation. This introduction outlines the key principles of patient-centred care and how it applies to pharmacy today.

What do we mean by a consultation?

A consultation is 'a meeting to discuss something or get advice'[1] with the goal of discovering the best course of action to take.

When we think of a pharmacy consultation we tend to think of the more structured interaction between a healthcare professional and a patient, but every time you speak with a patient you have an opportunity to make a difference. In this learning programme we are using the term 'consultation' to refer to any discussion between a healthcare professional and a person. We have also used the word 'patient' throughout, although this could be any person in the consultation environment, including customers in a community pharmacy and carers.

In this learning programme we are using the term 'consultation' to refer to any discussion between a healthcare professional and a person.

Reflective questions

Thinking about your last consultation, answer the following questions.

a. How confident are you that you...

...explored the patient's agenda at the beginning of the consultation?

1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

...explored and considered the patient's views and beliefs about their health, disease or medicines fully in a consultation?

1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

...viewed the patient as a true partner in the discussion?

1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

b. Moving forward, what do you hope to achieve by working through this programme?

It will help you to revisit these questions as you work through the programme.

The patient-centred consultation in pharmacy today

The NHS is committed to putting patients at the centre of their own healthcare, enabling them to make informed choices and share in the decision-making process for their own health.[2, 3]

Pharmacy professionals play a key role in supporting people to manage their own health, with the consultation process forming the basis of most patient interactions. This is the case whether you are a hospital pharmacist discussing treatment with a patient at the bedside or in a specialist clinic setting, a community pharmacist conducting a medicines use review or a pharmacy technician delivering a smoking cessation service.

The NHS Constitution states that as NHS healthcare professionals, pharmacy professionals have a responsibility to support people to promote and manage their own health[2] and the Royal Pharmaceutical Society has echoed this by making patient-centred care the focus of the four key principles of medicines optimisation.[4]

The NHS Constitution states that as NHS healthcare professionals, pharmacy professionals have a responsibility to support people to promote and manage their own health.

Being an effective healthcare professional is not just about knowledge of medicines and public health. Applying effective communication and consultation skills means that patients are more likely or perhaps more willing to follow healthy lifestyle advice and adhere to treatment, which in turn may lead to improved healthcare outcomes.[5]

Although most pharmacists and pharmacy technicians have had either an element of structured education and training and/or experience in conducting consultations, there is evidence to suggest that skills in conducting a patient-centred approach are lacking.[6, 7, 8]

One study showed that pharmacists exhibit good use of some skills, such as signposting and closing the consultation; however, skills such as listening effectively, eliciting the patient's perspective and taking a patient-centred approach are poorly demonstrated.[6] Healthcare professionals can be too eager to share information and move into the advice-giving role without establishing what a patient knows or would like to know. If this happens then patients may resist or reject the advice and feel their competence to self-manage has been questioned.[7]

There is a significant amount of research that considers the patient's perspective of medical consultations by doctors, but little that evaluates the relationship between patient and pharmacist. However, we can still use the research that exists to consider how it might apply to pharmacy professionals.

A number of studies have been carried out to look at how doctors performed in consultations.[9, 10, 11, 12] A GP usually works within a ten-minute timescale to conduct a consultation with a patient, reach a diagnosis and plan treatment or give advice. It is not surprising to learn that sometimes patients come away from the GP feeling as though they have not gained as much from the consultation as they would have liked. The style of communication used by the GP is an important factor in the consultation and may contribute to patients finding it difficult to raise their concerns. Patients may have issues that they want to raise but feel they cannot, for example, issues relating to side-effects, or a lack of understanding about prescribing decisions. This can result in patients feeling worried, undervalued and may lead to non-adherence.[13, 14] Taking a patient-centred approach and using everyday language as much as possible may help prevent this.[15, 16]

In summary, studies have demonstrated the following about patient consultations with doctors:

- only half of the complaints and concerns of patients were identified
- doctors obtained little information about the patients' perceptions of their problems or about the physical, emotional and social impact of the problems
- doctors provided information in a rigid way, tending to ignore what individual patients wished to know
- little attention was given to checking how well patients had understood what they have been told
- doctors recognised less than half of the psychological problems of their patients
- only about half of patients adhere to the treatment and advice given by the GP, and the levels of patient satisfaction with the consultation process were variable.

These findings suggest that we still have a long way to go to achieve healthcare that is truly patient-centred.

It would be reasonable to translate some of these issues to the pharmacy consultation, however, there are some differences to consider. The end point of the consultation with a prescriber is often the prescription, creating an opportunity to continue the doctor-patient consultation with a pharmacy-patient consultation regarding the prescription. Pharmacy professionals are ideally placed to offer evidence-based information and advice, should patients choose to know more about their medicines and health.

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Practice point

You can find out more about what patient-centred care means for pharmacy, and the GP perspective, by accessing the following video links.

The GP perspective: how has patient-centred care encouraged a change in your practice? **https://vimeo.com/78354366**

The professional perspective: what does patient-centred care and effective consultation skills mean to the pharmacy profession?
http://vimeo.com/78619272

Reflective questions

Before reading on, think about what a patient-centred care approach means to you and make some notes below.

Putting the patient at the centre of the consultation

Patient-centred care simply means that we should put the patient at the centre of all decisions about their healthcare. It is defined by the Institute of Medicine as:

> *'providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions'.*[17]

Taking a patient-centred approach reflects a shift from counselling a patient about their medicines, to true consultation with the patient.

Taking a patient-centred approach involves a culture shift from a position where the healthcare professional makes the decisions within the consultation (a paternalistic approach) to one of partnership working with the patient; a situation of equal power balance and shared decision making, based on eliciting the beliefs of the patient and providing evidence-based information and advice. This change in approach reflects a shift from counselling a patient about their medicines, to true consultation with the patient, or in other words, a shift from one-way communication of 'telling' to partnership working, involving eliciting the patient's perspective and 'listening'.[8] This may sound straightforward but can be complex and challenging to do.

> *'Patient-centred care' is care that meets and responds to patient's wants, needs and preferences and where patients are autonomous and able to decide for themselves.'*[18]

Supporting patients to take ownership and responsibility for their own health has the potential to improve health outcomes. It is important to remember, though, that while all patients should be given the opportunity to be involved in decisions about their health, not all will wish to be involved. Sometimes the healthcare professional needs to take a paternalistic approach, if the patient is at risk due to unfounded beliefs or unsafe behaviour. It is understandable that pharmacy professionals may sometimes be guilty of focusing purely on the medicines a patient is prescribed, but there are many factors that influence a patient's behaviour towards their medicines and health. Taking a patient-centred approach will support you to explore these with the patient, ensuring they:

- have full involvement in the discussion
- feel respected and valued
- are listened to.

There are some key steps to the patient-centred approach, which we have noted below, each of which will be addressed in more detail throughout this programme.

Communication

One of the most important skills to apply is to listen. When communication goes well both the healthcare professional and the patient benefit.

For healthcare professionals to be effective they need to communicate well with patients. One of the most important skills to apply is to listen. When communication goes well both the healthcare professional and the patient benefit.[19] By using effective listening skills, problems are identified more accurately and patients have a better understanding of their health problems, investigations and treatment options.[9] Using the right communication techniques at the appropriate time also has the potential to support people in making healthy

choices with respect to their lifestyle behaviours. Effective communication and consultation skills should be applied to the three key parts of the consultation:

- the information and messages that are communicated by both patient and healthcare professional (ie, the content)
- the way in which the information is communicated (ie, the process)
- consideration of what the patient is thinking/feeling.

Partnership working

In a patient-centred consultation the patient is a true partner in the discussion and is empowered to engage in decision making and planning should they wish to. This helps the patient to feel valued and redresses the balance of responsibility within the consultation, encouraging the patient to take greater ownership of relevant decisions.

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Taking a holistic view

Consider the full picture. Take a holistic view of the patient – socially, physically, psychologically and behaviourally. This requires exploring all aspects of a patient's life that may impact on their health. What is life like at home for them once they leave the hospital or the pharmacy? Work, family and social life, as well as their own beliefs about a long-term condition or health issue, may all have an impact.

Structuring the consultation

Applying elements of a consultation model or framework to your practice will support the structure of the consultation and ensure a more patient-centred approach.

It is true that sometimes patients may have their own ideas and beliefs about their medicines or health, which are not evidence-based. Regardless of this, they should be given the opportunity early in the consultation to communicate these. The only way to understand the patient's perspective is to ask them and establishing a shared agenda with the patient at the introduction phase of the consultation should achieve this. There may also be situations where the patient is well informed about their condition and medicines and their knowledge should be respected, for example, you may think you are being helpful by saying, "I'll just explain to you how these inhalers work" when actually the patient may already know. Offering premature advice and information without first establishing a patient's perspective can have a negative effect on the consultation.[7] Although it is not your intention, they may feel patronised. Appropriate questioning techniques can support this part of the process. There may be other situations when it may be necessary to correct erroneous beliefs so that the patient can follow informed adherence.

Practice point

Watch the following video to see the patient's perspective of patient-centred care.

The patient's perspective – what does patient-centred care mean to you?
https://vimeo.com/78354106

To assess your own learning needs related to patient-centred care and consultation you need to have an open and self-critical approach to your current performance and be aware of any barriers that may exist which prevent you from taking a patient-centred approach. Barriers can be practical, such as the environment of the consultation and the amount of time you have available to speak with a patient; they can be about knowledge; but most often they are about attitudes to others, for example, casting judgement on a patient, lack of consideration or empathy.

Reflective questions

You may have many years' experience of talking to patients, but how do you know you are really getting it right? What steps have you taken to develop your skills and get assurance that your consultations are effective and patient-centred? This could include attending face-to-face training or peer review by a colleague.

Write your thoughts here.

Key documents about consultation

There are several texts that are considered essential reading for medical students. However, they also contain useful ideas and information for all healthcare professionals. We would encourage you to read through them when you have the opportunity.

Pendleton, D. *The consultation – an approach to learning and teaching*. 1984[20]
There is a wealth of useful information in this text, which describes in detail the framework recommended for a patient-centred consultation, as mentioned above. The approach has been widely used and taught.

MacLeod's clinical examination[21]
This book links the consultation with examination skills and is an essential text for non-medical prescribers looking to extend their practice.

Neighbour, R. *The inner consultation*. 1987[22]
This is a very readable and entertaining view of consultation skills. It contains some insights that are invaluable. If you only read one book, read this one. As well as extending your own learning you may understand better how your GP's mind works.

Medicines optimisation and medicines adherence

Objectives

On completion of this section you should be able to:

- describe the concept of medicines optimisation and medicines adherence
- appreciate the patient experience when receiving a medicine
- state the reason for using the term adherence, as defined by the National Institute for Health and Care Excellence (NICE CG76)[23]
- appreciate the reasons why patients may not take their medicines as intended
- outline the role of the pharmacy professional in supporting patients to make informed decisions about their medicines which support a move towards adherence
- apply further consideration to adherence to medicines in different patient groups.

Medicines use today is too often suboptimal.[4] Studies have shown that many patients (between 30 and 50 percent) do not take their medicines as intended.[24] As few as 16 percent of patients prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.[25] It is clear therefore that there is much scope to support patients in getting the best outcomes from their medicines.

In this section we look at medicines adherence, what it means for you as a healthcare professional, what it means for the patient and the issues that surround it. We consider the skills that healthcare professionals can apply to recognise non-adherence and support improvements in medicines-taking. Any healthcare professional involved in the prescribing, dispensing and reviewing of medicines should, of course, be aware of and work within legal and professional codes of practice, but there are a number of additional skills you can develop that will further enhance your practice.

1.1 Medicines optimisation

Patient-centred care underpins the core principles of medicines optimisation.

Patient-centred care underpins the core principles of medicines optimisation. The Royal Pharmaceutical Society publication, *Medicines optimisation: helping patients to make the most of medicines*, highlights that a step change is needed in the way healthcare professionals support patients in maximising the outcomes from their medicines.[4] The figures are becoming all too familiar, with at least £300 million per year of medicines wasted in primary care[26] and at least six percent of emergency re-admissions caused by adverse medicines reactions that could

potentially be avoided.[27] With this in mind it is crucial that the right support is given to patients to ensure they get the most from their medicines. Improving adherence is likely to contribute to the reduction of medicines wastage, as well as to improved patient outcomes and reduced costs for the NHS.

Pharmacy professionals need to adopt the principles of medicines optimisation to everyday practice, which includes trying to understand the patient's experience of their medicines and health and offering an evidence-based choice of medicines. Discussing a patient's problems and concerns may clarify many issues for the patient, whether these are legitimate or not, and support the patient in making decisions about how they take their medicines.

Discussing a patient's problems and concerns may clarify many issues for the patient, whether these are legitimate or not, and support the patient in making decisions about how they take their medicines.

'The way a consultation is conducted influences patient adherence... Patients both prefer, and do better, when they are involved in the medical decision-making process.' (Pendleton, 2003)[28]

1.2 Understanding medicines adherence

How much do you know or understand about medicines adherence? Before reading on through this section work through Exercise 1 below to discover your learning needs in this area.

Exercise 1

Consider the following statements and decide whether you agree or disagree with each statement about adherence and medicines-taking.

	Agree	Disagree
a) Adherence is just another word for concordance.	☐	☐
b) Patients and healthcare professionals share decisions as part of adherence.	☐	☐
c) If the patient prefers the healthcare professional to take responsibility for decisions, adherence is not possible.	☐	☐
d) Adherence involves giving patients information before letting them decide what they want.	☐	☐
e) Research has shown that healthcare professionals' perceptions about patient expectations are mainly accurate.	☐	☐
f) Discussing the patient's views will lead to longer consultations.	☐	☐
g) In a consultation it is important that the healthcare professional explains their recommendations.	☐	☐

Turn to the end of the section for suggested answers.

In January 2009 NICE published a clinical guideline on medicines adherence (CG76): *Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence.*[23]

NICE define adherence as:

> *'the extent to which the patient's behaviour matches agreed recommendations from the prescriber'.*[23]

There are several other terms that may be used in relation to how a patient takes their medicines:

- compliance – defined as the extent to which the patient's behaviour matches the prescriber's recommendations. This term is no longer in common use as it has a tendency to imply that healthcare professionals consider non-compliance issues are the patient's fault. It also implies a lack of shared decision making.
- concordance – relates to the nature of the prescribing relationship and subsequent medicines-taking behaviour
- persistence – which relates to the length of time a patient continues to take their medicine.

The NICE guideline provides guidance on three key ways that healthcare professionals should support patients in adhering to their medicines:

a) involving patients in decisions about their treatment *(see Section 4)*

b) supporting adherence and offering evidence-based advice

c) reviewing medicines.[23]

1.3 The reasons for non-adherence

Non-adherence has consequences for both the patient and the healthcare system. For patients, the costs are a missed opportunity for treatment gain and potentially impaired health outcome. Findings from a meta-analysis suggested that the difference in health outcomes between high and non-adherers is 26 percent.[29]

Non-adherence inevitably increases the risk of treatment failure and disease progression, but the extent of that effect is difficult to predict. Our understanding of the barriers to adherence, how to improve it and the evidence base is limited. Meta-analysis of available randomised controlled trials suggests multiple interventions are required to maintain high adherence to long-term therapy.[23] High adherence follows a process, not a single event, and therefore adherence support must be integrated into all health contact with patients, especially during any follow-up consultations.

High adherence follows a process, not a single event, and therefore adherence support must be integrated into all health contact with patients, especially during any follow-up consultations.

Researchers from a range of disciplines have explored the reasons why patients do not take their medicines as prescribed. Demographic factors (eg, age, gender) are not consistently associated with adherence so there is no easy way to identify a patient who may have adherence problems. Identifying which other factors predict non-adherence has been an elusive aspiration for researchers in this field for several decades. Taken together, it is clear there are many wide-ranging reasons for non-adherence. It may be as simple as forgetting the odd dose or it could be more

complex and related to a combination of factors, such as not having any support at home or having strong beliefs against taking prescribed medicines.

Social science research has shown that people are neither passive nor obedient in their responses to treatment.[30] They are experts in 'themselves' and how they live with their condition or issue and draw on their own experience of treatment in order to decide what is 'best' for them. Patients amass a body of knowledge and use all kinds of information sources and materials in order to manage their illness. However, this approach may be at odds with the best medical evidence. On the other hand, patient understanding of their own healthcare needs may be significantly richer, more detailed and far more complex than that provided in medical texts and guidelines.

Sharing information with the patient about how they can get the best from their medicines is, of course, a professional duty. It is equally important, however, to explore their views, fears and experiences about medicines and treatment. There is growing awareness that these issues are relevant to the quality of patient care and that they may significantly affect health outcomes.

Exploring patients' beliefs and experiences about treatment, in an open and non-judgemental manner, is a key step towards developing truly professional patient-centred care.

Adherence is not simple to achieve and non-adherence should not be viewed simply as the patient's problem.[23] However, exploring patients' beliefs and experiences about treatment, in an open and non-judgemental manner, is a key step towards developing truly professional patient-centred care.[31]

The introduction to the NICE guideline emphasises that:
'Addressing non-adherence is not about getting patients to take more medicines per se. Rather, it starts with an exploration of patients' perspectives of medicines and the reasons why they may not want or are unable to use them. Healthcare professionals have a duty to help patients make informed decisions about treatment and use appropriately prescribed medicines to best effect.'[23]

Exercise 2

Most of us have taken at least one medicine at some point. If, for instance, you have been prescribed a course of antibiotics you may or may not, have found it a challenge to take the medicine as prescribed. Reflect on your experience as a healthcare professional and think about how this may compare to that of a patient who is prescribed multiple medicines.

Write down some of the feelings a patient may have towards taking their medicines and specific reasons for their behaviour towards adherence. It may also help to discuss this with friends or family members who have been prescribed medicines to gain a true patient perspective.

Write your thoughts here:

Here are some of things we considered:

- they may have experienced side-effects with the last medicine they took which may make them apprehensive
- they may know someone who has taken the same medicine but the medicine has not worked or has caused problems
- they may associate the medicine with the death of another person
- they may be afraid if they have had a new diagnosis
- they may be afraid of 'filling their body full of chemicals'
- they may feel as if they are no longer in control
- they may feel 'ruled' by their medicines
- they may have difficulty remembering to take them
- they may not understand the reasons for the medicines.

Sometimes it is difficult to understand why a patient has decided to use their medicines in a certain way, or not to use them at all, but by considering the patient's perspective and their previous experience of medicines you will be taking a patient-centred approach.

Practice point

The following video highlights a patient's perspective of taking medicines. Make a note of the most striking thought you take from the video and how this will influence the way you speak with patients who are non-adherent.
www.youtube.com/watch?v=A1R9USwPoE8

1.4 Unintentional and intentional non-adherence

One of the most useful conceptual distinctions in understanding why adherence is low for patients is to think about whether the reasons are intentional or unintentional. Unintentional non-adherence may reflect patients wanting to take their medicines in the right way and being quite happy to discuss any problems or barriers they are facing. Many patients who show intentional non-adherence have their own reasons and beliefs for this.

In Section 4 we look at the medication-related consultation framework (MRCF), a validated framework developed to support you in reflecting on your consultation skills.[32] The MRCF embraces the principles of pharmaceutical care and draws on the perceptions and practicalities model of adherence, as described by Professor Rob Horne.[33]

Practice point

Before you read on access the following video, which provides an interesting explanation of the perceptions and practicalities model of adherence and may support you in understanding the patient's perspective of their medicines and illness.
www.youtube.com/embed/R-6m7DTuXWI?rel=0

As we mentioned above, patients who show unintentional non-adherence may be willing to take the medicine as prescribed, but there is a barrier or problem that prevents them. Examples of unintentional factors include forgetfulness, an inability to open containers (for example, a patient with rheumatoid arthritis trying to open a foiled pack of tablets), tablets being too big to swallow, dosing regimes that do not match their lifestyle, devices they cannot operate. There may also be external reasons why the person cannot adhere, such as a child being unable to take a lunchtime dose of a medicine because the school will not allow it.

Patients who show non-adherence intentionally have made a decision not to take the medicine as prescribed. Their reasons for deciding not to adhere could include:

- a general concern about taking a medicine and the associated risks
- their health beliefs
- feeling that the doctor has not really listened to them or understood their problem
- taking the medicine and suffering unacceptable side-effects
- being unconvinced of the necessity of the medicine.

In reality, there is some overlap between these intentional and unintentional reasons for non-adherence; for example, if you are not particularly convinced that the medicine is useful, you may not put any effort into overcoming barriers to taking it. A typical example of this is a patient prescribed a medicine for high blood pressure. They may feel completely healthy and therefore feel, from a personal perspective, that the risks of taking the medicine outweigh the benefits. They may simply not see the reason for it. Conversely, a patient who is prescribed analgesics may be reminded to take their medicines by the pain they experience.

There is some overlap between these intentional and unintentional reasons for non-adherence; for example, if you are not particularly convinced that the medicine is useful, you may not put any effort into overcoming barriers to taking it.

Exercise 3

Think back to Exercise 1 *(page 2)* where you identified some of the reasons why patients may be non-adherent.

Now group these reasons under the headings below.

Intentional non-adherence	**Unintentional non-adherence**

We have included some suggestions at the end of this section.

Internal and external causes of non-adherence

An alternative approach is to think of the causes of non-adherence as internal and external. Internal causes are, crudely speaking, the ones within the patient's head. These could include the conscious decisions we make about medicines, but could also include forgetfulness, misunderstandings about how the medicine works and therefore should be used, and the odd errors that our brains make, such as slips and lapses when we know what we should do but unintentionally do the wrong thing. Mood and anxiety can also affect adherence.

External causes may involve the medicines themselves, such as ease-of-use, the ease of the dose regime that has been prescribed, the family and close friendship groups around the patient (for example, if the patient is a carer of someone else, or has a carer themselves), social factors, such as deprivation, the cost of prescriptions, and so on.

Reflective questions

When you are consulting with a patient, have you ever considered what happens when the patient gets home? Are they supported by other family members? Do they feel motivated by other factors to take their medicines or the converse? How will you adapt your consultation to acknowledge the challenges a patient faces? Which phrases could you introduce to check that a patient will cope with their medicines in their home environment? Write your thoughts below.

The overall approach recommended by NICE is one in which healthcare professionals are non-judgemental about discussing non-adherence with patients and the concerns they may have about their medicines; and patient-centred in dealing with relevant issues and encouraging informed adherence.[23]

When reviewing a patient's medicines you can improve your understanding of the patient's perspective by asking the patient what they already know and believe about their need for a medicine.

Informed adherence means that the relevant evidence-based information is discussed with the patient and forms the basis for the patient's decision to take a medicine. When reviewing a patient's medicines you can improve your understanding of the patient's perspective by asking the patient what they already know and believe about their need for a medicine.[23]

Some patients may still make an informed choice to rationalise their medicines. One of the key principles set out by NICE[23] states that healthcare professionals should:

'*Accept that the patient has the right to decide not to take a medicine, even if you do not agree with the decision, as long as the patient has the capacity to make an informed decision and has been provided with the information needed to make that decision.*'

To 'let go' and allow the patient to make this decision could present a challenge for some healthcare professionals *(see Section 4.3 Shared decision making)*. However, as long as the most up-to-date information has been discussed together and the different options explored (including the risks versus the benefits of taking/not taking a medicine), then you should feel more comfortable with the patient's choice.

Exercise 4

If a patient is firm in their decision not to take a medicine, which other factors should be discussed?

Turn to the end of the section for suggested answers.

Strategies to support adherence are recommended in the NICE guideline. There is no 'one size fits all' intervention, so the strategies used to support adherence should be considered on a case-by-case basis to meet patient's unique needs, and the concerns or specific difficulties they are experiencing. A set of examples of the key strategies from the NICE guideline are shown in Table 1.[23]

There is no 'one size fits all' intervention, so the strategies used to support adherence should be considered on a case-by-case basis.

TABLE 1 Key strategies to support adherence

1. Determine whether patients are having problems with adherence for intentional or unintentional reasons. Intentional reasons usually involve patients' beliefs, concerns or problems, such as side-effects. Unintentional reasons are mostly related to lack of understanding, poor memory or practical issues, eg, difficulty opening the medicine container.
2. Consider the options for supporting patients with their adherence and ask the patient what form of support they would prefer.
3. Address any beliefs and concerns that patients have that may have resulted in reduced adherence.
4. Practical problems should be tackled if patients raise a specific need. Strategies may include: suggesting patients monitor their condition and/or medicines-taking; simplifying the treatment plan; using a multi-compartment medicines system.
5. If side-effects are a problem then discuss with the patient how they would like to deal with them. Practical solutions can be suggested (eg, timing of medicines) or it may be necessary to refer back to the prescriber in order to consider adjusting the dosage or switching to another appropriate medicine.

Adapted from NICE, 2009[23]

There is strong and consistent anecdotal evidence that patients' concerns are a frequent cause of non-adherence.

NICE acknowledges that evidence for adherence-enhancing interventions is not conclusive, reflecting a lack of well-designed interventions and studies in this area. There is strong and consistent anecdotal evidence that patients' concerns are a frequent cause of non-adherence, so a patient-centred approach will allow pharmacy professionals to understand each patient's unique concerns and needs, and tailor their advice and support accordingly.

1.5 Assessing adherence

There is currently no standard way of measuring adherence; a range of methods are used in clinical trials, many of which are not suitable for use in everyday practice. One of the main methods is self-reporting.

Self-reporting

Patient self-reporting is a commonly-used measurement. The patient is asked to answer three questions, giving one answer from a range which has already been set.

In research, the use of self-completed questionnaires has been validated as highly accurate, although not perfect, since self-reporting may overestimate adherence to therapy *(see Figure 1)*.

FIGURE 1 Example of self-reporting from NICE clinical guideline CG76[23]

Circle the number of the answer and add together for your score.
Less than 10 = low adherence, more than 10 = high adherence.

How often do you feel that you have difficulty taking your medicines on time? By on time we mean within two hours of the time you discussed with your prescriber.

1. All of the time
2. Most of the time
3. Rarely
4. Never

On average, how many days per week would you say that you missed one dose of your regular medicines?

1. Every day
2. 4-6 days a week
3. 2-3 days a week
4. Less than once a week
5. Never

When was the last time you missed at least one dose of your regular medicines?

1. Within the last week
2. 1-2 weeks ago
3. 3-4 weeks ago
4. Between one and three months ago
5. More than three months ago
6. Never

Whether a patient takes their medicine as intended is more often than not unknown to the healthcare professional. Assessing adherence should not be about monitoring a patient but about applying the right skills to find out what the patient knows and believes about their medicine and whether more information may support them with adherence. You could begin to assess adherence by asking the patient if they have missed any doses of medicine recently; however, consider the power balance in the consultation and avoid posing questions that may appear judgemental. Mention a specific time period, such as "Have you reduced the dose, or stopped or started any of your medicines in the past few days". Explain why you are asking the questions. Use open questions that acknowledge that non-adherence is common.

Assessing adherence should not be about monitoring a patient but about applying the right skills to find out what the patient knows and believes about their medicine and whether more information may support them with adherence.

This question taken from the new medicine service interview schedule provides a good example:

> *6. People often miss taking doses of their medicines, for a wide range of reasons. Have you missed any doses of your new medicine, or changed when you take it? (Prompt: when did you last miss a dose?)*

You can access the full new medicine service interview schedule at the following link:
http://psnc.org.uk/services-commissioning/advanced-services/nms/

1.6 Discussing adherence with a patient

There are a number of different approaches you can take to help you discuss medicines adherence with a patient.

A health coaching approach, for example, takes into account that although the pharmacy professional is an expert in medicines, the patient is an expert in themselves, how their condition and medicines affect them and the social circumstances that may influence this.[34] Healthcare professionals who adopt a health coaching approach would:

- explore the patient's perspective
- share information and discuss the advantages and disadvantages of different options
- reach a position of shared decision making
- negotiate, agree and record the plan.

There is much more to learn about health coaching in Section 5. Shared decision making is critical to discussions about adherence. To learn more about this and the power balance within the consultation, visit Section 4.

Case study 1
George

George Redmond, age 71 years, has been admitted to hospital with a stroke. He has a history of alcohol abuse and has no fixed abode. While warfarin is recommended for reduction of stroke risk, you are told he is refusing to take warfarin. You are asked to speak with him.

Think about the questions you might ask George to establish the reasons why he has chosen not to take warfarin. It may be difficult to think of a logical order of questions, as any replies the patient may give would direct you to the next appropriate question, but consider the actual words/phrases you would use and the main issues to raise to ensure the consultation you deliver is patient-centred.

It may help you to consider the following factors:

- **what are George's ideas, concerns and expectations of taking warfarin?**
- **can you take a holistic view to consider the other things that may be happening in George's life which may influence his medicines-taking?**
- **what are George's perceptions about his illness and how do these balance with his perceptions of warfarin?**
- **what information would help support George to make a decision about taking warfarin?**

Write your questions here:

Turn to the end of the section for some suggested questions.

This case study is intended to get you thinking about the actual words you are going to use when carrying out a patient-centred consultation, ie, your ability to communicate effectively. The notes you have made should provide a basis for two tools that you can use on repeated occasions with different patients, ie,

i) a phrase to gauge the patient's interest and willingness to engage in medicines adherence, that you can use as a 'foot in the door' phrase

ii) a series of questions to use in a consultation.

You will read more about George in Section 5.

1.7 Interventions to improve adherence

We have considered the importance of addressing a patient's beliefs and concerns, but what else can you do to improve adherence? Often small, simple changes are the most effective.

- Make practical changes to the formulation, such as switching from tablet to capsule, via the prescriber if necessary.
- Think about offering compliance aids, such as larger labels or inhaler spacers. There are also several devices available that enable people to remove medicines from blister packaging more easily.
- Monitored dosage systems are another option, but should be the last resort after other changes have been made. If you are thinking of using them then you would need to make an appropriate assessment.
- Suggest changes to the medicines regime via the prescriber. This could include changing to a medicine that can be given once daily, combination medicines, sustained release preparations, or switching times of the day, so that most of the medicines can be taken together.

If you are aware of specific adherence difficulties that the patient is experiencing, then refer to the medicine or condition by name wherever possible, for example, "the problems you are having with the aspirin prescribed for you..."; "your views about medicines prescribed for your asthma...". It is also important to bear in mind the issues we raised earlier in this section, concerning intentional and unintentional non-adherence.

Ask the patient what form of support they would find helpful to increase their adherence to medicines. Interventions might include suggesting the patient:

- keeps a record of their medicines-taking
- keeps a personal diary about their condition, for example, a regular note of their blood pressure
- keeps a tally of their medicines, for example, the number of tablets they should have left on a certain date
- uses a pain scoring chart, for example, **www.nes.scot.nhs.uk/media/2701203/faces_scale_tool.pdf**

Discuss and anticipate side-effects:

- discuss how the patient would like to deal with side-effects
- discuss the risks and benefits; explain the side-effects and long-term effects with the patient to allow them to make an informed choice
- consider which other strategies might be used, for example, to change the time a medicine is taken
- consider asking the prescriber to switch to another medicine with a different range of side-effects.

1.8 Considering the needs of different patient groups

The use of medicines can be complex for some people. There are many factors concerned with the acceptability of medicines to patients, such as formulation, taste, ease of administration, times of administration, directions and reasons for taking the medicine. These factors are not easy for some groups of patients to interpret. It is important to be aware of these factors and not to underestimate the importance of giving appropriate, timely information, or non-adherence can often be the outcome.

Reflective questions

Supporting patients with adherence involves shared decision making *(see Section 4 for further information about shared decision making)*. Can you think of any patients for whom shared decision making would be more difficult?

Turn to the end of the section for suggested answers.

Older people and adherence

It is often assumed that older people will be less comfortable about participating in decisions and less likely to seek information about their medicines than younger patients. Older people were brought up in an era when 'the doctor knows best' and may assume that the doctor will make the decisions.

In a study carried out in 2000 by a GP, older patients were seen to prefer a directed consultation rather than a 'shared decisions' consultation.[35] However, there have been some criticisms of this study, mainly because patients were not counselled about the benefits of becoming involved in the decision-making process.[36]

Another study found that many older patients wanted to be actively involved in decisions about their warfarin treatment for atrial fibrillation.[37]

Discussions about adherence offer a chance for healthcare professionals to encourage older people to participate in therapy decisions.

Discussions about adherence offer a chance for healthcare professionals to encourage older people to participate in therapy decisions. If you are interested in studying healthcare related to older people in more depth, take a look at the CPPE distance learning programme, *Older people*: **www.cppe.ac.uk/programmes/l/older-p-03**

Younger patients and adherence

Giving health advice to younger people, especially those with long-term conditions, can present challenges. As we mentioned above, both internal and external factors influence adherence. Internal factors would include their own personal development and personal skills; external factors would include the influence of family, peers, healthcare professionals and society as a whole.[38] Another factor is that younger people may find it more difficult to acknowledge they are unwell.

To learn more about these patient groups take a look at the CPPE learning programmes on child and adolescent health; you can access these programmes at: **www.cppe.ac.uk**

Case study 2
Rebecca

Rebecca Sutch is eight years old and suffers from eczema. You know Rebecca and her mother Lynn well and Lynn has been very supportive in Rebecca's disease. She is an intelligent woman and has made it her business to find out as much as possible about eczema. She has also set up a local support group for other parents with children with the condition. Lynn has always been against the use of corticosteroids. There have been times when Rebecca has had to resort to steroid use, but an almost religious use of emollients and avoidance of irritating factors has meant that Rebecca has been exposed to very little steroid use.

Rebecca is currently experiencing what is probably her worst flare up of eczema. Lynn believes this is because Lynn and her husband have just split up and Rebecca has just moved to a new junior school. Nothing seems to be helping and so Lynn has taken Rebecca back to hospital. She was seen by a new consultant, whom Lynn did not particularly warm to. While he seemed to understand her fears about steroids, he was not keen to try the non-steroid immunomodulating products that Lynn wanted to try. He gave her a prescription for a potent steroid to be used for one week only.

Lynn is asking your opinion about skin thinning with corticosteroids, when you see that Rebecca is crying. When you ask her why she is crying, she sobs, "Please Mummy, let me get the cream. It made me so much better last time. I only have to use it for a week and then I can go back to school".

Work through the questions below. In order to consider the issues raised by this case study further, read through two articles relating to children and medicines use.[38, 39] One of the articles discusses children's attitudes to health and illness and may provide a few ideas to explore when dealing with children's health issues. The other looks at how health issues introduced by healthcare professionals may be opposed by family habits and attitudes at home.

From what age do you think children should be addressed directly about their illness?

Do you think Rebecca is of an age when she could be involved in conversations about her condition?

How easy do you find it to involve young children in discussions about their disease and its treatment?

Do you think that Rebecca's and Lynn's perceptions and attitude to health, disease and medicines use in this case are likely to coincide?

What aspects about medicines use are relevant to Rebecca?

Turn to the end of the section for suggested answers.

Physical or learning disabilities and adherence

Some patients may not be able to be fully involved in decisions about taking medicines because of physical or learning disabilities. Carers play a key role in the adherence process for these patients. However, you need to be sure of the role of the carer before making any assumptions.

People with severe mental health problems and adherence

Adherence with medicines use in patients with mental health problems is particularly low. Ideally, in order to encourage medicines adherence, you need to find ways of involving patients with mental health problems in decisions about their treatment.

Using negotiating skills and increased awareness should make it possible to listen to and respect patient's views, while still discussing and gaining agreement for the recommended treatment options.

Using negotiating skills and increased awareness should make it possible to listen to and respect patient's views, while still discussing and gaining agreement for the recommended treatment options.

The General Pharmaceutical Council's guidance on consent considers the Mental Capacity Act when dealing with patients with severe mental health problems or other problems, such as dementia. This guidance should be considered when helping people with mental health problems.

Take a look at the guidance at:
www.pharmacyregulation.org/standards/guidance

Advance directives are those where decisions about treatment are made in advance of them being needed. They are often used for people with mental health problems. Patients make choices when they are well enough to do so. The decision is recorded in their care plan and used if they are not able to make the decision for themselves, for example, they may agree to rapid tranquilisation if they start to show extreme violence towards a carer, when a previous episode had ended in them both being hospitalised. There is also a risk of relapse when patients believe they are better and stop taking their medicines. Side-effects can be intolerable for people with mental health conditions and so as a group they are much more likely to be non-adherent. People with mental health problems will usually have formal and informal support networks; proactive use of these key contacts by healthcare professionals is very important, as is the provision of good information.

If you would like to learn more about the treatment and management of patients with mental health problems, then take a look at the CPPE learning programmes on this topic (visit: **www.cppe.ac.uk**).

Side-effects can be intolerable for people with mental health conditions and so as a group they are much more likely to be non-adherent.

Exercise 5

The key principles of taking a patient-centred approach to an adherence consultation are set out below (taken from the NICE guidance on medicines adherence - you can access the guide using this link: www.nice.org.uk/guidance/cg76)

Which of these key principles do you feel confident in addressing?

Key principles

- ☐ Tick box — Healthcare professionals should adapt their consultation style to the needs of individual patients, so that all patients have the opportunity to be involved in decisions about their medicines at the level they wish.
- ☐ Establish the most effective way of communicating with each patient and, if necessary, consider ways of making information accessible and understandable (for example, using pictures, symbols, large print, different languages, an interpreter or a patient advocate).
- ☐ Offer all patients the opportunity to be involved in making decisions about prescribed medicines. Establish the level of involvement in decision making the patient would like.
- ☐ Be aware that increasing patient involvement may mean that the patient decides not to take or to stop taking a medicine. If in the healthcare professional's view this could have an adverse effect, then the information provided to the patient on risks and benefits and the patient's decision should be recorded.
- ☐ Accept that the patient has the right to decide not to take a medicine, even if you do not agree with the decision, as long as the patient has the capacity to make an informed decision and has been provided with the information needed to make such a decision.
- ☐ Be aware that patients' concerns about medicines, and whether they believe they need them, affect how and whether they take their prescribed medicines.
- ☐ Offer patients information that is relevant to their condition, possible treatments and personal circumstances, and that is easy to understand and free from jargon.
- ☐ Recognise that non-adherence is common and that most patients are non-adherent sometimes. Routinely assess adherence in a non-judgemental way whenever you prescribe, dispense and review medicines.
- ☐ Be aware that although adherence can be improved, no specific intervention can be recommended for all patients. Tailor any intervention to increase adherence to the specific difficulties with adherence the patient is experiencing.
- ☐ Review the patient's knowledge, understanding and concerns about medicines, and consider the patient's view of their need for medicine at intervals agreed with the patient, because these may change over time. Offer the chance for repeat information and follow-up reviews to patients, especially when treating long-term conditions with multiple medicines.

Summary

In this section we have started to understand some of the reasons why patients do not always take their medicines as intended and how healthcare professionals can help patients make informed choices about the way they use their medicines.

Healthcare professionals should work in partnership with the patient to try to resolve the patient's medicines-related problems. This is not the same as making them adherent – supporting them in a decision not to take a medicine, or agreeing with their decision not to take it, can be equally valid outcomes.

Intended outcomes

By the end of this section you should be able to:	Can you?
▶ describe the concept of medicines optimisation and medicines adherence	☐
▶ appreciate the patient experience when receiving a medicine	☐
▶ state the reason for using the term adherence, as defined by the National Institute for Health and Care Excellence (NICE CG76)[23]	☐
▶ appreciate the reasons why patients may not take their medicines as intended	☐
▶ outline the role of the pharmacy professional in supporting patients to make informed decisions about their medicines which supports a move towards adherence	☐
▶ apply further consideration to adherence to medicines in different patient groups.	☐

Suggested answers

Case study 1 – George *(page 12)*

Here are our suggestions for the questions you could ask George.

- I see from your notes you've been prescribed warfarin following your recent stroke....
- Tell me what you know about warfarin.
- How do you feel about taking warfarin?
- Do you have any specific concerns about warfarin?
- Can you explain those concerns to me?
- There is lots of evidence to say that warfarin works well in preventing further strokes, do you know much about that? Tell me about what you've read.
- How are things at home?

Case study 2 – Rebecca *(page 15)*

From what age do you think children should be addressed directly about their illness?

There is no set age for this; children develop at different rates, so their ability to understand and make decisions will vary. You should always try to include children in the discussion from the time they can talk, although some children will be very shy. With two- to four-year-olds most of the conversation will be with the parent. Healthcare professionals should also assess with each individual child, their parents and carers whether they can and want to be responsible for healthcare. The responsible adult, parent or carer should always be present during any consultation with a child under the age of 16, although you as a healthcare professional can also assess a younger child for competence (Gillick competency), if you consider this to be appropriate.[40]

As children grow and develop, they should be encouraged to participate in decisions about their health. Older children with a long-term illness should, where possible, assume complete responsibility, under the supervision of their parent or carer. Young people of 16 years or over are competent to consent to treatment even though they are under the legal age of majority (18 years). Under this age, young people can consent to treatment if the healthcare professional is satisfied the young person is competent to fully understand the implications of treatment options.

Do you think Rebecca is of an age when she could be involved in conversations about her condition?

Yes, probably. Rebecca has already expressed her opinion about the steroid cream. This is an indication that she is interested in how she is treated, so could be involved in the conversation. However, you would need to be extremely careful about how you approached this with her mother.

How easy do you find it to involve young children in discussions about their disease and its treatment?

This depends on your own experience and the frequency with which you deal with children in your work. It is often difficult for many reasons and depends on the individual child, their current illness and whether you have met them previously. Generally, if you speak at their level and ask simple questions using 'child-friendly' language, most respond very positively. This is a skill that you may consider important to develop. You could also refer to relevant books that are available to provide guidance on discussions with children with specific conditions.

Do you think that Rebecca's and Lynn's perceptions and attitude to health, disease and medicines use in this case are likely to coincide?

No, this is unlikely. Rebecca and Lynn already have different attitudes to the steroid cream, but this is as much as we know at this stage. It would be important to be able to negotiate a good result for both of them, which you may achieve by concentrating on discussing the probable lack of side-effects of the steroid cream over this length of use, and the fact that it has been needed so rarely due to their good management of the condition. Most health professionals would agree with Rebecca.

What aspects about medicine use are relevant to Rebecca?

Rebecca will not be very concerned about the side-effects. She is interested in her eczema being cleared up in as short a time as possible and in getting back to school. Rebecca wants peer approval, to fit in and not be different.

Ideally you need to explain to her that as the steroids are 'strong' they should only be used when she has a bad flare up, and that soothing emollients are available which she can use as much as she wants to, ie, every day and maybe four times a day, to make the condition bearable.

Exercise 1 *(page 2)*

Here are our suggested answers.

a) Adherence is just another word for concordance. **(Disagree)**

The difference is subtle, but we hope that we were able to describe it well enough to change your view, or maybe you agreed with us anyway.

b) Patients and healthcare professionals share decisions as part of adherence. **(Agree)**

c) If the patient prefers the healthcare professional to take responsibility for decisions, adherence is not possible. **(Disagree)**

The patient may wish to take the advice of the healthcare professional and still adhere to their recommendations.

d) Adherence involves giving patients information before letting them decide what they want. **(Agree)**

You may feel that providing appropriate evidence-based information and letting people make their own decisions is the biggest challenge.

e) Research has shown that healthcare professionals' perceptions about patient expectations are mainly accurate. **(Disagree)**

Research shows that we are not very good at understanding patient expectations.[14]

f) Discussing the patient's views will lead to longer consultations. **(Disagree)**

This is one of the commonly perceived barriers; again research shows that although it may take slightly longer to begin with, over the long term, consultations are more straightforward.

g) In a consultation it is important that the healthcare professional explains their recommendations. **(Agree)**

This is the essence of informed consent. The healthcare professional needs to give information in a clear and concise way so that the patient can make the decision.[9]

Exercise 3 *(page 7)*

There are many more reasons than the ones stated below. Well done if you had more than this on your list!

Reasons for non-adherence

Intentional	Unintentional
Fear of side-effects	Lack of understanding of instructions
Fear of dependence	Difficulty in obtaining repeat medicines
Thinking the medicine is not helping	Poor memory
Cultural beliefs	Carer does not understand how to give medicines
Not taking the medicine because it reinforces the fact that they are chronically ill	Misunderstanding relating to the need to continue the medicine for long-term conditions
The patient feels better so they don't feel the need for further medicine	Difficulty opening packages
Experiencing adverse effects	Unsuitable formulation
The patient disagrees with the doctor's diagnosis	Cognitive factors – confusion
Side-effects interfere with the patient's ability to work or undertake usual daily activities	Poor instructions/information from the healthcare professional

Exercise 4 *(page 9)*

If a patient is firm in their decision not to take a medicine, which other factors should be discussed?

Here are some suggestions, but you may have considered other factors.

- What may happen if they don't take the medicine
- Non-pharmacological alternatives
- Reducing or stopping long-term medicines
- Fitting medicines into their routine
- Choosing between medicines

Reflective questions *(page 14)*

Patients for whom shared decision making would be more difficult:

- children
- older people with confusion or poor memory
- patients with:
  - cognitive impairment
  - learning difficulties
  - mental health problems
  - complex medical conditions or on complex treatment regimes
  - physical disabilities preventing visits to the hospital/pharmacy/GP practice/clinic
  - language barriers
  - poor memory or poor mental capacity
  - extreme cultural, religious or ethical beliefs
- patients who feel embarrassed about talking to a person of a different gender about a particular topic, eg, a female patient talking to a man about women's health issues
- patients who have recently been discharged from hospital
- young adults who do not want the stigma of 'being ill'
- people who are housebound and are never seen in the pharmacy, whose carers always collect the prescription (be aware of the risk of breach of confidentiality)
- patients who are being looked after by more than one consultant.

Effective communication

Objectives

On completion of this section you should be able to:

- explain the key skills needed for effective communication
- describe the basic principles of effective communication in the healthcare setting
- consider the barriers to effective communication
- apply a framework to support you in taking a patient history.

Effective communication skills are critical if you are to conduct an effective consultation. They form the foundation on which to build your practice by improving consultation skills and applying new techniques. In this section we are going to look at the key skills you need to communicate effectively.

The term communication has a wide range of meanings and applications; in this programme we are referring to face-to-face or telephone discussions with patients about their healthcare. Bear in mind that other forms of communication, such as written or pictorial information, can also be useful to support discussions.

The term communication has a wide range of meanings and applications; in this programme we are referring to face-to-face or telephone discussions with patients about their healthcare.

Reflective questions

Think about the last time you talked with a patient and answer the questions set out below. You can return to these questions at the end of the section to reflect on whether your learning has altered your responses.

Hint: At this point it may be helpful to distinguish that there is a difference between talking 'to' and talking 'with' a patient.

How confident are you that you...

...listened fully to what the patient was telling, or trying to tell you?

1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

...used appropriate language which the patient could understand throughout?

1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

...addressed any barriers within the consultation and worked positively towards overcoming them?

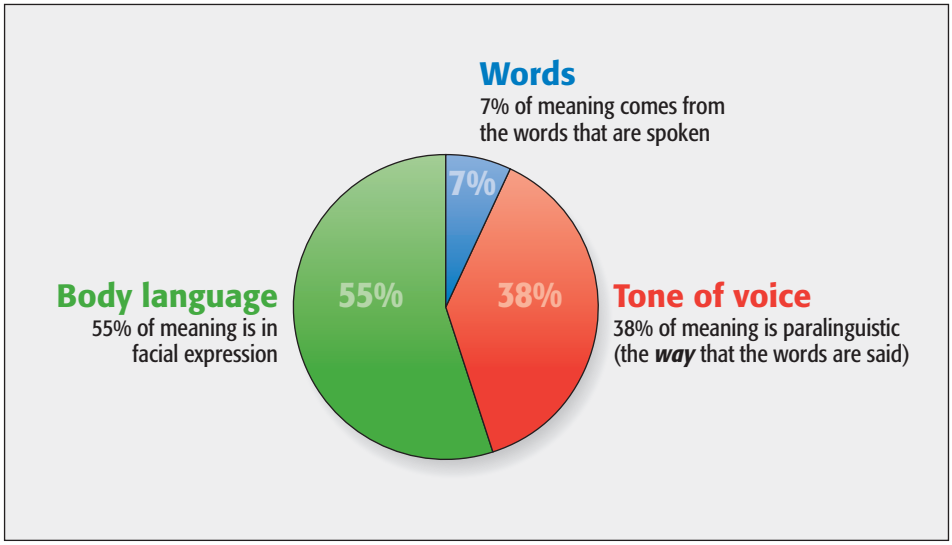
1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

2.1 Key communication skills

We will be looking at consultation skills in more detail in Section 4, but first it is useful to understand the fundamental skills of good communication.

Albert Mehrabian's research shows how a message is communicated:[41]



Body language

Body language is the unconscious and conscious transmission and interpretation of feelings, attitudes and moods through:

- body posture, movement, physical state, position and relationship to other bodies, objects and surroundings
- facial expression and eye movement.[42]

Our body, facial expression and eyes can speak a thousand words. When a person's body language is inconsistent with the words they are saying, it is the body language that tells the story and not the words that are spoken.

Body language is a 'two-way street'. Being able to interpret the body language of a patient helps us to know how they feel about the consultation, or the extent to which they understand what is being discussed. If closed body language is observed it may provide a signal that they are not feeling comfortable, or that they disagree with something you have said, or feel challenged. It may also mean that the patient feels uncomfortable with their own feelings and thoughts and is not fully sharing their concerns and beliefs.

While you are interpreting the body language of the patient, they will be interpreting your body language. Demonstrating relaxed and open body language in a consultation will help put the patient at ease and build rapport. When you have reached a point of good rapport with the patient you may see that your body language is synchronised with theirs.

Demonstrating relaxed and open body language in a consultation will help put the patient at ease and build rapport.

How do we interpret body language?

Interpreting body language is not an exact science and when you start to explore it there are many different signs to look out for. We have included some examples of the main ones here.

	Open	Closed
Facial expression	Keep an open facial expression. Smile and display empathy and curiosity when appropriate.	Take care not to display curiosity as a frown. Facial expression, such as a furrowed brow, could indicate to the patient that they have said something you disagree with.
Eyes	Display good eye contact. This usually means reflecting that of the patient. Show attentiveness with direct eye contact when listening. Direct eye contact when speaking displays truthfulness; wide eyes show interest.	Avoid looking down or away, especially when a patient is talking. You may appear disinterested and this will cause disengagement. Avoid raised eyebrows.
Hands/arms	Arms should remain uncrossed and, along with hands, should be animated. Take care not to over-animate as this can appear false and may be off-putting.	Crossing arms is a defensive stance that creates a barrier. Take care not to misinterpret, as the patient or you may just be feeling the cold! People also use objects as a barrier if they feel vulnerable, such as placing a handbag on their knee and gripping it.
Legs	Legs should remain uncrossed and relaxed in an open stance.	Crossed legs (particularly with crossed arms) indicate a closed attitude, which may be due to a degree of uncertainty, disagreement, or general disinterest.
Body position	Leaning slightly forwards while facing a person shows interest and listening. Keep shoulders relaxed. Having an upright posture shows inward confidence in what you are saying.	Leaning too closely may invade personal space and make a person feel uncomfortable. Avoid turning away. You may need to adjust your body position to make some notes. If this is the case then let the patient know you are about to take notes.
Head	Occasional nodding of the head provides reassurance you are listening and encourages the patient to continue with their story. Tilting the head to one side shows interest.	Shaking of the head from side to side, no matter how subtle, can indicate disagreement and be interpreted as dominance from the receiver.

Reflecting the body language of the person you are speaking with also reflects you are listening. Be cautious, though, if the person starts to show closed body language because they are uncomfortable, you should remain 'open' to keep them at ease.

Exercise 6

Have you ever considered your own body language when you speak to others? Ask a friend, family member or colleague to take a video of you when you are in conversation with another person (using any type of mobile device). This does not need to be a medical conversation. Watch the video back but turn off the sound, and make a note of your body language and also how you reflect the body language of the other person.

Note: **Be cautious of using a patient for this exercise as you would need consent from them and perhaps your employer to do this.**

Make a note of the body language you demonstrate here.

Open	Closed

Now engage in another conversation but this time sit back-to-back with the person so you cannot see their body language. What effect does this have on the conversation? This is something to consider when conducting a telephone consultation *(we look at this in more detail in Section 4)*.

Practice point

Reflect on your body language during a consultation with a patient. What changes will you aim to make?

You can learn more about body language by accessing the following links:

www.businessballs.com/body-language.htm#body-language-introduction

www.ehow.com/video_4438807_appear-relaxed-body-language.html

www.ehow.com/video_4438802_examples-open-body-language.html

Verbal language

Language is important in the consultation, not only the words we use but the way in which the words are said. Adopting the general rule of avoiding medical jargon and terminology gives assurance that messages are communicated clearly. However, the patient may be knowledgeable about their condition or medicines – they may themselves be a healthcare professional. If they have used medical terminology early in the consultation then to respond by using layman's terms may send out signals that you are not listening, or that you do not respect the patient's knowledge. Reflecting the language of the patient will help build rapport.

Reflecting the language of the patient will help build rapport.

Avoid using words or a particular tone of voice that sends the wrong message, for example, "What is your problem today Mr Davies?" can be delivered in many different ways, with empathy, or with exasperation.

Listening

You may have often heard the advice, "Listen to the patient, they are trying to tell you the diagnosis".

Listening does not only involve using your ears. Facial expression, body language and verbal tone can give you clues and fresh ideas about how the patient is feeling and what they are thinking. Being aware in this way can be useful when there is a psychological origin for a certain behaviour relating to lifestyle choices or medicines adherence. The patient may be unaware, but you may notice that part of their story makes them uncomfortable or hesitant. Think about what you read above regarding body language and bear in mind the same applies to a patient; you can learn a lot by looking as well as listening.

Facial expression, body language and verbal tone can give you clues and fresh ideas about how the patient is feeling and what they are thinking.

Tips to help your practice

- Listen with your eyes. As well as listening make sure you look, to note non-verbal cues and body language.
- Don't be afraid to use silence to allow a pause in the consultation. When you first start to introduce a pause, the silence may make you slightly uncomfortable. Applying this to your practice offers both you and the patient time to reflect on what has been said so far and may encourage the patient to provide more information or ask further questions.

Barriers inhibiting your practice

- Time. Having enough time to conduct the consultation can be a challenge in busy pharmacy practice. Knowing that there are ten more patients to visit on the ward or clinical checks on prescriptions to be done in the dispensary can add pressure and may lead to both you and the patient feeling dissatisfied with the consultation. Applying some of the techniques and skills from this learning will help you prioritise the key issues in the consultation and make effective use of the time available.
- Making notes can create disengagement, especially if the patient is still speaking. Think about whether it is appropriate to make notes as the patient speaks, or whether you can do it later. If you do need to make notes then explain to the patient what you are doing.

- Our own internal agenda often gets in the way of really listening to the patient. You may be distracted by your own ideas about what the patient's problem may be, or you may be thinking about your own concerns. Often, if someone speaks very slowly, our internal thinking mechanism can come into play, as we are thinking faster than they are speaking. We need to use this spare thinking capacity effectively by preparing questions to ask, or relating the information to other situations you might have encountered to help you to provide the most effective advice and support.

Listening is key to effective communication and consultation skills.

Listening is key to effective communication and consultation skills. Without effective listening skills, patients' problems may not be unearthed and a patient-centred approach is not achieved. When we look at consultation skills in more detail in Section 4 you will learn more about listening, and more importantly, the skills of reflecting and responding.

2.2 Basic principles of effective communication

For communication to be successful, the receiver of the information must understand the information in the way in which the sender intended.

For good communication to take place the basic rules of effective communication apply. There must be a sender and a receiver of information. For communication to be successful, the receiver of the information must understand the information in the way in which the sender intended. When this happens in the healthcare setting both the healthcare professional and the patient benefit.

Suzanne Kurtz outlines five principles of effective communication for doctors in consultations with patients *(see Table 2)*.[43]

TABLE 2 Principles of effective communication

Effective communication	Explanation
Ensures interaction rather than direct transmission	The sender and receiver of the information are interdependent. There needs to be some interaction or feedback about the impact of the message; just listening or just giving advice is not enough.
Reduces unnecessary uncertainty	If common ground and mutual understanding have first been established, then any uncertainty can be openly discussed. If areas of uncertainty are not resolved, then blocks to effective communication, such as lack of concentration or anxiety, can result.
Requires planning and thinking in terms of outcomes	It is important to have planned and thought about the aims of the consultation beforehand, if possible.
Demonstrates dynamism	It is important to be flexible, engaged and responsive in any given situation, and to recognise that what may be appropriate for one situation may be inappropriate in another.
Follows the helical model	Communication gradually evolves through interaction in a spiral way, each person influencing and building on what was said by the other. This also fittingly produces repetition and summary.

From these principles we can begin to understand why it is that – in any situation, not just healthcare – when someone communicates effectively we feel that we have really understood.

Reflective questions

Look at the five principles of effective communication *(see Table 2)* and the skills outlined above and assess your current competence. Make a note of any areas that you feel you need to consciously practise in order to progress?

2.3 Transactional analysis model

In the 1960s Eric Berne developed a useful model, based on states of mind, and how these influence transactions between people. He applied the model to the medical consultation, which he described as a series of exchanges.

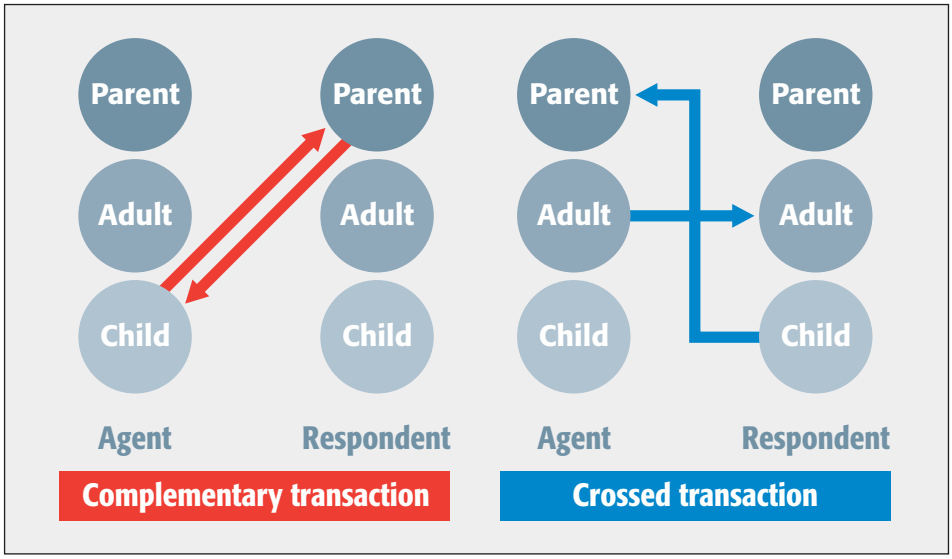
He suggested that throughout our lives, irrespective of age, we are in one of three states of mind (or 'ego states') which categorise the way we think, feel or behave:

- adult – this is the grown up 'here and now' state that gives an appropriate response to a stimulus based on a rational, factual, thinking, questioning, assessment of our situation
- child – this is an ego state from the past that causes us to behave in ways which echo how we have responded in the past; this can take the form of the natural child (spontaneous, playful) or the adaptive child, who has learned to adapt by conforming
- parent – this is another ego state from the past that has developed from reflecting the behaviours of parents or parental figures and can be authoritarian, paternalistic, or caring.

Berne defined child and parent ego states as being based on replayed memories of our childhood experiences. He went on to explain that a complementary transaction is needed for communication to be successful, with the adult-adult transaction being the simplest of these. This involves each person remaining in the same ego state during the communication process. Communication is disrupted during a crossed transaction, ie, one in which one person or both switch from one ego state to another during the communication process.

This can be explained by the diagrams shown in Figure 2 overleaf:[44]

FIGURE 2 Complementary versus crossed transactions in communication



exhibiting the feelings and behaviour of parent (P), adult (A) or child (C) ego state.

Healthcare professionals may risk going into the parent ego state, which could consequently push the patient into child mode. An example would be a healthcare professional who provides all the information and makes all the decisions (ie, parent) and a patient who agrees with everything that is said (ie, child). This is rarely helpful for either of them, but produces no conflict. Conflict may arise if the patient then switches to either adult or parent mode and challenges the authority of the healthcare professional.

Exercise 7

Based on the transactional analysis model, where healthcare professional and patient are in different ego states (parent, adult or child), a discussion might go like this:

Healthcare professional:	Why haven't you been taking your tablets? (P)
Patient:	Because they were making me feel awful. (C)
Healthcare professional:	Then you should have come back to see me or rung me to talk about it. (P)
Patient:	Sorry (C). I've been reading up about a new tablet for my condition, what do you think about it? (A)
Healthcare professional:	I know the ones you mean, you can't have those because of your blood pressure. (P)
Patient:	Well, I suppose I'll have to try these tablets again then. (C)

If the consultation had ended after the patient had said "sorry", there would have been no conflict. The conflict only occurs after the patient has challenged the healthcare professional by asking an 'adult' question.

The best interactions happen when both parties are acting in adult mode, using factual, non-emotional dialogue and showing respect toward each other. What might this conversation look like if both parties are in adult mode? Write your suggestions here:

Healthcare professional:

Patient:

Healthcare professional:

Patient:

Healthcare professional:

Patient:

Turn to the end of this section for one suggested approach.

Practice point

During your next consultation consider your own ego state and that of the patient and try to identify with what Berne proposes. Can you identify the ego states being used by you and the patient? Is it adult to adult or something else?

2.4 Barriers to effective communication

However good your skills, there are times when, despite keeping an open mind and working to a flexible plan, the consultation does not go as expected. Sometimes you will be able to identify a reason for this and it may be something you can tackle, but sometimes the reason will be outside your control. Here are some suggested barriers:

- a lack of skill and understanding of the structures of discussion and conversation
- inadequate knowledge of other communication skills, including body language
- lack of personal insight into other people's communication difficulties
- a lack of inclination to communicate with patients; this may be due to lack of confidence, concerns related to confidentiality or because difficult topics are being discussed
- personal barriers, such as tiredness or stress, or personality differences
- providing information in a haphazard or inconsistent way
- language barriers
- organisational barriers, such as lack of time, pressure of work and interruptions
- physical barriers, eg, sitting behind a desk or using a question sheet in an inappropriate manner, as discussed in Section 2.6 below.

Telephone consultations

However much we computerise records, there can be no better way of gathering information than talking to the patient, usually face-to-face.[45]

Telephone conversations can never be equivalent to face-to-face consultations. Although the patient may feel they are convenient, both of you are restricted to verbal communication. Building rapport with the patient can be more difficult without the use of body language and giving advice can be limited without the opportunity to pass on information in the form of leaflets, or visual guidance (eg, inhaler technique).

However, there may be situations when it is preferable for the patient to have a consultation on the telephone.

Respecting a patient's confidentiality is critical whenever you speak with a patient, but during a telephone consultation you should be even more aware of confidentiality issues. You need to be confident that you are talking with the right person and that you conduct your conversation in a quiet and private area where you cannot be overheard.

Respecting a patient's confidentiality is critical whenever you speak with a patient, but during a telephone consultation you should be even more aware of confidentiality issues.

Here are some tips to help you make sure your telephone consultations are confidential, professional and effective.

Tips for your practice

- Environment – if your pharmacy phone does not have a mobile facility then consider relocating it to a quiet area where you can have a confidential discussion with minimal interruption and without being overheard by other patients.
- Patient identity – make sure you are talking to the right person. You can ask additional questions, such as address and date of birth, to establish identity.
- Introduce yourself clearly – many people get frustrated with sales calls so right from the start it is important to ensure they know who you are and where you are calling from.
- Explain the reason for the call and make sure the patient is happy to continue with the discussion. Set a timeframe with them. If you have caught them at a busy time it may be more productive to arrange another time for the call.
- Verbal communication

  You – you can only communicate verbally, so be aware of your tone of voice. Remember the patient cannot see you smile so use a relaxed and calm tone of voice, be polite and speak more slowly to build rapport. If a patient is hard of hearing you may need to raise your voice slightly. Speaking a little more deeply when talking with elderly patients may also help, as it is often the higher sound frequencies that are lost in old age. Intonation in your speech can be used to show empathy and understanding, but avoid using it to express judgemental feelings. You will have no visual cues from the patient, so ask open questions to gather information.

  The patient – be aware of the patient's tone of voice and listen for signs that might show the patient does not understand or is not totally happy with a suggested plan. Listen to the patient and reflect back the main issues so they are reassured you are listening. Allow a pause after you have given advice or are establishing a solution to a problem, to give the patient a chance to air their feelings.
- Information – check that the patient understands any key points of advice or information by asking them to repeat them back. Explain that you are happy if the patient wants to make notes if they would find that helpful.
- Throughout the call check repeatedly that both you and the patient are happy the telephone consultation is working well and is appropriate.
- Ending the call – let the patient disconnect first, so you know you have given them the opportunity to clarify any last minute issues.
- Document your calls – record both the date and time of calls (even the ones that are unanswered), the details of the consultation and any extra advice or information you have given to the patient.
- If the patient is out and another member of the household answers the phone do not be tempted to tell them the nature of your call.

Blocking behaviours

In addition to barriers, there are other negative behaviours that may be used; these are called blocking behaviours.

We often respond to emotional cues by blocking further discussion, which in turn leads to poor communication.

Healthcare professionals may find it difficult to move away from medical concerns regarding the patient in order to deal with psychosocial issues, and struggle to adopt a more negotiating and partnership style. This is demonstrated if there is reluctance to ask about the social and emotional impact of problems on the patient and family. We may have a tendency to think that it will increase patients' distress, take up too much time, and threaten our own emotional survival. We often respond to emotional cues by blocking further discussion, which in turn leads to poor communication.[28, 46]

Blocking behaviour from healthcare professionals includes:

- offering advice and reassurance too soon in the discussion
- explaining distress as 'normal'
- considering physical aspects only
- changing the topic
- 'jollying' patients along.

Blocking behaviour is also used by patients, mainly to prevent disclosure of important information, usually unintentionally. The reasons that patients may use this behaviour include:

- a belief that nothing can be done
- they don't want to burden the healthcare professional
- they don't want to seem pathetic or ungrateful
- they feel uncomfortable or feel it is inappropriate to mention certain things
- they expect the healthcare professional to block their disclosures
- they worry that their fears of what is wrong with them will be confirmed.

Reflective questions

What have you learnt so far? Have you learnt anything about yourself and the way in which you communicate? Do you ever create barriers when communicating with a patient? Are you aware of any blocking behaviours you might use?

Write down three things that you would like to do better in your future practice or that you would like to explore further. How can you improve your communication skills? Is there anyone else you could work with to help you? Think about the benefits for you in improving your communication skills.

1.

2.

3.

Case study 3
Lily

Lily Jenson, aged 75 years old, has been recovering in hospital following a hip fracture. Jonathon, the pharmacy professional, discusses new medication with Lily. Read through the following dialogue and think about how effective Jonathon's communication skills are.

Jonathon	Hello Mrs Jenson, I believe you've been prescribed some new medication.
Lily	Yes, that's right. Daft me fell over and broke my hip so now I need to take these tablets on top of all the others.
Jonathon	OK, well I'd just like to ask you a few questions to make sure you know how to take them in the right way. Is that OK?
Lily	Well, I suppose so. I'm not in any rush to go anywhere. There's only me now my Ronald has gone, so no-one to go home to.
Jonathon	So, do you know why you've been given the new tablets, alendronate?
Lily	Yes.
Jonathon	Are you sure?

Lily	Yes, I told you I know that... they said my bones are weak. Osteoporosis. And the tablets would work with my calcium tablets to make my bones stronger. Trying to stop me getting any more fractures. I might be old but I'm not daft!
Jonathon	That's right. You need to take this tablet just once every week, and it has to be the same day each week.
Lily	My sister has these. Said they can give you terrible heartburn. I don't really want to take anything dangerous, I'm in enough trouble.
Jonathon	They're not dangerous, as long as you stick to the instructions.
Lily	I'll take them on Saturday.
Jonathon	OK, one tablet every Saturday. Take the tablet half an hour before food with a good glass of water and stay upright after taking it. You can carry on with your calcium tablets as before.
Lily	I can read instructions you know! I'll just need to make sure I keep them at my bedside, sometimes it takes me a while to get up and about with this back pain.
Jonathon	Sorry yes, it's just we like to make sure you know what you're doing with them once you get home.
Lily	How would you know anyway? I might just flush them down the loo.
Jonathon	I'm sure you are far too sensible to do that Mrs Jenson. Now, is there anything else you would like to discuss?
Lily	No, thank you.

In Section 1 we looked at the importance of the patient's perspective and so far in this section we have considered basic communication skills. Thinking about these issues, consider the points we have highlighted in the left column below. Did Jonathon achieve these? What could have been done differently?

	Achieved yes/no	Describe anything that could have been done better
Identify the patient's problems and concerns		
Share relevant information at an appropriate level		

	Achieved yes/no	Describe anything that could have been done better
Involve the patient		
Discuss treatment options		
Assess the patient's reaction from cues		
Be supportive		

Turn to the end of the section for suggested answers.

2.5 Taking a patient history

Most consultations with patients will involve an element of history taking, whether this is during a discussion for an over-the-counter medicine, in relation to their past and present medicines use, or about lifestyle behaviours. Much of the information available to support healthcare professionals in history taking is based on the medical model, but there are important elements of this that can be applied to a pharmacy consultation.

Taking a patient medical history is a structured approach to finding out about health problems in a way that enables the healthcare professional to obtain all the relevant information and applies to any consultation, whether it relates to taking medicines or healthy lifestyle advice. It is one of the main functions of the consultation and is a useful tool for both the patient and healthcare professional. If we also bear in mind the five principles of effective communication, *(see Table 2, page 28)* we can start to measure how good our communication skills are when taking a patient history.

Patients often say that they have to repeat the same thing over and over again to lots of people. However, taking a medical history from a patient is still considered to be the best way to obtain relevant information and make an accurate working diagnosis, or in other words, establish what is really happening for the patient.

Taking a medical history from a patient is still considered to be the best way to obtain relevant information and make an accurate working diagnosis, or in other words, establish what is really happening for the patient.

Taking a medical history gives the patient the opportunity to talk about their situation, and can uncover problems that the patient has not acknowledged themselves.

Taking a medical history is not just a means of establishing the main problem, or for diagnosis, it is part of the process of sharing information. It gives the patient the opportunity to talk about their situation, and can uncover problems that the patient has not acknowledged themselves, for example, depression. It helps develop the patient/healthcare professional relationship and promotes empathy and understanding. We all know of people who visit regularly, who are a challenge to help and are more difficult to communicate with, so we need good history-taking skills to make best use of the available consultation time.

When you take a medical history the information the patient gives during the discussion will be their real or perceived symptoms of illness. If you are planning to make a physical examination, you might then need to identify clinical signs. Matching clinical signs to reported symptoms enables the healthcare professional to make a working diagnosis; for example, if a patient presents with an itchy scalp, and on examination live head lice are found on the hair shafts, then a diagnosis of head lice could be made.

There is little point taking a medical history unless you are able to act on it. It is helpful to consider if you are likely to be able to address the main complaint. If not, then the priority is to ensure that the patient is referred appropriately to someone who can take the right course of action to help them. However, if you can supply or prescribe a product, or offer support in other areas (as in the example above for head lice treatment) then you should take a structured approach in gathering the information you need.

The approach below is just one way of history taking and some of the areas may not be applicable for each consultation but have been included here.

1. Make sure you identify the patient correctly.
2. Encourage the patient to describe the main problem, Discuss each problem completely before moving on to another, asking questions to clarify any information about duration, severity, date and time of onset, links to events that may have been the cause and nature of the problem. If the patient then mentions multiple complaints, you may say:

   "If I can improve one thing for you which would it be?"
3. Patients may already be undergoing treatment, or have been treated a while ago. Explore what was done and whether anything already tried was effective or if it made any difference at all. Ask about their current health status and medical care. Has any medical help been given, or has anything been tried by the patient?
4. Have there been any recent changes to sleep, diet, tobacco or alcohol use, exercise?
5. Ask about any past illness, including mental health problems, hospitalisations, surgery or long-term treatment.
6. Discuss any medicines taken – both current and in the past, prescribed and purchased – and whether they have been effective.
7. Ask about family diseases, including diabetes, hypertension, kidney disease, heart disease, heart attack or stroke, asthma, allergies, cardiac rhythm problems, cancer, osteoporosis or mental health problems.

8. Find out their social history, which may include marital status, children, occupation and living arrangements. What support do they have at home?
9. Interpret the information given to you and think, 'What do I make of these responses, do they make sense, am I missing something, or do I need clarification?'

Tips to help your practice

- Don't ask too many questions unless you have decided fairly early on in the process that you can provide care; whether that is medicine or lifestyle advice, or unless you plan to undertake a physical examination. Short interventions should be linked with short history taking.
- Ensure you show respect for any cultural, religious or ethnic differences.

Practice point

As we mentioned above, the approach we have outlined is just one way of history taking. It is important to develop a method suitable for your own practice that you are comfortable with. You may want to consider different approaches for different situations, eg, short interventions, medication review, or full medical consultation. Also, you may find it helpful to develop a history-taking template(s) for ongoing use.

2.6 Tools to support your practice

There are many different tools available that can help you construct a question template for your consultation, such as the interview schedule for the new medicine service, the AUDIT tool for establishing alcohol consumption and the medicines history-taking charts used in secondary care. Some of these may be linked to provision of a service, such as supply of emergency contraception. These provide benefits in that they:

- support you in structuring your consultation
- act as a safety net so you do not miss any vital information
- can reassure the patient that your practice is consistent and they are being treated the same as other patients.

However, if the tools are used in a formal way there is a risk that they will restrict the flexibility you need during a consultation. To get the best from these tools you should be familiar with their content and use them as a guide, while remembering that each patient is an individual and needs an individual approach and flexibility within the consultation.

To get the best from practice tools you should be familiar with their content and use them as a guide, while remembering that each patient is an individual.

Practice point

Take an example of a questionnaire tool you use in your role. Think about how you apply it in practice. Do you go down the list from one question to the next, or are you able to approach it in a more informal manner? Try out the tool on one of your colleagues and ask for some feedback on your consultation. Taking a video will also help you reflect on your performance.

Exercise 8

Take a look at some of the online examples of consultation training accessed from the link shown below, which show various aspects of history taking. Cross-reference them to the points raised above and think about how to create your own approach(es) to history taking.

www.youtube.com/sgulcso

2.7 Recording your consultation

Good record-keeping is difficult to do well, because of all the conflicting pressures on working lives.

It is important to keep a record of a summary of the main points covered in the discussion and also to record and measure the outcome of the consultation. Good record-keeping is difficult to do well, because of all the conflicting pressures on working lives. However, it is worth bearing in mind the viewpoint of a court of law regarding medical records, ie, 'if it isn't recorded, it didn't happen'.

Recording the history, physical examination, assessment, advice given and the management plan, allows recall of these facts at a later date. The record of the consultation serves as a legal document, describing the course of care offered to the patient, and provides a reference source for all the healthcare professionals caring for the same patient.

It is essential that pharmacists undertaking either a medicines use review (MUR) or a new medicine service consultation obtain signed consent from the patient before recording any information.[47]

Exercise 9

What written notes of a consultation do you need to make to protect yourself legally?

Turn to the end of the section for suggested answers.

Summary

Good communication plays an important part in patient-centred healthcare, so it is important for healthcare professionals to gain the necessary skills to communicate well. The benefits can be seen not only in the patient/healthcare professional relationship, but also in good working relationships within the healthcare team.

Intended outcomes	
By the end of this section you should be able to:	Can you?
▶ explain the key skills needed for effective communication	☐
▶ describe the basic principles of effective communication in the healthcare setting	☐
▶ consider the barriers to effective communication	☐
▶ apply a framework to support you in taking a patient history.	☐

Suggested answers

Case study 3 – Lily *(page 35)*

	Achieved yes/no	Describe anything that could have been done better
Identify the patient's problems and concerns	No	Lily mentioned several potential problems: her concern about side-effects; her back pain; and also the fact that she lives alone. Asking "Is there anything in particular that concerns you about your medicine...or anything else you would like us to discuss?" could have opened up a much more effective discussion.
Share relevant information at an appropriate level	Partly	When Lily mentioned her concern about side-effects Jonathon's response could have appeared patronising to Lily. A more appropriate response could be "I can understand why you might be worried about side-effects, but there are some specific instructions that will help avoid this. Shall we chat about those?"
Involve the patient	Partly	From the conversation there were points when Lily was very much 'told' what to do, rather than opening a balanced discussion. Lily did not appear a true partner and the balance of 'power' was very much towards Jonathon.
Discuss treatment options	No	There were no other treatment options discussed. At the point when Lily mentioned side-effects it would have been helpful to mention that there are other options, should she experience any problems. Jonathon also did not pick up on the discussion about back pain.
Assess the patient's reaction from cues	No	Lily provided several cues to Jonathon that indicated she felt as though he had not valued her knowledge or input to the discussion. These points, such as "I'm not daft you know", could have offered Jonathon a chance to start rebuilding rapport with Lily.
Be supportive	No	Jonathon failed to show empathy to Lily at points, for example, when she mentioned she had lost her husband and also that she suffered back pain. A phrase such as "I'm so sorry you have suffered the loss of your husband. How do you manage to cope at home by yourself?" may help build rapport by demonstrating empathy.

Exercise 7 *(page 30)*

This is how the conversation may have gone with both parties in adult mode.

Healthcare professional:	I've just been looking on the computer and you don't seem to have been getting your tablets recently. **(A)**
Patient:	No, not for three months. **(A)**
Healthcare professional:	Have you spoken to anyone about it? **(A)**
Patient:	Yes, I discussed it with my wife Helen and she suggested I come back to see you again, so here I am. I've been reading up about a new tablet for my condition, what do you think about it? **(A)**
Healthcare professional:	I'd really like us to discuss together some of the reasons why you have decided not to take your tablets before we consider trying something new. This might help us decide what the next best step is. **(A)**
Patient:	Yes, OK. Well, to be honest I took one tablet and it made me feel so sickly. I couldn't bear the thought of that again so I left them alone. **(A)**

Exercise 9 *(page 41)*

What written notes of a consultation do you need to make to protect yourself legally?

Litigation with regard to medical malpractice is now common in our healthcare system. As a minimum, any notes taken need to contain the identity of the patient, including their NHS number or date of birth. It should identify any other people present, for example, if carers or other observers were also present. The person writing the record should be identified and they need to ensure the record is timed, dated and tamperproof. You need to record all the relevant facts about the problems, including examinations, decisions, risk/benefit information given, any care planned, advice given and current information on the care or condition of the patient. You should make these written notes within 48 hours of the consultation in a clear, concise and legible way, and in chronological order.

Section 3

Consultation models and the theory behind them

Objectives

On completion of this section you should be able to:

- outline the main consultation models and the theory behind them
- describe the different consultation models that are applied to practice today
- begin to identify your preferred models and how you can adapt and apply these to develop your own consultation style
- describe how you plan to adapt your consultation style to individual patients.

This section explores some of the theory and background to the various consultation models and highlights the main models applied to practice.

There are a variety of approaches to the consultation process. Over the years consultation theory has evolved and a number of consultation models have been identified and proposed. The models help healthcare professionals to take a more structured approach to the consultation and can act as an aid in developing consultation skills and personal consultation style. Some models also support a patient-centred approach.

This section explores some of the theory and background to the various consultation models and highlights the main models applied to practice.

The first part of this section looks at the theory of the medical model and shows the transition through to the psycho-social models. Psycho-social models underpin the importance of involving the patient in the consultation, highlighting a move from thinking of the patient purely as a 'condition or disease' to taking a holistic view that puts the patient at the centre of the consultation.

We then look at some of the true consultation models that are applied to healthcare practice today and those that are more commonly applied to pharmacy practice. The section will encourage you to reflect on your own style of consultation and what you can do to enhance this.

Reflective questions

Thinking about your most recent consultations answer the following questions. You can return to these questions at the end of the section to reflect on whether your learning has altered your responses.

a. How did you structure the consultation?

1 2 3 4 5 6 7 8 9 10

(I did not consider structure) (I based it on existing models I know)

b. How confident are you that you remained flexible throughout the consultation and adapted the structure in response to the patient's agenda?

1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

c. Do you always have enough time to complete the consultation satisfactorily for both you and the patient?

1 2 3 4 5 6 7 8 9 10

(never) (always)

3.1 The history of consultation theory

We have summarised below some of the medical and psycho-social models and theories that represent different approaches to the consultation and have contributed to the development of the medical consultation.

- Bio-medical model
- Balint theory
- Transactional analysis model
- Health belief model
- Anthropological model

Bio-medical model

Originally developed in the 1800s, the bio-medical model concentrates solely on disease and diagnosis and is based on the concept that all disease has a physical or biological cause. A hypothesis, generated early in the process, assumes that all conditions, including mental health problems, have a physical cause and should be treated medically. In later years the bio-medical model was criticised as studies of disease, including mental illness, showed links with patient behaviour. However, this model is not completely discredited, but should only be used in appropriate circumstances.

The bio-medical model concentrates solely on disease and diagnosis and is based on the concept that all disease has a physical or biological cause.

The bio-medical model uses a scientific approach, including:

- aetiology
- history taking – (some people using this model consider history taking on its own is sufficient to make a diagnosis)
- physical examination
- laboratory testing
- diagnosis
- treatment.

Balint theory

Balint suggested that the problems described by a patient might not be the real reason for wanting a consultation.

During the 1950s Michael Balint was the first to recognise that psychological problems are often revealed physically and that physical problems can have a psychological effect.[48] Balint suggested that the problems described by a patient might not be the real reason for wanting a consultation. He said that both the doctor and the patient play roles; that both the personality of the doctor and the willingness of the patient to adopt the role of being sick are the 'machinery of the consultation'. He also promoted the use of the long consultation to really get to the bottom of problems for 'heartsink' patients (those who visit regularly and who are difficult or impossible to help). The book that he wrote in 1957, *The doctor, his patient and the illness*, is still very readable today.

Transactional analysis model

The transactional analysis model developed by Berne in the 1960s proposes an interesting concept based on states of mind and transactions between people.[49] When applied to the medical model it describes how both healthcare professional and patient can take on one of three ego states within the consultation: child, parent or adult. A complementary transaction must take place between ego states for communication to be successful. The model is covered in detail in Section 2. If you have not yet read Section 2 you may wish to read more about this model and how it influences your communication with patients and complete the exercise *(see page 30)*.

Health belief model

In the 1970s Becker and Maiman developed a psychological model to try and explain patients' beliefs about health.[50] They identified a number of factors that can both influence and predict behaviour and outcomes, including personality and social factors, how vulnerable the patient feels to a particular disease, the patient's thoughts about the benefits of treatment, and external factors, such as advice from family or friends, or reports in the media.

The model is based on the idea that a person will take a health-related action if they feel that a health problem can be avoided, or that by taking the action they can achieve a successful outcome. An example of this might be that by competently using a condom an individual can avoid contracting HIV.

Consultations based on this model would involve thinking about things from the patient's viewpoint and exploring their beliefs and feelings and then providing relevant evidence-based information to help the patient work towards a personal plan of care. The patient is also offered follow-up advice and support.

Several elements are identified within the model:

- perceived susceptibility: the chances of contracting a particular illness and the consequences of not receiving treatment
- perceived severity: the variation in the way people perceive the severity of a specific condition and how that links to the advice they are prepared to listen to
- perceived benefits: the perceived advantages of taking a particular course of action
- perceived barriers: the perceived costs of taking the advised action
- cues to action: the triggers and prompts that cause us to seek action for health problems
- self-efficacy: the level of people's interest in health and the degree of change they are prepared to undergo.

Becker and Maiman also described a concept they called the 'locus of control'. This refers to the extent to which a person believes they can control the events that affect them. The theory suggests that there are three types of people: the internal controller, the external controller and the powerful other. The internal controller believes that they are in control of their own future health, ie, that it is the result of their own actions. The external controllers are fatalists, believing that they have no control over their own health. The powerful other type of patient believes that the healthcare professional is in charge and can help them with all their problems. The 'heartsink' patient is in this category.

Anthropological or 'folk' model

In the 1980s Cecil Helman, a medical anthropologist, identified a set of questions that all people seeking medical advice ask themselves.[51]

- What has happened?
- Why has it happened?
- Why has it happened to me?
- Why has it happened now?
- What would happen if nothing was done?
- What should I do about it?
- Who should I consult for further help?

He suggested that if the healthcare professional can answer these questions during the consultation – even if they are not clearly expressed – then the consultation is more likely to be considered satisfactory from the patient's point of view.

3.2 Consultation models and current practice

Consultation models offer a range of techniques to apply to the different types of consultation you conduct; for example, you may need to apply different skills when talking to a person about emergency contraception, compared with a consultation about medicines adherence. There are many different models to consider. As you read, try not to think about the models in isolation or in too much detail. The best approach is to think of them as part of your practice 'toolbox', providing skills to help you get the best outcome for you and the patient.[52]

The best approach is to think of consultation models as part of your practice 'toolbox', providing skills to help you get the best outcome for you and the patient.

By studying the different models you will identify particular ones that fit best with your natural consulting style. As you read, select key points from particular models that you can begin to apply to your practice. Applying models to practice not only helps you develop style and assure content, but can add structure to make the most effective use of time within the consultation.

There are several different models that are most commonly applied to pharmacy practice. We have listed the main ones here, which we cover in more detail below.

- Calgary-Cambridge guide
- Pendleton
- Neighbour
- BARD.

As you look at the models in more detail you will find key elements that you will identify with. There is no 'one size fits all' approach. Some will appeal to the global thinker, while others will satisfy those who prefer more detail. You may choose to use one model or certain elements of different models, but the key to applying them effectively is to develop your consultation skills and regularly revisit the model to reflect on how you can develop further.

Key point

We have already mentioned that patients recognise rigidity in a consultation, which can lead to them feeling dissatisfied. Although every consultation requires some structure, each one will be different and requires a flexible approach to ensure the patient's agenda is considered throughout. Applying models to practice, while ensuring flexibility within the consultation, is a learnt skill that is unlikely to be achieved from experience alone.

Reflective questions

How do you currently structure your consultations? You may find that you apply a different structure to certain consultations; for example, you may be speaking with a patient before discharge from hospital while handing out a discharge medicine, or you may be discussing their care with them than at the hospital bedside, or if you are community based, you may be discussing healthy lifestyle options, rather than medicines use.

Think about your most recent consultation.

Who do you think had the most 'power' within the consultation? This is something we will revisit throughout this programme but it will help you to consider this now before moving forward.

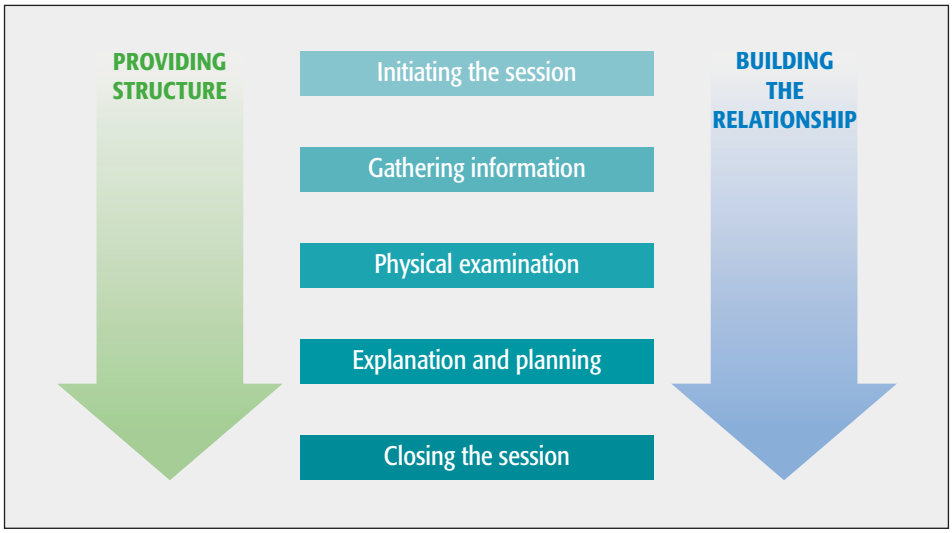
Make a note of your thoughts here:

Calgary-Cambridge guide

In the 1990s, Kurtz and Silverman developed a guide within a practical teaching framework, known as the Calgary-Cambridge guide *(see Figure 3 below)*.[53] This guide is based on the evidence of effectiveness of many of the earlier models mentioned in Section 3.1 and was developed as a medical model. However, it has been shown to be applicable to pharmacy consultations.[6] It is now used widely to teach consultation skills to healthcare professionals.

The Calgary-Cambridge guide is now used widely to teach consultation skills to healthcare professionals.

FIGURE 3 The basic guide



Source: Kurtz SM *et al* 2003[54]

The guide sets out a number of different steps and within each step are key consultation skills that should be applied to achieve the best outcomes from each interaction.

1. Initiating the session

a. Prepare yourself for the consultation. Consider how you will get into the right frame of mind to speak with a patient. Make sure you are organised with the relevant information, such as a patient's medicine history beforehand.

b. Introduce yourself and welcome the patient.

c. Establish an initial rapport with the patient.

d. Identify the reason for the consultation. The patient's aim may differ from that of the healthcare professional.

2. Gathering information

a. Explore the problems through effective questioning and listening skills.

b. Elicit the patient's perspective.

Practice tool

To understand the patient's perspective you should try to establish their thinking. The ICE acronym is often used to establish the patient's perspective.

I Ideas
What can the patient tell you about their medicine or health problem? Some patients may be very knowledgeable, while others may have inaccurate thoughts and ideas. Be prepared to accept both situations.

C Concerns
Sometimes a patient may have concerns that you have not considered.

E Expectations
What does the patient think will be the outcome, what do they think might happen?

We look at the ICE acronym again in Section 4 *(page 79)* where we consider some example questions that can be used in a consultation.

3. Physical examination

This may not be routine in many pharmacy-based consultations, but if there is an element of 'examination', such as screening, taking a blood pressure measurement or monitoring parameters, such as U&Es, then it should occur at this point.

4. Explanation and planning

a. Provide the right type of information in an appropriate manner suitable for the patient.

b. Aid accurate recall and understanding.

c. Achieve a shared understanding, incorporating the patient's perspective.

d. Develop an action plan which involves shared decision making.

5. Closing the session

a. Summarise the key messages.

b. Make a final contract with the patient to agree the action plan.

c. Put contingency plans in place in case things do not go to plan (safety-netting.

d. Run through a final check to ensure the patient agrees and is comfortable with the plan.

There are also two key processes which run throughout the consultation:

Providing structure

a. Agree the agenda.
b. Summarise and recall throughout to check understanding.
c. Signpost and use transitional statements to progress from one part of the consultation to the next.
d. Apply a logical structure.
e. Keep to time.

Building the relationship

a. Continue to build rapport throughout.
b. Show empathy.
c. Share the discussion as a partnership.
d. Use open body language and appropriate eye contact.

In total there are 71 key consultation skills that align to the Calgary-Cambridge guide.[6] It is not expected that healthcare professionals showcase each skill in every consultation, this would be unachievable. However, you should try to work towards knowing which skills to apply at the appropriate time. Some of these will be covered in Section 4.

Exercise 10

Watch the following video clip of a community pharmacist delivering the intervention stage of a new medicine service consultation. Think about the key stages of the Calgary-Cambridge guide above. As you watch the video check if you can identify these different stages and make a note of any good practice points you see that you could adopt in your practice.

You may practise as a pharmacy technician or in a different sector, such as hospital, but try not to think too deeply about the clinical element of the consultation or topic. It is the delivery of the consultation that is the focus throughout this programme.

Make your notes here after watching the video: www.youtube.com/watch?v=XDTtz-Jp_cM

Calgary-Cambridge guide	Points of good practice to adopt
Initiating the session	
Gathering information	

Calgary-Cambridge guide	Points of good practice to adopt
Explanation and planning	
Building rapport throughout	
Providing structure	
Closing the session	

Turn to the end of the section for suggested answers.

Pendleton's framework

In 1987 David Pendleton and colleagues established a framework to help increase the effectiveness of the consultation process and make it more patient-centred.

Pendleton's framework focuses on four key questions:

- Who is the patient?
- What has changed for the patient?
- Why has the patient come now?
- How do we tackle the problem?

Reflective questions

Have you ever thought why patients might seek to consult with you? Write down as many possible reasons as you can think of.

Turn to the end of the section for suggested answers.

To answer the four key questions *(set out above)* Pendleton suggested seven basic tasks:

1. Discover the reason for attendance

Before trying to find out why the patient has come to see you, you need to consider who the patient is and what you can do to establish a rapport with them so that you can both have a useful discussion. Patients often use this initial phase to consider who the health professional is too.[22]

Early in the consultation you need to find out the history of the problem.

The questions you should be asking yourself would include:

- Why did the patient really come, what is their agenda?
- Are their expectations realistic?
- Do they need reassurance about any fears?
- Are there any other issues that need to be addressed?
- Is there a hidden agenda?

Sometimes patients present with something trivial and then move on to the real reason they came. Healthcare professionals should be alert to the possibility that the presenting problem may not be the true or deeper problem. Putting patients at ease from the outset might enable them to present with their real concerns.

The best consultation models focus on ways that achieve partnership working with the patient.[22] Your intention here should take into account the patient's ideas, concerns and expectations (the acronym 'ICE') and their views and beliefs. Most people construct a story in their head of what has happened and what they are planning to say when they are entering a consultation, for example, "I started taking the tablets last Wednesday and since then I haven't been sleeping very well. I don't know if it's my imagination but I seem to be having some very vivid nightmares". Such a narrative, if you can get it from your patients, is invaluable and the quickest route to establishing their aims of the consultation.

The best consultation models focus on ways that achieve partnership working with the patient.

2. Consider other problems

It is important to consider continuing problems and risk factors. These might include health promotion, medication review, tests that may be needed, as well as addressing risk factors, such as smoking or obesity. You should also be aware of any other relevant factors, such as the patient's living conditions and social circumstances.

3. Choose an appropriate action

What is the most appropriate clinical management? It may be treatment, reassurance or referral; it may involve follow-up or monitoring. The consultation is not only about carrying out the elements of good clinical practice, such as delivering information and advice, it is also about involving the patient in the decision-making process, understanding and responding to their emotional needs related to their problems. It may not be possible to solve all the problems in one consultation. Prioritising the main action at the outset will help tackle the main problem with a more effective outcome. Other problems can then be considered later in the consultation or at a follow-up visit.

4. Achieve a shared understanding

It is important that the patient understands the health concern, its aetiology and its treatment, as this may improve adherence. The patient may need to know why and how a change in certain lifestyle behaviours and following specific treatment plans may support them in an improved quality of life. This helps support a move towards the patient taking shared responsibility for their own healthcare.

5. Involve the patient in management

Patients are autonomous and may not always do what you think is right or what the evidence suggests they do.

The long-term outcome of the consultation depends on informed consent being achieved, and linked to this is getting the patient to take responsibility. Patients are autonomous and may not always do what you think is right or what the evidence suggests they do. There are many reasons for this. You need to know the patient's preferences in terms of any decisions that need to be made; it may be valid to talk about alternative approaches. You will need to balance the available evidence, however, sometimes the evidence is so compelling that there is little to discuss, but the patient needs to know this. The problems that need to be tackled should be agreed and a plan made. If you can define the problems from the patient's perspective it will help you approach the decision-making process as a team or partnership with the patient.

6. Use time and resources appropriately

Time and resources need to be used appropriately both during the consultation and long term. Inefficient use of time might include being too meticulous or allowing the discussion to go off track. Your knowledge and application of consultation frameworks and skills will support you in delivering more efficient and effective consultations.

7. Establish or maintain a relationship

If you appear disinterested, aloof or judgemental, the patient will retreat.

Smile and demonstrate empathy when needed; always be interested in the patient. The patient needs to trust you and believe in mutual honesty. If you appear disinterested, aloof or judgemental, the patient will retreat. We may hold our own personal values and moral stance, but it is not our place to pass judgement.

A note about empathy – empathy is the capacity to recognise emotions that are being experienced by another person. Be cautious not to confuse this with sympathy and pity.

The Pendleton framework, originally developed for doctors, has been developed over the years by others and is still considered of value today. The approach is appropriate for all healthcare professionals, irrespective of place, circumstance or level of skill.[20]

Case study 3
Lily – revisited

Lily Jenson, aged 75 years, has been recovering in hospital following a hip fracture. Jonathon the pharmacy professional discusses new medicines with Lily.

Read through the following dialogue and think about the seven basic tasks of Pendleton's framework that you should try to achieve in a patient-centred consultation.

Jonathon	Hello Mrs Jenson, I believe you've been prescribed some new medication.
Lily	Yes, that's right. Daft me fell over and broke my hip so now I need to take these tablets on top of all the others.
Jonathon	OK, well I'd just like to ask you a few questions to make sure you know how to take them in the right way. Is that OK?
Lily	Well, I suppose so. I'm not in any rush to go anywhere. There's only me now my Ronald has gone so no-one to go home to.
Jonathon	So, do you know why you've been given the new tablets, alendronate?
Lily	Yes.
Jonathon	Are you sure?
Lily	Yes, I told you I know that... they said my bones are weak. Osteoporosis. And the tablets would work with my calcium tablets to make my bones stronger. Trying to stop me getting anymore fractures. I might be old but I'm not daft!
Jonathon	That's right. You need to take this tablet just once every week and it has to be the same day each week.
Lily	My sister has these. Said they can give you terrible heartburn. I don't really want to take anything dangerous, I'm in enough trouble.
Jonathon	They're not dangerous, as long as you stick to the instructions.
Lily	I'll take them on Saturday.
Jonathon	OK, one tablet every Saturday. Take the tablet half an hour before food with a good glass of water and stay upright after taking it. You can carry on with your calcium tablets as before.
Lily	I can read instructions you know! I'll just need to make sure I keep them at my bedside, sometimes it takes me a while to get up and about with this back pain.
Jonathon	Sorry yes, it's just we like to make sure you know what you're doing with them once you get home.

Lily	How would you know anyway? I might just flush them down the loo.
Jonathon	I'm sure you are far too sensible to do that Mrs Jenson. Now, is there anything else you would like to discuss?
Lily	No, thank you.

Did Jonathon achieve the seven tasks steps suggested by Pendleton? Note down what you feel he did achieve and what he could have done better.

	Achieved yes/no	Describe anything that could have been done better
Discover the reason for attendance		
Consider other problems		
Choose an appropriate action		
Achieve a shared understanding		
Involve the patient in management		
Use time and resources appropriately		
Establish or maintain a relationship		

Turn to the end of the section for suggested answers.

Roger Neighbour – The inner consultation (1987)

The inner consultation is an approach to teaching and learning of consultation skills based on cultivating the healthcare professional's ability to identify and act on certain information-rich moments within the consultation.[22] It describes an intuitive five-stage framework:

- **connecting** with the patient, developing rapport and empathy
- **summarising** reasons for attending; the patient's feelings, concerns and expectations
- **handing over** or sharing with the patient an agreed agenda and management plan which returns some responsibility to the patient
- **safety-netting** or making contingency plans to cover unforeseen or foreseen eventualities after the consultation
- **housekeeping**, recognising that tiredness and stress are among some of the many factors that can distract a healthcare professional, eg, "Am I in good enough shape for the next patient?".

BARD – Ed Warren (2002)[55]

The BARD framework considers the whole of the relationship between a healthcare professional and a patient and the roles that are being enacted. It acknowledges that personality will have considerable influence on the consultation, as will a healthcare professional's previous experience of the patient. It encourages the healthcare professional to use their personality and behaviour positively in the consultation. This framework may be useful for the global thinker as it addresses four key areas to address.

The BARD framework encourages the healthcare professional to use their personality and behaviour positively in the consultation.

Behaviour

Healthcare professionals have choices in how they present themselves in the consultation; sometimes it may be appropriate to inject a mild amount of humour into the consultation when at other times it would be totally inappropriate. The key is to choose the most appropriate behaviour for each individual patient.

Aims

It is important for the aims of a consultation to be clear. However, not all the aims will necessarily need to be achieved in one consultation, and priorities have to be clarified. It is also important to consider that the aims of the patient may not align with those of the healthcare professional.

Room

The consultation will be affected by the environment in which the pharmacy professional is conducting the consultation, as well as the position they take. A patient may be concerned about lack of privacy at the hospital bedside and, although it is inappropriate to sit on a patient's bed, by standing alongside it may make the patient feel as though you are exerting authority.

Dialogue

The way in which you speak with the patient is crucial to the consultation. You should give careful thought to your tone of voice, the language and words you use and how you might confront or challenge a patient's perceptions appropriately without affecting the rapport you have built up. How can you be sure that you are speaking the same language as the patient?

Exercise 11

Watch one of the following videos and consider either the Neighbour or BARD frameworks above and try to identify the key areas within the consultation. Make notes here about the key points from the model that are identified in the video.

Community pharmacist consultation: **https://vimeo.com/78354273**

Hospital pharmacist consultation: **http://youtu.be/YQbPcLEcoik**

Smoking cessation consultation: **www.youtube.com/watch?v=pL3zIl2hS-o**

Practice point

Think about each of the models set out above and those you may have researched yourself.

Bear in the mind that 'no one shoe fits all'. As you develop your skills in the area of consultation delivery you will adapt to using different elements of different models depending on the consultation. As a starting point, choose one model that you feel comfortable with and note three key things that this model will influence you to do differently next time you consult.

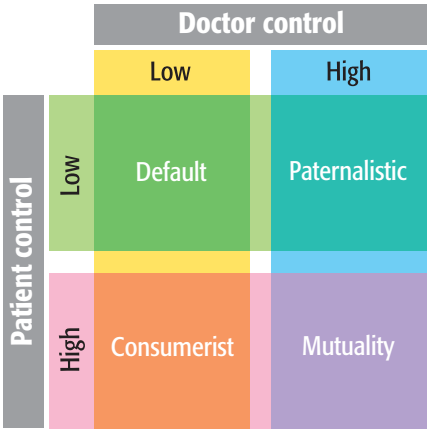
1.

2.

3.

3.3 Consultation styles

The style of the consultation says much about the personality of the healthcare professional, and sometimes the patient. With the medical consultation in mind, a spectrum of styles has been described, ranging from a doctor-dominated consultation, with any contribution from the patient severely curtailed, to a virtual monologue by the patient, with the doctor as a passive listener.[56] As with other concepts linked to consultation skills this would also be applicable in a pharmacy consultation.



Four main styles of consultation have been identified for doctors:

The **default** style is when the doctor is trying to relinquish control, but the patient is unwilling to accept it. The result is an impasse. Decisions are not made easily and both parties can be left frustrated about the outcome of the consultation.

The **paternalistic** style is characterised by a doctor-centred approach, with the doctor retaining all the power. It relies on closed questions to obtain 'yes' or 'no' answers. The doctor will tend to use the medical model and be focused on reaching a diagnosis, rather than on the patient's individual needs. The doctor is the expert and the patient is expected to do what they are told.

The **consumerist** style is patient controlled. The patient knows exactly what they want and forces the doctor into a patient-centred approach.

The **mutuality** style is the most effective. The doctor uses open questions to encourage the patient to talk. Decision making is shared, and although this requires commitment from both parties (patient and doctor) this style should result in truly patient-centred decision making. This is the style we should aim for, when both parties negotiate and share key decisions.

When healthcare professionals other than doctors are in consultation with patients, paternalistic consultations might still result, but it is arguably easier to move towards mutuality, as the patient's expectations of other healthcare professionals can be different to their expectations of doctors. You may be familiar with patients sharing additional information with you in the consultation because they 'didn't want to bother the doctor'.

You may be familiar with patients sharing additional information with you in the consultation because they 'didn't want to bother the doctor'.

Different consultation styles can also be thought of as being located along a continuum that ranges from a product-centred approach at one end to a patient-centred approach where advising, supporting and coaching all play a part within the consultation *(see Figure 4 below)*.[34]

FIGURE 4 Moving towards a patient-centred approach

Healthcare professionals should adapt their style to the specific consultation and the patient facing them; it is likely that several styles will be applied in one discussion. The true skill is applying the most appropriate style at the right time in the consultation.[34]

Advising

By exploring the patient's needs at the beginning of a consultation, you can provide tailored information and advice, making it more likely that the patient will be receptive. A patient may, for example, have a misunderstanding about a medicine or lifestyle issue that could be detrimental to their care and if you are able to frame your response in an appropriate context for the patient you will be able to provide evidence-based information to support the patient that will be well received.

Supporting

There are many ways in which healthcare professionals can support patients within the consultation. You can help a patient to make an informed decision by providing all the facts, such as explaining the benefits of a medicine and the impact of not taking it, and discussing any barriers to adherence that the patient may identify.

Coaching

Coaching helps promote patients as their own problem solvers. If you would like to learn more about a health coaching approach read through Section 5.

Practice point

Have you ever considered your own consultation style? Are you able to adapt your style as the consultation evolves? What will you do differently in your practice to improve this skill?

Summary

Consultations between patients and healthcare professionals will always be at the heart of healthcare and the starting point for truly patient-centred care. Every consultation brings the opportunity for learning and reflection because every encounter with a patient is different. Considering the way in which you structure your consultations and adopting new techniques from consultation models will help your professional development by improving the efficiency of your consultation and ensuring that the patient feels a true partner in discussions about their own health.

Intended outcomes

By the end of this section you should be able to:	Can you?
▶ outline the main consultation models and the theory behind them	☐
▶ describe the different consultation models that are applied to practice today	☐
▶ begin to identify your preferred models and how you can adapt and apply these to develop your own consultation style	☐
▶ describe how you plan to adapt your consultation style to individual patients.	☐

Suggested answers

Case study 3 – Lily *(page 55)*

Did Jonathon achieve the seven tasks steps suggested by Pendleton while talking with Lily?

	Achieved yes/no	Describe anything that could have been done better
Discover the reason for attendance	The reason was clear due to the nature of the consultation.	There was no in-depth history taking. There are a few 'cues' from Lily that suggest she has other issues which she would have valued a discussion about (back pain, situation at home) but these were not addressed.
Consider other problems	No	Her back pain is a risk factor for her mobility and the fact she lives alone. A more holistic view of Lily may have produced a more valuable discussion for both.
Choose an appropriate action	Partly	The correct information was 'given' regarding medication but rapport was not built. A situation of 'telling' rather than 'listening' to the patient evolved.
Achieve a shared understanding	Partly	Lily may not understand the true implications of her fall because this was not discussed. The discussion did not pass responsibility to Lily for her medication.
Involve the patient in management	Partly	Lily made the choice to take her medication on Saturday but there is still a lack of shared understanding throughout.
Use time and resources	Partly	Discussion was probably too short. More appropriate questioning *(see Section 4)* appropriately may have taken only slightly longer but may have led to a more successful outcome for Lily.
Establish or maintain a relationship	Difficult to establish but unlikely	Jonathon made lots of assumptions about Lily and aimed to keep the position of power in the consultation. This does not facilitate a patient-centred approach and can make a patient feel patronised and lead to Lily rejecting Jonathon's advice.[7]

Exercise 10 *(page 51)*

These are just a few of the things we noted.

Calgary-Cambridge guide	Points of good practice to adopt
Initiating the session	Introduction was very clear and the pharmacist immediately begins to build rapport while starting efficiently with appropriate questioning. It would have been helpful to recap and agree the purpose of the consultation.
Gathering information	The pharmacist asked questions throughout while demonstrating listening skills by allowing the patient to answer fully.
Explanation and planning	This comes after the information gathering within the consultation but still stimulates more questioning. The pharmacist allows the patient to take part in the shared decision about how to remember the inhaler, which supports ownership by the patient.
Building rapport throughout	Open body language builds rapport and the pharmacist acknowledges the patient's answers by reflecting them back. The pharmacist takes a non-judgemental approach.
Providing structure	Although the new medicine service interview schedule is used as a tool the pharmacist is flexible in applying this, allowing for a more natural delivery.
Closing the session	The pharmacist clearly indicates the closing of the session. Appropriate questioning is used to make sure the patient has all the information they would like, although an element of 'safety netting' is not entirely clear.

Reflective questions *(page 52)*

Have you ever thought why patients might seek to consult with you? Write down as many possible reasons as you can think of.

Your responses may have included some of those given below.

It is usually because something has changed.

They may be worried.

They are looking for better information.

It is a starting place to tackle their problem.

They want to exclude serious conditions.

Their problem is psychological.

There are changes to their long-term condition.

They are seeking support or reassurance.

They have a new health problem or symptom.

They have an acute condition.

They have a minor ailment.

They have changes in their symptoms.

They have personal problems they don't want to discuss with family or friends.

They are concerned about a problem.

They want to prevent a negative change to their health.

They feel their condition is worsening.

They have been asked to attend, eg, for review or check-up.

They are seeking answers.

They want to find out about test results.

They want a second opinion/referral.

They are worried, anxious or frightened about symptoms.

Their condition is the same and they were expecting it to have improved.

They have come in their role as a carer/parent.

They have come for social reasons, eg, an elderly lonely person.

They have come to have a diagnosis confirmed.

A relative/friend has suggested they should.

They want their symptoms 'cured'.

They have had good advice from you before.

Effective consultation skills

Objectives

On completion of this section you should be able to:

- assess and reflect on your personal consultation skills using the medication-related consultation framework (MRCF)
- describe the key skills needed for effective consultation
- engage in shared decision making in the consultation.

There are many reasons why patients do not adhere to treatment plans or make choices to improve their own health. They may be concerned about side-effects, or they may lack understanding about the medicines they take or the disease(s) they have. The skills needed to conduct an effective consultation are as important as clinical knowledge and are essential for effective patient-centred care. They are not difficult to understand or to recognise, in fact many of them are skills that we use on a day-to-day basis, but refined to a higher level. However, they can be a challenge to achieve in a healthcare setting when you are dealing with all the other complexities of daily work.

The skills needed to conduct an effective consultation are as important as clinical knowledge and are essential for effective patient-centred care.

This section looks at the key consultation skills that you can apply to support an effective patient-centred consultation and builds on the learning from Section 2 on communication and Section 3 on consultation models. We begin with an introduction to the medication-related consultation framework (MRCF), a validated framework based on the Calgary-Cambridge guide *(see Section 3)* that can be used in practice to reflect on and develop your consultation skills.

We then go on to look specifically at consultation skills. The skills are grouped into five broad areas *(linked to the Calgary-Cambridge guide discussed in Section 3)*.

Reflective questions

Thinking about your most recent consultation, answer the following questions. You can return to these questions at the end of this section to reflect on how your learning may alter your responses.

How confident are you that you...

...establish good rapport with the patient at the start of the consultation and throughout?

1 2 3 4 5 6 7 8 9 10

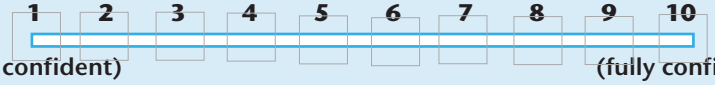
(not confident) (fully confident)

...use open questions appropriately to gain information from the patient?

1 2 3 4 5 6 7 8 9 10

(not confident) (fully confident)

...involve the patient fully in agreeing an action plan and moving forward?



(not confident) (fully confident)

Conducting more effective consultations for patients also brings benefits to you personally. Consider what these might be and how you could continue to improve your skills. Perhaps you are already implementing a patient-centred approach and just need to improve in one or two specific areas?

4.1 The medication-related consultation framework (MRCF)

The medication-related consultation framework is a validated framework that relates to a pharmacy consultation and is based on the structure of the Calgary-Cambridge guide.

The medication-related consultation framework (MRCF) is a validated framework[32] that relates to a pharmacy consultation and is based on the structure of the Calgary-Cambridge guide *(see Section 3)*. It also incorporates relevant elements of other consultation models. The framework places medicines at the centre of the consultation by including drug history taking, but it can easily be adapted for other pharmacy consultations. You can use the framework to complete a self-assessment of your consultation skills and consider the structure of your consultation.

Practice point

Access the following link to watch a short presentation which introduces the MRCF and gives further information on how you can apply it to your practice: www.youtube.com/embed/ixeh3y9JV8E?rel=0

Exercise 12

How do I know how effective my consultation skills are now?

The next time you consult with a patient take time to reflect on your skills and behaviours. Work through the MRCF and highlight the key areas in which you did well and the areas in which you would like to develop. If you are a pharmacy technician you may wish to meet with the pharmacist to discuss how you can use MRCF together as a team to reflect on your practice.

If your work focuses more on public health interventions we have included a link to another useful assessment tool for *Making every contact count*.

We have included a copy of the MRCF here *(see Figure 5 overleaf)* and it can also be accessed on the *Consultation skills for pharmacy practice* website at: www.consultationskillsforpharmacy.com

FIGURE 5 The medication-related consultation framework (MRCF) A reflective tool to support the development of consultation skills for pharmacy practitioners

Practitioner's name:
Name of reviewer (if applicable, eg, peer or mentor):
Date of consultation with patient:
Date of review / self-assessment completed:

How well did you undertake the following activities when consulting with the patient?

A. INTRODUCTION – Was I fully able to build a therapeutic relationship with the patient? Did I…?		**Yes / No**	**Comments / reflections**
1.	Introduce myself		
2.	Confirm the patient's identity		
3.	Discuss the purpose and structure of the consultation		
4.	Invite the patient to discuss medication or health-related issue		
5.	Negotiate a shared agenda		
Learning needs (ie, areas for improvement / action points):			

B. DATA COLLECTION AND PROBLEM IDENTIFICATION – Was I fully able to identify the patient's pharmaceutical needs? Did I…?		**Yes / No**	**Comments / reflections**
1.	Document a full medication history		
2.	Assess whether the patient understands the rationale for prescribed treatment		
3.	Elicit the patient's (lay) understanding of his/her illness		

		Yes / No	Comments / reflections
4.	Elicit concerns about treatment		
5.	Explore the patient's social history		
6.	Ask how often the patient misses dose(s) of treatment (ie, assess patient adherence)		
7.	Establish reasons for missed dose(s), if any (ie, intentional or unintentional non-adherence)		
8.	Identify and prioritise the patient's pharmaceutical problems (summarising)		
Learning needs (ie, areas for improvement / action points):			

C. ACTIONS AND SOLUTIONS – Was I fully able to establish an acceptable management plan with the patient? Did I…?		Yes / No	Comments / reflections
1.	Relate information to the patient's illness and treatment beliefs (risk-benefit discussion)		
2.	Involve the patient in designing a management plan		
3.	Give advice on how and when to take medication, length of treatment and negotiate a follow up		
4.	Check the patient's ability to follow the plan (are there any problems?)		
5.	Check the patient's understanding		
6.	Refer appropriately to other healthcare professional(s)		
Learning needs (ie, areas for improvement / action points):			

D. CLOSURE – Was I fully able to negotiate safety-netting strategies with the patient? Did I…?		Yes / No	Comments / reflections
1.	Explain what to do if the patient has difficulties in following the plan and who to contact		
2.	Provide a further appointment or contact point		
3.	Offer the opportunity to ask further questions		

Learning needs (ie, areas for improvement / action points):

E. CONSULTATION BEHAVIOURS – Did I fully demonstrate the following consultation behaviours?		Yes / No	Comments / reflections
1.	Listen actively and allow the patient to complete statements		
2.	Use open and closed questions appropriately		
3.	Demonstrate empathy and support the patient		
4.	Avoid or explain jargon		
5.	Accept the patient (ie, show respect, not be judgemental or patronising)		
6.	Adopt a structured and logical approach to the consultation		
7.	Summarise information at appropriate time points		
8.	Manage my time effectively (work well within the time available)		
9.	Keep the interview 'on track' or regain 'control' when necessary		

Learning needs (ie, areas for improvement / action points):

OVERALL IMPRESSION

Overall, my ability to consult with the patient meant that their pharmaceutical needs were:

Not addressed ☐ Partially addressed ☐ Mostly addressed ☐ Fully addressed ☐

Main strengths:

Main areas of weakness / further improvement:

Now prioritise your key learning needs and design an action plan for further development of specific consultation skills.
Please describe WHAT you need to develop further and HOW you plan to achieve this.

Learning need identified	Action plan	Timescale
1.		
2.		
3.		
4.		

Once you have completed the learning associated with the above, don't forget to transfer each of these into a CPD record. This learning serves as an excellent example of CPD starting at reflection.

Patient feedback
You may wish to obtain further feedback from the patient and use this to inform the development of your consultation skills.

Source:Abdel TR *et al*, 2011[32]

How did you get on? Have you identified specific areas where you would like to develop further? Make a note of them below.

Practice point

To see an example of how others approach the completion of this reflective tool visit the self-assessment area of the *Consultation skills for pharmacy practice* website at:
www.consultationskillsforpharmacy.com

Access the following link to see some example videos of a consultation that applies the MRCF:
http://jpbsoutheast.org/assessment-tools/medication-related-consultation-framework-mrcf/

Another useful tool for public health interventions is the individual and team assessment tool for *Making every contact count*. You can access the link to the tool in the self-assessment area of the website:
www.consultationskillsforpharmacy.com

4.2 Skills for effective consultation

Here we look at the key consultation skills in relation to the Calgary-Cambridge guide. As you work through the skills you will see we have highlighted some tips for your practice and flagged up some of the possible barriers that may prevent you from performing these skills effectively. We have also included suggested phrases and questions that may support you at certain points.

Initiating the session

Research has shown that the impression you give the patient has a significant impact on their view of you and their readiness to share sensitive health concerns. So, when you welcome the patient it is important that you create the right environment. Be aware of your personal appearance; a professional approach is important. Patients want to speak to someone who is friendly, confident and competent, in order to trust you with their health and personal information.

Patients want to speak to someone who is friendly, confident and competent, in order to trust you with their health and personal information.

Preparation

Getting the start of the consultation right is a key to success. The consultation may be one of many in your working day, but for the patient it may be the most important part of their day.

- Prepare yourself – make sure you have completed any outstanding tasks and place yourself in the right frame of mind for the consultation.
- Prepare the consultation area. Ensure it promotes a professional and private environment. If you are at the hospital bedside it is just as important to respect the patient's privacy. It is also important to consider that patients in hospital may feel more vulnerable if they are confined to their bed.
- Prepare your information – are there any patient medication records or other history you require before the start of the consultation?

Establishing initial rapport

Welcoming the patient is your opportunity to make a vital first impression and to start to build a relationship.

Welcoming the patient is your opportunity to make a vital first impression and to start to build a relationship.

- Greet the patient with a simple "Hello". It may not be appropriate to say "Good morning" to someone who is feeling unwell.
- Introduce yourself; give your name, and let the patient know who you are (for example, "Hello, my name is Georgina and I am the pharmacy technician responsible for running the stop smoking service) – giving your first name is appropriate in most circumstances.
- Make sure you know the patient's name and ask how they prefer to be addressed, for example, "Hello Mrs Gill", or "May I call you Jayne?" This may not be appropriate in brief consultations, such as over-the-counter sales in community pharmacy.
- Demonstrate open body language and appropriate eye contact. Leaning forward slightly shows that you are interested in what is being said and that you want to provide encouragement, comfort and trust from the start.
- Establish that the patient can hear and understand you; identify any language barriers. Check whether English is their first language.
- Attend to the patient's physical comfort and obtain consent when appropriate.

Establishing the reason for the consultation

- Identify the reason for the consultation. This may be pre-determined in a pharmacy situation (for example, a smoking cessation consultation) but it is still important to explain the purpose clearly and then ask the patient if there is anything else they would like to discuss during the consultation. If the patient has a different agenda to that of the healthcare professional this can then be incorporated. If the patient has asked to see you then using an open question will establish the reason more quickly, for example: "What would you like to talk about today?" or "How can I help you?"
- Listen – allow the patient to talk. This may seem time consuming but the patient will be satisfied that they have been able to communicate all their issues and this will ultimately free up more time within the consultation.
- Demonstrate respect and interest.

- Recap the key points to check you have the full picture, for example, "So, you are struggling to take your tablets at the same time each day. Is there anything else you'd like to discuss today?"
- Set the agreed agenda.

Tips to help your practice

- Acknowledge that you are only human and you will be in a better frame of mind to consult with patients on some days more than others. However you are feeling, remember you have an ethical responsibility to deliver an effective consultation each time "Treat each patient as if they were your own grandmother!".
- Review the patient's records and check any relevant information before you see the patient, so that you can offer your full and undivided attention once you start the consultation.

Barriers inhibiting your practice

- Environment. A private and professional area where you are unlikely to be interrupted will support your consultation, whereas an inappropriate environment will have a negative impact on your welcome and initial rapport building.
- Cognition. You need to identify whether the patient has any cognitive barriers. These could include language, hearing, sight, learning difficulties and memory problems.
- Language. Generally avoid using medical jargon, such as 'chronic', 'acute'; use 'length of time' and 'severe' instead. However, you may have a knowledgeable patient who prefers to use medical terminology, in which case you should pitch the level of the language to reflect that of the patient, to avoid patronising them.
- Time. You may be having a particularly busy day that has put you behind and is making you feel stressed. If the person has been kept waiting, apologise and provide a brief explanation. Practise the application of skills and models to make your consultations more time efficient.
- You. Mental distractions or not being in the right frame of mind will affect your ability to carry out a successful consultation. How can you distance yourself from them?

Gathering information and eliciting the patient's perspective

Gathering the essential information from a patient is vital to get the most from the consultation, for problem solving and establishing a suitable action plan together. The key skills required are questioning and active listening.

Before you can offer any advice, treatment or information you need to identify the patient's needs. The most effective and direct way to do this is to ask questions. If you can recognise the quality, purpose and types of question and develop the ability to use them appropriately, then you are well on your way to communicating effectively in a consultation setting.

Before you can offer any advice, treatment or information you need to identify the patient's needs.

However, there is a need for balance, because if all the questions are asked by the healthcare professional and none by the patient, this might suggest that the healthcare professional is relying too heavily on questioning.[19, 57, 58] Think back to the video clip you looked at in Exercise 10 *(Section 3)*; what is the balance of questioning between the healthcare professional and the patient? Commonly it is the healthcare professional who asks the majority of questions to gain the information they need. However, the patient should also be given every opportunity to ask questions throughout the consultation. Introducing a pause or a phrase such as, "Is there anything you would like to ask me at this point?" gives you and the patient time to reflect and may stimulate further questions. This technique can give you the opportunity to provide further information if there's something the patient hasn't understood, and gives the patient a chance to reveal something that has been troubling them that has not been raised so far in the discussions.

Questioning

Try not to overwhelm the patient with questions; only ask one question at a time and use different types of questions at different stages of the consultation.

Effective questioning is a key skill; asking the right questions at the right time in a consultation can help facilitate the best outcome for you and the patient. You are more likely to obtain the information you need if you allow the patient to 'tell their story'. Try not to overwhelm the patient with questions; only ask one question at a time and use different types of questions at different stages of the consultation.

At the start of the consultation your questioning should focus on finding out why the patient has presented now, if this is not predetermined. If it is predetermined (for example, a medicines use review), then the patient should be given the opportunity to mention any other issues they would like to address. This informs a mutually agreed agenda. The patient may overwhelm you with questions. If this happens then ask the patient which question is the most important and tackle one question at a time.

We have summarised different types of questions below which you could use within the consultation, together with suggestions about how and when to use them.

i) Open questions

Open questions are broad in nature and need more than a one or two word answer. This type of question does not suggest a 'right' answer and allows the patient to give an unlimited range of responses, for example:

"**What** would you like to discuss today?"

"**Why** have you asked to see me today?"

"**How** are you getting on with your new medicine?"

"**How** can I help you today?"

"**When** did you start to feel sickly?"

"**Where** do you feel the pain mostly?"

They can also be used effectively as a way to broach a subject or unexplored symptom. Using open questions conveys empathy and helps to show that you are interested in the ideas, concerns and expectations of the patient.

ii) Questions with options

If the information you need cannot be obtained using open questions, then you

might be able to give the patient some options. If a female patient complains of 'stomach pain' and it is difficult to tell what she means, even after being given a chance to say more, you could ask, "Is it linked with eating, going to the toilet or with your periods?". This technique must be used with caution as there is a danger that you lead the patient's thinking. The patient may feel compelled to choose one of your options when it is in fact none of them. Using an open question, such as "How are your bowels working?" is more likely to give you a true picture of what is happening.

Using an open question is more likely to give you a true picture of what is happening.

iii) Leading questions

These are used to encourage the patient to give the answer that the healthcare professional expects and should be avoided if at all possible. They tend to lead the patient down the wrong path and it can be hard to get them back from there. An example would be, a patient presents with stomach pain; you know he is a smoker and overweight so you start asking questions that would help you to decide if the pain is of gastric origin. You ask, "Is it worse after you've eaten?". The patient is not sure of the answer, not having thought about this, but answers "Yes" because he remembers an evening meal when he ate too much and his pain was bad. If you had asked an open question, such as, "Have you noticed that anything you eat makes your pain worse?" and he then answers "fish and chips" you are on much firmer ground.

However, you might want to use this type of question when you are trying to establish a rapport with a patient, or to get a more constructive answer.

iv) Probing questions

Probing questions are used to dig a little deeper and gain a better understanding, for example, "You said you feel pain when getting out of bed – tell me more about that?".

Practice tool

A common acronym for this is TED, a tool which outlines three ways to start a question:

TED – Tell, Explain, Describe

T = Tell
"Tell me more about the feeling you get when you take the blood pressure tablet."

E = Explain
"Explain to me why you're worried about taking this new tablet."

D = Describe
"You say you feel out of sorts after taking your tablet, describe that feeling to me."

You should be mindful of your tone of voice when using these questions; if you use the wrong tone they may come across as authoritative.

Closed questions have their place, especially for winding down a discussion and finalising options.

v) Closed questions

Closed questions are more likely to provide only "Yes" or "No" or one word answers, for example, "Does it happen every day?", "What time did you take your last tablet?".

They can be used to clarify key facts, but there are obviously some dangers in using them. Information not covered by the question will be missed, so they often add to unnecessary uncertainty in the person answering and discussions rarely flow. A common example is: "You don't smoke do you?".

However, they do have their place, especially for winding down a discussion and finalising options. They are also easy for patients to answer and can help to elicit a response from patients who are not comfortable talking at length.

Tips to help your practice

- The majority of questions should be open, giving the patient the opportunity to give any answer.
- It is important to listen to the patient's answers and to avoid interruption.
- If a patient says something that you want to come back to later, make a note of it and return to it before the patient leaves, rather than breaking their train of thought. Most importantly, don't disregard it. The patient must feel their contributions are relevant in order to feel valued.

Barriers inhibiting your practice

- Try to avoid inappropriate leading questions as these can lead to a poor relationship with the patient, for example, "Am I right in thinking that you never use your brown inhaler?" Whether the patient says "Yes" or "No", they will either be disagreeing with you or admitting to never using the inhaler.

Exercise 13

Revisit the video link from Section 3 *(Exercise 10)*. As you listen, make a note of examples of the different types of questions the pharmacist uses within the consultation. Would you have done anything differently? Make a note of any of the questions you would reword and the words you would have chosen.
www.youtube.com/watch?v=XDTtz-Jp_cM

Open

Question with options

Leading

Probing

Closed

Turn to the end of the section for suggested answers.

Active listening

Active listening means that you listen fully to what the patient has to say, throughout the consultation, rather than thinking about when you can next speak. Active listening involves both verbal and non-verbal behaviour and is a two-way process. It involves you listening and observing these behaviours while communicating your own. Remember, the patient is also an expert in the consultation, an expert in their own condition and their life. If you haven't listened well to a patient you won't be able to respond appropriately or effectively and a patient-centred approach will not be achieved. Applying active listening skills is a crucial skill for the consultation. It helps you hear the underlying message from a patient, not just the words that are spoken and involves reflecting and responding to ensure information has been interpreted correctly. Section 2 looks at communication skills and contains useful content on basic listening skills. If you have not yet visited Section 2 turn back to page 27 now, before moving on to learn more about reflecting and responding to the patient.

Paraphrasing, reflecting and responding are an important part of active listening and are often missed. Paraphrasing what the patient has said to you and repeating it back to them shows that you have listened and understood. Paraphrasing and reflection help to clarify any ambiguity, summarising a specific point in the consultation, repeating what has been said, stating any impressions you may have and reaching an understanding. This process can help prevent misunderstandings during the consultation and avoid false impressions being formed.

Paraphrasing and reflection can help prevent misunderstandings during the consultation and avoid false impressions being formed.

There are different ways of achieving this:

Paraphrasing: Restating to the patient the information they have just given, using similar words and phrases, but not necessarily in the same order, ie, putting it in your own words. This helps demonstrate to the patient that you are listening and understand their point. It also helps to ensure your interpretation of the information is correct and gives the patient an opportunity to hear what they have just said and reflect on it.

Summarising: By concisely reiterating the main points of the consultation you can highlight the key agenda points and form an agreement with the patient, for example, "So you haven't had a cigarette now for five days, you've been doing OK but now feel desperate to smoke and have been very short tempered at home."

Clarifying: Aim to clarify any confusing messages immediately, for example, "I'm not quite sure I understand what you mean by 'feeling at odds', could you explain that a little more?".

Reflection: Reflection involves processing and reiterating the information in your own words while mirroring the feelings a patient may be demonstrating. This requires empathy and withholding judgement and although it can be a difficult skill to demonstrate it will help you to build rapport. When you sense doubts or concerns from a patient this is reflected back, for example, "You seem worried about the side-effects of the new tablet. You haven't started taking them yet but want to discuss the possible side-effects a little more".

Tips to help your practice

When reflecting back feelings or emotions, use less emotive words, for example, 'like' or 'admire' rather than 'love'.

Barriers inhibiting your practice

- If you haven't listened well, you can't respond properly.
- Avoid interpreting rather than paraphrasing what has been said.
- Make sure you do not reflect back inaccurate information.
- Make sure you do not 'overuse' reflecting and responding. Use these skills at appropriate times when you wish to reiterate a key point.

Understanding the patient's perspective

Patients form their own perspective of their medicines and conditions. These may not always be 'evidence based' but should be respected. Patients may provide verbal and non-verbal cues that can give an indication of their thoughts or feelings about an issue which they may not feel ready or confident to raise at that point. There are often things happening in the background in a patient's life that influence these thoughts and ideas which may not immediately come to light without appropriate questioning and observation of cues. You can read more about the patient's perspective in Section 1.

i) Verbal cues

A patient may provide clues to the way they are feeling by the way they speak. For instance, the use of words such as 'worried', 'frightened' or 'upset' should alert you to their real feelings. A change in tone of voice, such as using a soft, low tone, may indicate that they are concerned about sharing information, whereas using a louder tone may indicate defensiveness or anger. Hesitation may indicate that they would like to say more but are reluctant to share. If you have established rapport then effective questioning at these points may draw out hidden information. Verbal cues may also be extremely subtle. Think of Lily in the case study we have been following *(see pages 35 and 55)*. During the consultation she mentions being alone at home. For some patients this may be something they can cope with, but for others it could be a signal that they are not managing at home and would like help. You may feel that you do not have enough time to pick up on these potential problems but they could be the root cause of other problems, such as low adherence.

Asking questions such as, "I'm sorry to hear that, how are you coping at home?" may unearth other problems.

ii) Non-verbal cues

Understanding body language will help you understand how patients reflect different emotions using body language.

Non-verbal cues may be more difficult to identify. Understanding body language will help you understand how patients reflect different emotions using body language. We look at the fundamentals of body language in Section 2. Apply this knowledge to identify points in the consultation where a patient may feel uncomfortable or in disagreement with something you have said. *(It may be helpful to refresh your knowledge at this point by looking back at page 24.)*

A patient's perceptions may be deep seated; the experience family members or friends may have had of certain medicines may lead to certain beliefs, for example, "My sister was prescribed warfarin and died two weeks later". The patient may

then associate the death of their sister with warfarin, although it was not the cause. Understandably this may make them afraid to take it themselves. The patient may not always offer information about their concerns or beliefs as they may feel they will be brushed aside or misunderstood. Building rapport and using appropriate questioning techniques are key to eliciting this information from a patient.

The easiest way to understand the patient's perspective is to ask them.

Practice tool

Using the ICE mnemonic *(see page 50 for a reminder)* here are some examples of questions that may help you elicit information from a patient:

I Ideas
"Why do you think this has happened?"
'Have you any ideas about it yourself?"

C Concerns
"What has been going through your mind?"
"Is there anything in particular that is worrying you?"

E Expectations
"What do you think might be the best approach?"

It is also important to consider a patient's feelings about a problem, not just the physical effect that a problem may have on them. An example is, a patient may come into the consultation room and tell you they have been diagnosed with cancer. Rather than just saying "I'm sorry" and moving on to the purpose of the consultation, by using a phrase like, "I'm really sorry, how do you feel about that?" followed by, "What effect is this having on your family?" will help build the relationship, make the patient feel valued and show them that you understand their circumstances fully. Gathering background information in this way is helpful for the healthcare professional as it builds a true picture of the patient's perspective.

It is important to consider a patient's feelings about a problem, not just the physical effect that a problem may have on them.

Tips to help your practice

- You may not always get the answer to a question you expect or would like. Some patients may share very personal information, others may tell you about actions you may not agree with or fully understand. Whatever their reply, this is an indication that you have started to build a relationship with the patient. Remain professional at all times; avoid showing any obvious signs of disagreement by paying attention to your facial expression, body language and most importantly tone of voice. As a healthcare professional your ultimate aim should be to support the patient and not to judge.
- Remember the mnemonic ICE.

Barriers inhibiting your practice

- Thinking that your perspective is more important or more valid than that of the patient will present a barrier to conducting an effective consultation.

Practice point

Apply ICE to your next consultation. If you have not used this approach before it may or may not initially feel strange or uncomfortable. What benefits did it bring to your consultation? Will you apply this approach in future?

Explanation and planning

The patient's perception of what is wrong needs to be explored, including any previous experience of the problem.

Once problems have been identified and summarised then establish what advice or information might support the patient in moving forward with a plan. Use a systematic approach and language that the patient will understand and, most importantly, find out what the patient already knows or 'perceives'. It is important to clarify any uncertainties and give information and advice in a simple, straightforward manner. The patient's perception of what is wrong needs to be explored, including any previous experience of the problem. Find out how much information the patient requires and check that any information about their treatment or lifestyle has been understood.

The easiest way to do this is to get the patient to repeat the information back to you, for example:

"So, we've chatted about the problem you were having in remembering to take your blood pressure tablet and agreed a solution. Before we move on, can you tell me what your plan is to remind you to take them?"

A word of warning – by this stage you should have an idea of your patient's prior knowledge and involvement in their own health. If this part of the consultation isn't addressed in the right way a patient may feel you are checking up on them and rapport may be broken.

Tips to help your practice

- Provide important information first.
- 'Chunk and check'. Provide information in manageable chunks, check for understanding and use the patient's response as a guide to how to proceed.
- Use visual methods of conveying information, such as leaflets and diagrams.
- Discuss the options and the potential outcomes of these options. *(You will read more about this in Section 5 – Health coaching in patient consultations).*
- Involve the patient in all decisions about their healthcare and provide them with the knowledge and confidence to take responsibility. Shared decision making is a key part of the explanation and planning process. This is covered more widely in Section 4.3.

Closing the session

Effective closure of a consultation is needed as a safety net for both parties. If things do not go to plan the patient needs clear direction about what to do next and what to do if things go wrong, as well as where to go for further advice.

You should be aiming to establish what is expected of the patient, the next steps, in terms of any treatment plans, or what the patient should do if there are further problems. This can be accompanied by subtle visual clues, such as changing your position, leaning back or putting your notes together.

Tips to help your practice

- Discuss a safety net. Things may not go to plan once a patient goes home. Explain where they can get further support should they need it.
- Ask the patient to tell you the most important things they will take from the consultation, for example, "Well, we seem to have covered everything, so before you/I leave, let's just recap. What are the main things you are going to do regarding your medicines once you get home?"
- Consider if referral to another healthcare professional or other support is needed at this point.
- Effective closing should also include appropriate visual clues to show that it is time for the consultation to end.

In Section 3 we explained that, in addition to these five key steps, there are two key processes that should be considered throughout a consultation:

- structuring the consultation
- building relationships.

We will look now at these processes in a little more detail.

Providing structure

Structuring the consultation is important in managing the time effectively in the consultation and ensuring key points are covered. However, as discussions evolve and patients' problems and concerns are unearthed you should be prepared to be flexible. Applying a rigid approach is not patient centred and may mean that important information is not considered. Applying the consultation models set out in Section 3 will help you to be responsive to the patient's needs in a consultation.

Applying a rigid approach is not patient centred and may mean that important information is not considered.

Building the relationship

Building rapport

In addition to building rapport at the start of the consultation it is important to consider elements of relationship building throughout the consultation.

Body language can betray you! Demonstrate open body language.

Smile. If a patient has already implied they are upset or concerned it may not be appropriate to smile, but in general a smile is one of the most important factors in building rapport.

Eye contact. Be aware of how you make eye contact; do not stare at a patient or avoid their gaze. Eye contact is usually made by the listener, while the eyes of the person speaking tend to move around. The level of eye contact should reflect that of the patient. Be aware of cultural differences.

Make sure your arms and legs are uncrossed. Folded arms may look defensive or may imply you are disinterested. Subtle use of your arms and hands to animate a conversation is helpful, provided you are not overzealous.

Leaning forward slightly when the patient is providing key points of information demonstrates that you are listening and are interested.

Consider your tone of voice and the rate and volume at which you speak and adapt this to the nature of the consultation.

Demonstrating empathy

Empathy in healthcare simply means identifying with and understanding the patient's situation and feelings, while taking into account their vulnerability.

- Empathy in healthcare simply means identifying with and understanding the patient's situation and feelings, while taking into account their vulnerability. This should be acknowledged appropriately, for example: "I can see this is difficult for you to discuss"; "It must be difficult for you with no-one at home to help you with these new medicines".

  A word of caution – do not confuse empathy with sympathy. Avoid saying to a patient "I know how you feel"; this may provoke a "How do you know how I feel?" response.

- Provide support by expressing concern, understanding and willingness to help.
- Deal sensitively with embarrassing and disturbing topics.

Demonstrating appropriate competence and confidence

- Inform the patient that you will need to make some notes at certain points, for example: "That's a really important point, I'm just going to make a note of it".

  Making notes provides an opportunity for a pause within the consultation, allowing both you and the patient time to reflect.

- Answer patients' questions honestly and openly in a manner that they will understand. If you do not have the answer to hand then explain that you will take the appropriate steps to find it and get back to the patient later.

Involving the patient

- Agree a shared agenda: involve the patient from the start of the consultation. Explain the purpose and structure of the consultation (if pre-defined) before inviting them to offer their agenda.
- Encourage the patient's involvement throughout, for example: "What I'm thinking now is that you may be getting some mild side-effects from the new medicine…" or "Based on what you've just told me you seem in a good place to start your stop smoking programme".
- Accept that the patient may have different views and ideas to you. Avoid being judgemental at all costs.
- Explain your rationale. Some questions may be obvious to us as healthcare professionals, but to the patient they may trigger concern, for example, "I'm asking you this question because..."
- Engage in shared decisions, for example, "How do you feel about those two options?".

4.3 Shared decision making

'No decision about me, without me'.[3]

This statement from the government document *Equity and excellence: liberating the NHS* has been promoted widely within healthcare and has since been articulated as 'nothing about me, without me'. The concept affirms a culture change that will enable patient involvement to become everyday practice in the NHS.

To deliver a truly patient-centred consultation both healthcare professional and patient should enter into shared decision making. The personal values of individual patients have a huge part to play in any health-related decision. A shared decision-making process takes into account these values when deciding on the plan of action. Engaging the patient in the decision-making process means they are much more likely to feel ownership for the decision and take more responsibility for their own healthcare.

To deliver a truly patient-centred consultation both healthcare professional and patient should enter into shared decision making.

Evidence shows that by providing patients with more opportunities to make informed choices and be an active participant in their healthcare, there is a greater potential to improve health outcomes.[59] But how easy is it for healthcare professionals to 'let go' and encourage patients to be involved in decision making?

Reflective questions

Consider this scenario. You are speaking with a patient who has been prescribed methotrexate for rheumatoid arthritis. You are discussing the medicine at length, including the risks and benefits of treatment and evidence base to support this. You feel the patient is fully informed. The patient tells you that they have decided not to take the methotrexate. How do you feel about this?

	True	False
1. I have not done my job in the right way.	☐	☐
2. I disagree with the patient's decision.	☐	☐
3. I feel uncomfortable with this and want to continue to persuade the patient to take the methotrexate.	☐	☐
4. I need to engage the prescriber to see if they can change the patient's mind.	☐	☐

How did you feel completing the reflective question above?

It is important to remember that within every consultation there are two experts, the patient and the healthcare professional.

Sharing expertise

Healthcare professional	Patient
Diagnosis	Their own experience
Long-term condition	Social circumstances
Public health priorities	Attitudes and beliefs
Treatment/management options	Values
Outcome probabilities	Preferences

'Shared decision-making is a process in which clinicians and patients work together to clarify treatment, management or self-management support goals, sharing information about options and preferred outcomes with the aim of reaching mutual agreement on the best course of action.'[59]

The ultimate decision about whether to use a medicine or not lies with the patient, even if the healthcare professional does not agree with the decision.[23] However, if evidence-based information regarding all the options, the benefits versus risks and the potential outcomes of those options is shared with the patient, then they are able to make an informed decision.

It is also important to consider whether the patient has the capacity to make an informed decision. Guidance on assessing capacity and information about consent can be found in the General Pharmaceutical Council document *Guidance on consent*.[60]

Achieving shared decision making

Shared decision making involves exploring the patient's perceptions and knowledge and may require an element of negotiation.

Shared decision making involves exploring the patient's perceptions and knowledge and may require an element of negotiation. To negotiate well you need to be aware of the balance of power in the encounter. In most negotiations, one party will usually drive the decision-making process and have the upper hand, ie, the most power. In healthcare, this is usually the healthcare professional. Confidence and power need to be evenly matched for successful negotiations, so you need to be prepared to adjust your level to match that of your patient. If possible you should plan beforehand what you want to achieve and consider what might be involved.

Specific issues to consider include:

- what is the evidence base, what would be the outcome of following the patient's pathway?
- ask patients what information they would like and prioritise their information needs
- think about providing written or pictorial information about the medicine (as appropriate).

Once the negotiation is complete, formal agreement is needed. This involves ensuring there is informed consent, that the patient understands what they are agreeing to; that the decisions made are ethical and appropriate for the patient and they are achievable. Both parties need to be in agreement about the way forward. What will the patient and the healthcare professional do, or not do? The

negotiation may result in a difference of opinion, and this difference should then be acknowledged and recognised. It may be an agreement to differ! What are the outcomes that will be monitored by the patient and the healthcare professional?

Supporting patients by providing them with evidence-based information is critical to the process. In addition to this, patient decision aids should be considered if there is more than one feasible option and there should be a system in place for recording and implementing patients' choices. Patients should be encouraged to contribute their thoughts about the information and options provided and ask questions.

Some healthcare professionals use decision aids in their consultations to support the process. These are based on research evidence and are designed to help patients consider what the different options available might mean for them. They are available in a variety of formats, ranging from simple leaflets to DVDs and pathway tools which patients can 'walk through' to get to an end result. You can find a range of resources developed by NHS prescribing experts relating to medicines use on Dr Chris Cates' EBM website.[61] These help describe the risks versus benefits of particular medicines to patients using 'smiley faces' in different colours. The different colours represent the different outcomes, based on the evidence.

Examples of patient decision aids

Note: The clinical information in the first two examples below has not been updated as they come from an archived website, but we have included them here as useful examples of the concept.

- Atrial fibrillation decision aid
  www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797
- Liquid modification decision aid
  www.nice.org.uk/guidance/cg181/resources/patient-decision-aid-pdf-243780159
- Inhalers for asthma decision aid
  www.nice.org.uk/guidance/ng80/resources/inhalers-for-asthma-patient-decision-aid-pdf-6727144573

Decision aids provide patients with more knowledge, a clearer understanding of risk and make them more at ease with the decisions they make.[62] They differ from general information leaflets as they do not tell the patient what to do, they set out the facts for them to consider so that they can make a decision based on these facts. It is important to explain to patients how to use these aids; their use can also be enhanced using a health coaching approach. You will find more information relating to health coaching in Section 5.

Decision aids provide patients with more knowledge, a clearer understanding of risk and make them more at ease with the decisions they make.

The competencies listed for shared decision making include a number of different skills, some of which we have already looked at.[23, 63] These include:

Building a partnership[63]			
Listening Applying of active listening skills		**Communicating** Delivering information in a way which is meaningful to the patient	
Managing a shared consultation			
Context Agreeing the purpose of the consultation with patient		**Knowledge** Applying up-to-date evidence-based information and advice	
Sharing a decision			
Understanding Each patient is an individual	**Exploring** The patient's own ideas, concerns and beliefs	**Deciding** Agreeing a plan	**Monitoring** Agreeing of what happens next

Some patients are highly knowledgeable about their condition and treatment and may wish to take responsibility for decisions without much input from a healthcare professional.

Negotiating a mutually acceptable plan is the goal (even though this may not always be your preferred plan of action). There may be situations when shared decision making is not appropriate. Some patients are highly knowledgeable about their condition and treatment and may wish to take responsibility for decisions without much input from a healthcare professional. This should be respected. Others may feel completely lost if the decision involves a complex issue they know nothing about and they may rely on the healthcare professional to facilitate the decision. There are also specific patient groups that warrant extra consideration with respect to shared decision making, such as people with learning difficulties *(see Section 1.8 for further information)*. By following a patient-centred approach and asking the right questions you will be able to establish the patient's needs in terms of information and guidance.

Barriers inhibiting your practice

If the patient feels they have not been involved in the decision making and planning process they may feel disempowered and may not agree to suggestions that are made, or may regret a decision they make for themselves. This may mean, for example, that despite making an informed decision and agreeing during the consultation to follow a certain approach, they may not take their medicines as agreed once they have left.

Case study 3
Lily – revisited

We first met Lily in Section 2. Lily Jenson, aged 75 years, has been recovering in hospital following a hip fracture. Jonathon, the pharmacy professional, discusses new medication with Lily. This time consider the key consultation skills which Jonathon demonstrates throughout the consultation and make a note of them in the box below.

Jonathon	Hello Mrs Jenson, I believe you've been prescribed some new medication.
Lily	Yes, that's right. Daft me fell over and broke my hip so now I need to take these tablets on top of all the others.
Jonathon	OK, well I'd just like to ask you a few questions to make sure you know how to take them in the right way. Is that OK?
Lily	Well, I suppose so. I'm not in any rush to go anywhere. There's only me now my Ronald has gone so no-one to go home to.
Jonathon	So, do you know why you've been given the new tablets, Alendronate?
Lily	Yes.
Jonathon	Are you sure?
Lily	Yes, I told you I know that... they said my bones are weak. Osteoporosis. And the tablets would work with my calcium tablets to make my bones stronger. Trying to stop me getting anymore fractures. I might be old but I'm not daft!
Jonathon	That's right. You need to take this tablet just once every week, and it has to be the same day each week.
Lily	My sister has these. Said they can give you terrible heartburn. I don't really want to take anything dangerous, I'm in enough trouble.
Jonathon	They're not dangerous, as long as you stick to the instructions.
Lily	I'll take them on Saturday.
Jonathon	OK, one tablet every Saturday. Take the tablet half an hour before food with a good glass of water and stay upright after taking it. You can carry on with your calcium tablets as before.
Lily	I can read instructions you know! I'll just need to make sure I keep them at my bedside, sometimes it takes me a while to get up and about with this back pain.
Jonathon	Sorry yes, it's just we like to make sure you know what you're doing with them once you get home.
Lily	How would you know anyway? I might just flush them down the loo.
Jonathon	I'm sure you are far too sensible to do that Mrs Jenson. Now, is there anything else you would like to discuss?
Lily	No, thank you.

	Achieved yes/no	Describe anything that could have been done better
Initiating the session		
Questioning		
Listening		
Paraphrasing and responding		
Explanation and planning		
Shared decision making		
Closing		

Turn to the end of the section for suggested answers.

Practice point

Developing effective consultation skills takes time, practice, self-criticism and self-awareness. You should be prepared to identify your areas for development, in addition to your strengths, in order to improve your skills. Visual observation of yourself is one of the best methods to do this, so if you have a mobile device which can accommodate this, ask a colleague to take a video clip of you. Even a short clip of two minutes can tell you a lot about the way you communicate.

From a legal perspective you must always obtain patient consent if a 'real' patient takes part; many organisations provide a standard consent form for the patient to complete. Check with your employer. If not, then try out your skills on a colleague or family member.

Reflective questions

What have you learnt so far?

Think about all you have done and read so far about consultation. Write down three things that you would like to do better in your future practice.

1.

2.

3.

Summary

Consultations between patients and healthcare professionals will always be the keystone of healthcare and the starting point for truly patient-centred healthcare.

While it is critical to have good clinical knowledge, it is also important to be able to understand the complexities of patient contact. Being aware of these aspects of consultation and introducing them into your day-to-day practice will lead to more rewarding discussions for you as well as your patient.

Intended outcomes	
By the end of this section you should be able to:	Can you?
▶ assess and reflect on your personal consultation skills using the medication-related consultation framework (MRCF)	☐
▶ describe the key skills needed for effective consultation	☐
▶ engage in shared decision making in the consultation.	☐

Suggested answers

Case study 3 Lily - revisited *(page 86)*

	Achieved yes/no	Describe anything that could have been done better
Initiating the session	Partly. He said "Hello" and opened with the reason for the consultation. Body language cannot be gauged.	Jonathon did not introduce himself, so it was likely that Lily didn't know who he was. He could have asked if it was OK to call Lily by her first name and explained the reason for the visit more clearly.
Questioning	Partly	Many open questions. "Do you know why you've been given the new tablets?" An alternative would be, "You have some alendronate tablets, can you tell me why you've been prescribed those?". This would elicit Lily's understanding of her medicine.
Listening	Partly – Jonathon did acknowledge Lily's concerns about side-effects, although perhaps did not deal with those concerns in a patient-centred manner.	Lily mentioned several verbal cues referring to back pain and the fact that she lives alone. Jonathon did not acknowledge either of these things which would have given Lily an opportunity to open up a little more.
Paraphrasing and responding	Partly - Jonathon reflects back the day of the week Lily has chosen to take her tablet as a form of shared agreement.	The comment "We like to make sure you know what you're doing with them once you get home" is not very patient-centred and could be patronising.
Explanation and planning	Partly	There was very much an element of 'telling' the patient rather than eliciting her knowledge and perceptions with a limited plan for moving forward.
Shared decision making	Partly	There was agreement that the tablet would be taken on Saturday but the decision was not entirely a shared decision. In reality, Lily could have replied with any day just to move the conversation on. It may have been a more effective conversation if Jonathon had asked "What day of the week would be best for you?"
Closing	Partly	Jonathon does ask if there is anything else Lily would like to discuss. It is sometimes helpful to ask this question at the beginning of the discussion too to make sure that both Jonathon's and Lily's aims are met.

Exercise 13 *(page 76)*

Having watched the video did you identify examples of the question styles listed? Was there anything you would have done differently?

Open	How are you getting on with it (new inhaler)? Is there anything you could do differently so you can remember (to take the new inhaler)?
Question with options	Is that something you'd ever considered, either reducing down or cutting out (cigarettes)?
Leading	None
Probing	You mentioned that you don't always manage to take your brown inhaler twice a day. How often would you say that happens?
Closed	Have you had the chance to start taking the new inhaler yet? Do you feel your inhaler is working for you? Any side-effects? Is there anything else you would like to ask or talk about?

As with many cases the discussion is weighted towards more closed questions, although the pharmacist does use these appropriately in most instances. Asking a patient "Have you had the chance to start using the new inhaler yet?" almost gives them permission to open up and be honest about the use of their medicine, as the question is offered in a non-judgemental style. A good example of a probing question is used to obtain important information from the patient. Rather than asking about "any side-effects?" the pharmacist could ask, "Tell me about any problems you may be having with the new inhaler".

Health coaching in patient consultations

Objectives

On completion of this section you should be able to:

- explain the meaning of the term health coaching
- describe the purpose and key features of a consultation based on a health coaching approach
- apply two health coaching tools which support medicines adherence and healthy lifestyle behaviours
- give examples of situations where you could use a health coaching approach to support your consultation
- assess a person's motivation to change behaviour
- describe motivational interviewing techniques and identify appropriate consultations for its application.

Now that you have reached this section of the learning programme you will be familiar with the key skills required to consult and communicate effectively with patients. You will also have reflected on the consultation skills models that you can apply to provide structure, help to develop your consultation style and assure content. Putting these skills and principles into practice is crucial to developing your consultation technique.

Once you have established these key principles, how do you build on them to ensure the patient is a true partner in the consultation?

In this section we look at the patient consultation through the methodology of health coaching and consider the skills that practitioners may wish to develop in order to use a health coaching approach in their consultations. These skills are applicable to all healthcare practitioners who wish to empower patients to take control of their health and are particularly relevant to those who are involved with medicines.

Health coaching skills are applicable to all healthcare practitioners who wish to empower patients to take control of their health and are particularly relevant to those who are involved with medicines.

NICE guidance CG76 on medicines adherence[23] clearly sets out the need for an approach to medicines adherence support that is practical, but also perceptual, ie, taking account of emotional or non-cognitive issues. The earlier sections of this programme explain the importance of being aware of intentional and unintentional reasons for non-adherence, together with consideration of patients' physical and cognitive ability to adhere to medicines regimens. In this section we look at the part that health coaching can play in identifying patients' beliefs about medicines and explain how using this approach can help you to support patients in making decisions about their health.

Health coaching is an excellent way to support shared decision making.

5.1 Health coaching and medicines optimisation

The Royal Pharmaceutical Society principles of medicines optimisation[4] are all supported through a health coaching approach, which encourages the patient to be an active participant in their own care and aims to improve the patient's experience by building trust and rapport. Health coaching is an excellent way to support shared decision making. Patients are encouraged to take responsibility for their own health, supported by practitioners who use their medicines-related expertise to explain the benefits of evidence-based practice, while facilitating the patient in balancing their personal risk/benefit analysis of taking a medicine. Patient safety is also addressed by discussing medicines risk in the context of the patient's agenda and offering the patient the maximum opportunity to explore these risks in relation to their situation.

Practice point

Now you have had the opportunity to reflect on your current practice and apply new skills and techniques, take a moment to reflect on your current consultations.

- **How do you currently conduct a consultation?**
- **How effective do you think your consultations are? What works well for you in the consultation and what doesn't work so well?**
- **Are there any particular skills you struggle with?**
- **In terms of benefits, what might the addition of a coaching approach offer your patients?**

5.2 The background to health coaching

In Section 1 of this programme we pointed out that less than 50 percent of medicines are taken as intended. We know that there is room to improve medicines optimisation through adherence support, however, the issues are wider than medicines alone. The World Health Organization stated that by 2020 three-quarters of all deaths would be from chronic disease.[64] In the UK, 15 million people suffer with long-term conditions, which account for more than two-thirds of NHS spending.[65] Lifestyle changes to improve long-term conditions currently stand at an efficacy rate of 10 percent[66] and health coaching has been employed as a measure to improve this.

Exercise 14

You may be familiar with the concept of health coaching or it may be completely new to you. Before you start learning how to apply this concept, work through the following questions to reflect on your own understanding and perceptions of health coaching and consider your learning needs in this area.

Consider the following statements and decide if you agree or disagree with them.

	Agree	Disagree
Coaching is a form of teaching used mainly in sport.	☐	☐
Health coaching is about increasing patient awareness of their health.	☐	☐
Health coaching is about passing on all decisions about a patient's health to the patient.	☐	☐
Research shows that about half of patients with adherence issues have beliefs about medicines that can negatively impact on adherence.	☐	☐
Health coaching consultations are beneficial but take at least 30 minutes.	☐	☐
Motivational interviewing and health coaching are the same thing.	☐	☐
Health coaching involves advising/educating patients where required about clinical issues.	☐	☐

Turn to the end of the section for suggested answers.

Coaching methodology was first used in the post-war period with the sports industry and over the last 20 years, the techniques used have been translated through to business and performance coaching. While sports coaching focuses on individuals and teams in order to motivate for improvement in performance, business coaching focuses on organisations and change to resolve problems.

Coaching methodology involves active listening, appropriate questioning techniques and support for decision making without direct guidance.

These concepts are now being used in the field of healthcare, with health coaching focusing on the individual to provide insight and self-awareness of health goals, increasing patient responsibility for managing their own health, rather than trying to find solutions directly. It is a skill that involves active listening, appropriate questioning techniques and support for decision making without direct guidance;[59] in fact, many of the skills we considered in Section 2.

There are a number of definitions of health coaching; three commonly used definitions are:

- 'A behavioural intervention that facilitates participants in establishing and attaining health-promoting goals in order to change lifestyle-related behaviours, with the intent of reducing health risks, improving self-management of chronic conditions, and increasing health-related quality of life.'[67]

- 'The coach may help to educate the coachee on specific health-related topics and subsequently support them in achieving their health-related goals.'[68]
- 'Health coaching can be defined as helping patients gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.'[66]

These definitions underpin some of the key principles of health coaching, which include:

- working in partnership with patients as a meeting of equal 'experts', where the patient sets the agenda
- believing in the potential of the patient to recognise and solve their own problems and set their own goals
- encouraging the patient to take an active role in their healthcare
- holding yourself back and resisting the temptation to give advice at the first opportunity, before allowing the patient thinking time
- viewing the patient in a holistic way in order to support sustainable change
- applying an appropriate level of challenge to support patients in addressing barriers or unhelpful beliefs about their medicines or health
- exploring the potential options for the patient
- a balanced discussion of the risks and benefits of potential options
- encouraging patients to choose their preferred option, rather than the healthcare professional making that choice for them
- encouraging patient accountability and responsibility for the chosen outcome.

Health coaching moves us towards a more patient-centred approach that empowers patients to take responsibility for their care.

As healthcare professionals, we may often consider our key role is to educate the patient. In our eagerness to pass on our knowledge to the patient, it is easy to provide advice without sufficient consideration of the patient's concerns, beliefs or aspects of their life that may impact on the way they manage their medicines or health. Health coaching moves us towards a more patient-centred approach that empowers patients to take responsibility for their care, through exploring their goals, looking at the options available to them, and reflecting on the consequences of those options. It is an approach that supports strategic priorities on shared decision making *(see Section 4)*, improving the patient experience and improving patient engagement with their clinical care.[69]

Health coaching combines three key elements that the health practitioner can offer to support improvements in health. These are:

- health expertise/knowledge
- health advice/recommendations
- behavioural change interventions.

From a medicines perspective, pharmacy professionals are usually experienced in managing practical adherence-related issues, providing health expertise and advice for patients with reminder charts, compliance aids, delivery services and other support to improve adherence. However, patients' beliefs about medicines are rarely discussed in practice and yet we know that the issues that nearly half of patients have with adherence relate to their perceptions about medicines. Health coaching may provide a way to address these issues. This approach can also facilitate discussions around lifestyle interventions that support patients in optimising their health.

Patients' beliefs about medicines are rarely discussed in practice and yet we know that the issues that nearly half of patients have with adherence relate to their perceptions about medicines.

5.3 Evidence for health coaching

A recent review of health coaching interventions, commissioned by the Health Foundation, found that while there were a significant number of health coaching studies, the evidence was conflicting regarding benefits.[65] It was difficult to compare results as studies used a variety of outcome measures. The review suggests that interventions supporting self-efficacy, which is a measure of a person's own ability to complete their task or reach their goal, are more effective than education alone. Recently Hibbard developed a way of tailoring the coaching approach to individual patients by using the 'patient activation measure' as a method of assessing a patient's ability and confidence to manage their own health.[70] Hibbard proposed four key stages which assess a patient's level of activation:

1. The patient believes their role is important

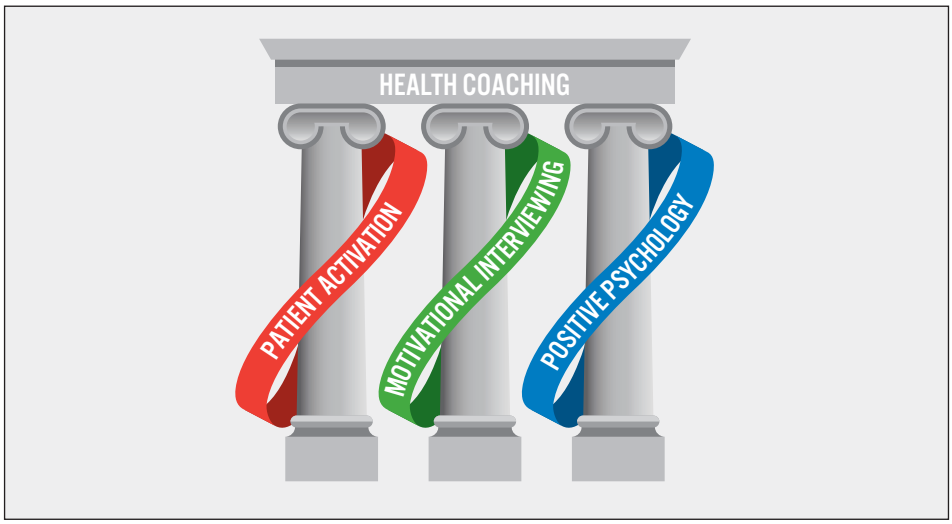
2. The patient has the confidence and knowledge necessary to take action

3. The patient takes action to maintain and improve their health

4. The patient stays the course, even under stress.

Her research showed that patients with higher activation had fewer hospital readmissions after 30 days, were less likely to experience a medical error, or suffer a health consequence because of poor information transfer between providers. The concept of patient activation may have relevance to medicines adherence and forms the first pillar of Hibbard's three pillars of health coaching model *(see Figure 6 overleaf)*.[71]

FIGURE 6 Three pillars of health coaching



Source: Adapted from Hibbard J *et al* 2010[71]

The second of Hibbard's pillar is motivational interviewing, which is described later in this section and the third pillar is positive psychology – exploring what helps people to improve their sense of wellbeing and happiness.

Health promotion and health coaching

The literature suggests that health coaching can improve healthy lifestyle behaviours, especially in areas that address dietary advice, weight management and physical activity.

An integrative review of the literature by Olsen and Nesbitt looked at the effectiveness of health coaching interventions for promoting healthy lifestyle behaviours. The literature suggests that health coaching can improve healthy lifestyle behaviours, especially in areas that address dietary advice, weight management and physical activity.[72]

Medicines adherence and health coaching

As a relatively new field, health coaching is still in its infancy with regard to robust evidence.[73, 74]

One study of patients with diabetes found that there was increased medicines adherence among participants who received health coaching; resulting in patients being more likely to present insulin prescriptions for dispensing.[75] Melko *et al* used a six month coaching model that included face-to-face and telephone coaching consultations. This study suggests that the use of health coaching, combined with tools (ASK-20) to identify barriers, increased medicines adherence.[76]

Another study enrolled patients to the COACH programme and showed sustained improvements in cardiovascular risk factors and adherence to recommended medicines for patients at a two year follow-up. The study involved 656 patients, recruited in hospital, who were followed up by telephone at six-monthly intervals. Results showed a substantial improvement in cardiovascular risk factors from discharge and an increase in patient adherence for renin-angiotensin antagonists and statins.[77]

Examples of evidence include a recent study of telephone health coaching (USA) for patients with diabetes that showed a reduction in HbA1C.[78] In contrast, a recent *British Medical Journal* study of telephone coaching in Birmingham showed

no reduction in hospital admissions. Examination of these studies reveals two very different interventions and demonstrates that the term 'coaching' as applied to health is used for a wide variety of interventions, making development of an evidence base difficult.[80]

5.4 The skills needed for health coaching

In Sections 3 and 4, we considered the structure of a patient consultation and ways of developing the required skills to put this into practice. Health coaching builds on these same communication and consultation skills. However, health coaching also requires the practitioner to suspend any pre-existing judgements and perceptions of a patient.

Central to a good health coaching conversation is the belief that the patient has the potential to solve their own problems; contrary to the traditional approach where practitioners are the problem-solving experts. Health coaching encompasses a continuum of approaches,[34] and uses tools to raise patients' awareness of their health issues and increase their personal responsibility for solving them.

Central to a good health coaching conversation is the belief that the patient has the potential to solve their own problems.

There may be circumstances that cause concern, such as when a patient displays behaviours and beliefs that jeopardise their safety – this would be a red flag situation. In these circumstances the safety of the patient is your prime concern and a clear, direct approach is needed, using your professional knowledge and judgement to inform a patient of the risks and also rectify beliefs that may be inaccurate. In general, if a patient displays unrealistic or untrue health beliefs then a more directive approach can be helpful to help the patient to identify and address these beliefs. Applying effective consultation skills, such as safety netting and offering sound evidence-based information will support this approach and it may also be appropriate to signpost to another healthcare professional for further support.

Exercise 15

Think back to Section 4 and the key skills you need to adopt to deliver an effective consultation. Which of these skills/qualities are important in health coaching? List them here. Have you ever used coaching skills to help a family member or friend outside the work environment? It may help to reflect on this experience.

Remember, individuals will translate health coaching skills into practice in slightly different ways, based on your existing skills, experiences and shaped by your own personality.

Patient factors

You need to believe your patient has the potential to manage their own health and overcome their health challenges.

As we explained above, a health coaching approach involves considering your patient's motivation to improve their adherence to medicines and how confident they feel about making these changes. You need to believe your patient has the potential to manage their own health and overcome their health challenges. These factors are important in turning thoughts and conversations into action.

Case study 1
George revisited

George Redmond, age 71 years, has been admitted to hospital with a stroke. He has a history of alcohol abuse and has no fixed abode. While warfarin is recommended for reduction of stroke risk, you are told he is refusing to take warfarin. You are asked to speak with him. You review George's current medication, which he has with him, and initially he says he knows nothing about what he is taking. You are thinking about his alcohol consumption and the fact that this will affect his medication and you ask about his management of this.

When you initially read George's story in the section on adherence (Section 1), what picture did he produce in your mind, what questions did you ask yourself?

Making assumptions is natural for everyone. What assumptions might you make about George and his reluctance to take warfarin?

How much potential do you think he has to manage himself and why?

How did you get on? Did you find you made assumptions about George due to his circumstances?

Here is George's story ...

"Hello my name is George. I live in London, well, kind of live, where I practised as a solicitor for 30 years. Life used to be good but then work pressures and a marriage breakdown brought me down and I started to drink. This got more and more out of control, I lost my family, my home and my friends. My life now seems a million miles away. When I say I kind of live in London, I have no home, just sleep where I can and live from begging. I couldn't believe it when I had a stroke. Alcohol blurs the reality of things. I suppose one good thing to come from it was that I met up with one of my old friends, Dave, who is a nurse in the hospital where I was admitted. I broke down when I saw him and it all came flooding out. I knew I had to get help with my alcohol problem. Dave's letting me stay in his spare room now and I've actually seen the alcohol liaison team twice already and am making good steps in stopping my drinking. I really don't want another stroke.

"I've read a lot about warfarin mainly on the internet. I know it's risky looking for information there but if you go to a trusted site like NICE then it's great information. I know there's a two-third reduction in stroke risk if you take it. At first I had major reservations about warfarin, didn't want to take it as I had no home and didn't know how I'd get to a clinic to be monitored. Just another complication in life. The pharmacist who came to see me in the hospital thought I was being difficult but then again he didn't ask me why I was resisting it. Luckily Dave's place is just around the corner from the hospital so I've started my anticoagulant and feel a bit less anxious about suffering another stroke."

Now you have read George's story, what principles of health coaching could you consider when consulting with him?

You can see some suggested answers at the end of this section.

While it is hard to avoid being judgemental, you should acknowledge your judgements and actively put them to one side in order to support your patient. Remember that while you may be an expert in medicines, the patient is the expert in themselves, their lives and their circumstances. Exploring a patient's beliefs about their medicines may reveal problems that you as a healthcare professional had not considered, problems that can be solved by discussing options and the potential risks and outcomes of those options.

Exploring a patient's beliefs about their medicines may reveal problems that you as a healthcare professional had not considered, problems that can be solved by discussing options and the potential risks and outcomes of those options.

5.5 Health coaching models and medicines adherence

There are a number of health coaching models and associated tools that have been developed to support healthcare professionals in their practice. We have made reference to two models of health coaching here, which you could adapt to practice.

GROW

The most widely known coaching model was first promoted by Sir John Whitmore.[80] It is now a validated approach and is known as the GROW model. Coaching conversations can be structured around this model which looks like this:

G	Goal(s)	What do you want to change/achieve from this conversation?
R	Reality	What is happening now?/Tell me about the current situation.
O	Options	What could you do differently? What might get in the way?
W	Way forward	How committed are you? Action points (SMART).

Health coaching interventions using the GROW model have been successfully used in short (ten minute) consultations by GPs, hospital doctors and other clinical professionals.

The GROW model has been further enhanced with similar models adding 'I' for 'What's the Issue' or 'T' for 'Topic', prior to the 'Goal', where the patient is asked what they want to talk about in the time available, to help them focus on a goal.

The four Es

The four Es model has been developed based on the principles of the validated GROW model. This method considers four key elements of a patient consultation (Explore, Educate, Empower and Enable), which can be used sequentially, partially or individually. This model can be used to structure a short (ten minute) consultation with patients in any healthcare setting and has been used by community pharmacists to structure medicines use reviews and new medicine service consultations.[34, 81]

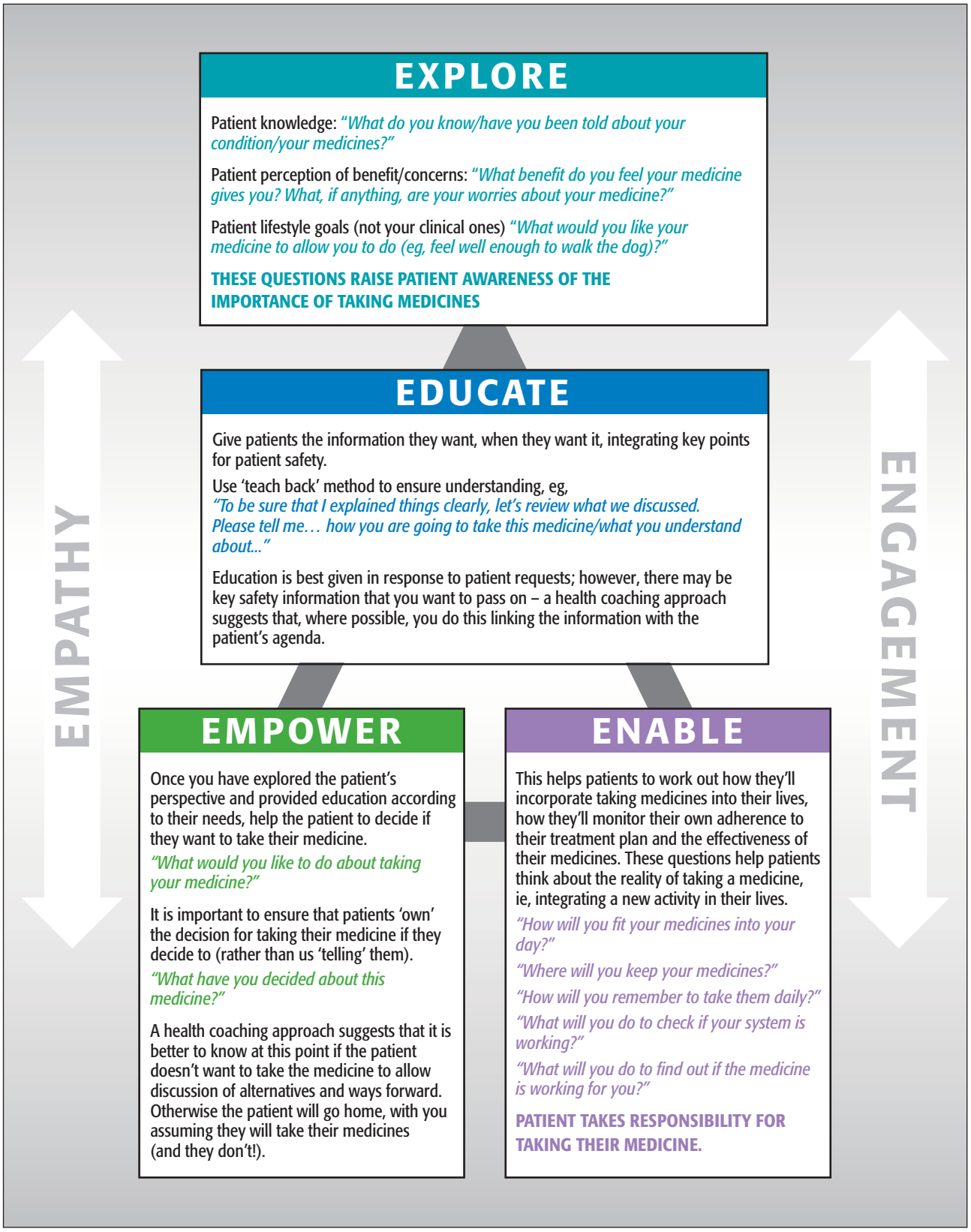
The diagram opposite *(see Figure 7)* shows key questions that may be used at each stage. Using the four Es' approach you can address goal setting, action planning and the process of review, all of which are components of health coaching.

The diagram shows two other important Es that run concurrently throughout the method; these are: Empathy and Engagement. Building rapport and a relationship with the patient is critical for any discussion where the patient is an equal partner with the healthcare professional (a point raised above when we discussed the Calgary-Cambridge guide). These additional dimensions help healthcare professionals reach shared understanding prior to shared decision making.

Building rapport and a relationship with the patient is critical for any discussion where the patient is an equal partner with the healthcare professional.

Practice tool

FIGURE 7 The four Es – Supporting ExcEllEncE in medicines adherence



Exercise 16
For community settings

If you are based in a community setting

How could you use the four Es as part of an MUR or NMS? Take a look at the interview schedule for the new medicine service and think about how each question may apply to the four Es and how they may be reworded to put more focus on a health coaching approach.

Here are some suggestions for alternative questions for the new medicine service, using a coaching approach.

1. Have you had the chance to start taking your new medicine yet?
   How much of your new medicine have you felt able to take so far, if any?
2. How are you getting on with it?
3. Are you having any problems with your new medicine, or concerns about taking it?
   What concerns have you had about your new medicine, if any?
4. Do you think it is working?
   How well do you think the medicine is working?
5. Do you think you are getting any side-effects or unexpected effects?
   What unexpected effects have you had since starting your medicine?
6. People often miss taking doses of their medicines, for a wide range of reasons. Have you missed any doses of your new medicine?
   How many doses of your medicine have you missed in the last week?
7. Do you have anything else you would like to know about your new medicine or is there anything you would like me to go over again?
   What else would you like to discuss or revisit?

Now watch the following video and see how the new medicine service questions can be used with a health coaching approach. How do the four Es relate to this discussion?
https://vimeo.com/78354273

Exercise 16
For hospital settings

If you are based in a hospital setting

As part of discharge consultation, which questions would help you develop a more coaching style approach with your patients?

Here are some suggestions we have thought of:

Explore – as an opening statement use, "Let's talk about what you already know about your medicines".

Educate – use this after 'explore', rather than first. You may find your patient is well informed about their medicines and so the discussion from 'explore' will frame the 'educate' discussion.

Empower – ask patients what they think about taking their medicines.

Enable – instead of instructing from labels, ask patients how medicines will fit into their day, where they will keep medicines, how they'll remember it daily and (especially if asymptomatic treatment) what they'll do to check if it's working.

Now watch the following video to see if you can apply the four Es to this discussion – the video highlights the use of questions to help the patient find their own solutions.
www.youtube.com/watch?v=YQbPcLEcoik&feature=youtu.be

Practice point

Choose one question from the four Es and try it out with three patients. Make a note about how you felt using the question and what responses you got from the patients. Was it what you expected? What did you learn that you might not have learnt using a traditional approach?

5.6 Motivational interviewing

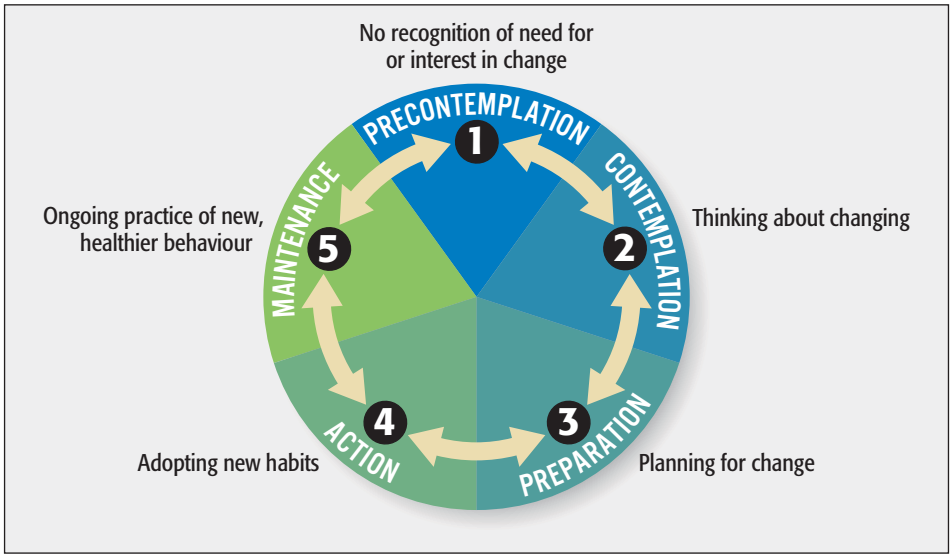
You may come across patients who don't want to change their lifestyle or medication habits. Motivational interviewing is a particularly helpful technique to use when there is some resistance to change or ambivalence from a patient. As a

technique for supporting behavioural change motivational interviewing has been described as:

'a collaborative, person-centred form of guiding to elicit and strengthen motivation for change'.[82]

The technique (developed by Miller and Rollnick[83]) is based on work by Proschaka and DiClemente who developed the 'transtheoretical stages of change' model.[84] This model can be used to assess a patient's readiness to change and helps the practitioner to give appropriate support at an appropriate time within the 'cycle of change' *(see Figure 8 below)*, so that advice is more likely to be well received and a better patient outcome can be achieved.

FIGURE 8 Stages of change model



Source: Prochaska, J. O. & Di Clemente, C. C., (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19(3), 276-288. Figure 2, p. 283.

Precontemplation	Where the person doesn't see the need to change
Contemplation	Some awareness of need with ambivalence (healthcare professional can tip the balance here)
Preparation	Increasing awareness of need to change and healthcare professional can support and encourage this
Action	Patient making a change requires ongoing support and encouragement
Maintenance	Accomplished change requires tools to maintain, particularly in changing circumstances to prevent relapse.

The key skill in motivational interviewing is to recognise that change is difficult and that patients may need a number of attempts to successfully change their behaviour.

People can, and do, make their own choices. Motivational interviewing is a conversation about change. It aims to explore and resolve ambivalence, providing a direction for change and strengthening a person's personal motivation.

The key skill in motivational interviewing is to recognise that change is difficult and that patients may need a number of attempts to successfully change their behaviour. Where there is resistance to change, this should not be challenged, rather it should be acknowledged and explored. You may have heard the term 'roll

with the resistance', which describes this. Using appropriate questioning can enable a patient to explore their own reasons about why they may or may not wish to take a different approach, by getting them to think about what would motivate them to change. This may not specifically be connected to how they feel about their own health, but could, for example, be linked to other strong emotions, such as the effect their behaviour has on a family member.

Motivational interviewing is well suited to supporting behaviour change in a variety of conditions and outperforms traditional approaches.[85] It has the most evidence of success in public health interventions, such as weight management and treatment of addictions; it helps patients to think about the benefits of change. There is evidence of use of the technique by pharmacists in helping patients to stop smoking.[86] It is also suitable for some medication adherence support consultations.

Motivational interviewing is well suited to supporting behaviour change in a variety of conditions and outperforms traditional approaches.

Motivational interviewing is just one of a number of tools and techniques that can be used within a health coaching conversation to support behavioural change. All of them focus on encouraging a patient to move towards talking about change, which is sometimes referred to as 'change talk'. They are used to help patients explore their beliefs regarding medicines and healthcare and support them to believe that they can change.

Exercise 17

Before you read on, take a look at the following video, which looks at motivating a client during a stop smoking consultation. Write down the key points you note and will adapt to your practice.
www.youtube.com/watch?v=uGVq-j76yPo

There are several other tools that are based on motivational interviewing techniques, including:

- OARS
- scaling questions
- Rollnick's top ten useful questions.

We outline each of these overleaf.

OARS

The OARS model helps to motivate patients early on in the consultation.[87]

Open-ended questions – use of this type of question encourages the patient to think and may promote personal insight.

Affirmations – these are statements that recognise the patient's strengths, for example, "So you did really well last time you decided to quit". This type of statement must be expressed genuinely and will build rapport and help the patient understand that you are not there to judge.

Reflective listening - this encourages the patient to continue talking, maintains the momentum of the conversation and helps you truly understand how the patient sees things.

Summaries – summarising all or certain parts of the conversation. It is useful to highlight both the advantages and disadvantages of the behaviour change that the patient has identified at this stage. Carefully selecting and identifying the key points can have much influence on this, for example, "So, you really enjoy a cigarette when you're out with friends, but at the back of your mind you still have this worry about having another heart attack".

This can then lead to more exploratory questioning.

Exercise 18

Watch the following video on healthy lifestyle advice. Try to identify the different elements of OARS above.
www.youtube.com/watch?v=hWK66pELZkM&feature=youtube_gdata

Scaling questions

The use of scaling questions is designed to provide a more objective view of an otherwise subjective situation, and can help patients focus on their goal. The concept involves adding an objective measure or scale to an otherwise subjective statement, for example:

Subjective statement: I want to remember how to take my medicines more regularly.

Objective measure: On a scale of 1-10 how well do you think you remember your medicines now?

What number on the scale would you need to achieve to feel confident?

The patient's response would then lead into a conversation about what the patient would need to do to achieve their desired 'number'.

Rollnick's top ten useful questions

Rollnick's top ten useful questions is another approach, based on motivational interviewing techniques.[88]

1. What changes would you most like to talk about?
2. What have you noticed about...?
3. How important is it for you to change...?
4. How confident do you feel about changing...?
5. How do you see the benefits of ...?
6. How do you see the drawbacks of...?
7. What will make the most sense to you?
8. How might things be different if you...?
9. In what way...?
10. Where does that leave you now?

These questions are designed to help the patient to see things relating to their specific issue from a range of perspectives.

Exercise 19

Compare the features of a health coaching consultation with a traditional one.

	Traditional	Health coaching
Who is the expert?		
Who makes the decisions?		
Who is responsible for problem solving?		
Who sets goals for treatment?		
Are psychological barriers to change considered?		
Who measures success of the intervention?		

Summary

Taking a health coaching approach to consultations is an effective way of improving medicines adherence and can support patients in achieving healthy lifestyle goals. Pharmacy practitioners are well placed to consider these skills and develop them as part of their 'tool box'. Existing services, such as MUR and NMS, can include a health coaching approach and models, such as the four Es, can be included in even the shortest consultation.

Intended outcomes

By the end of this section you should be able to:	Can you?
▶ explain the meaning of the term health coaching	☐
▶ describe the purpose and key features of a consultation based on a health coaching approach	☐
▶ apply two health coaching tools which support medicines adherence and healthy lifestyle behaviours	☐
▶ give examples of situations where you could use a health coaching approach to support your consultation	☐
▶ assess a person's motivation to change behaviour	☐
▶ describe motivational interviewing techniques and identify appropriate consultations for its application.	☐

Suggested answers

Case study 1 George – revisited *(page 100)*

Here are some of the key health coaching principles we considered in relation to George's story.

Principle	
Working in partnership with patients as a meeting of equal 'experts', where the patient sets the agenda.	On first impressions you may have considered working in partnership with George would present a challenge. George says that the pharmacist did not ask why he was being resistant, so this indicates his wish to be involved. As his story evolves it is clear to see that he is motivated and also displays some confidence and knowledge to take action *(see Hibbard's patient activation measure on page 97)*.
Believing in the potential of the patient to recognise and solve their own problems and set their own goals.	George has already made some headway in solving problems relating to his social circumstances and made a decision to take his warfarin. This shows potential for George to recognise future problems and solve issues, should his circumstances change.
Holding yourself back and resisting the temptation to give advice at the first opportunity, before allowing the patient thinking time.	George has obviously given a lot of thought to his circumstances and made positive changes as a result. Sometimes patients need thinking time to come to their own solutions, solutions which they are more likely to follow.
Exploring the potential options for the patient.	An open and honest discussion could take place about what may happen if George's circumstances change. For instance, if George could no longer stay with his friend and did not have access to the clinic, would he be a candidate for self-testing?
Viewing the patient in a holistic way in order to support sustainable change.	George provides a good example of how a patient's social circumstances may influence their attitude to taking medicines.
A balanced discussion of the risks and benefits of potential options.	An open and honest discussion could take place, encouraging George to identify his own risks as to what may happen should his circumstances change and what options are available; for example, how does he plan to manage his warfarin if he starts to drink alcohol again?

Exercise 14 *(page 95)*

Health coaching may be a term you are familiar with or something that is completely new to you. Before you start learning how to apply this concept, work through the following questions to help you reflect on your own perceptions of health coaching and think about your learning needs in this area.

Consider the following questions:

- Coaching is a form of teaching used mainly in sport. **Disagree**
- Health coaching is about increasing patient awareness of their health. **Agree**
- Health coaching is about passing on all decisions about a patient's health to the patient. **Disagree**
- Research shows that about half of patients with adherence issues have beliefs about medicines that can negatively impact on adherence. **Agree**
- Health coaching consultations are beneficial but take at least 30 minutes. **Disagree**
- Motivational interviewing and health coaching are the same thing. **Disagree**
- Health coaching involves advising/educating patients where required about clinical issues. **Agree**

Exercise 15 *(page 99)*

Think back to Section 4 and the key skills you need to adopt to deliver an effective consultation. Which of these skills/qualities are key to health coaching? List them here. Have you ever had to coach a family member or friend outside the work environment? It may help to reflect on this experience. We have suggested some key skills below, but you may have thought of others.

- Active listening
- Being supportive and respectfully challenging when appropriate
- Taking a non-judgemental approach
- Using appropriate questioning techniques (probing when necessary)
- Reflecting back to the patient
- Allowing a pause for thought and time to think and consider

Section 6

Moving your practice forward

Objectives

On completion of this section you should be able to:

- reflect on your learning to date
- consider a series of action plans to put your learning into practice.

This section has been developed as an action planning section to support you in consolidating your learning and moving your practice forward.

If you have reached this section after completing Sections 1 to 5 you have done a significant amount of learning. You may be thinking 'what next?'. You might be wondering how best to put your learning into practice in working towards the patient-centred consultation.

By completing the action plans below you will be able to identify the key points you have learned and those you have already started to apply to your practice. These action plans will also help you to reflect on your future learning needs and how best to further develop your skills and behaviours.

After completing your action plans your next step will be to consider how you can practically apply your learning, to 'test drive' your knowledge, skills and behaviours and reassess yourself against the MRCF and the national practice standards. To supplement your learning to date, you may want to consider attendance at a workshop, peer review and feedback. Visit: **www.consultationskillsforpharmacy.com** for more information.

Remember this is your **personal** action plan. As you complete it identify the key points of learning you have achieved to date and the steps you have taken to change your practice. We have included a column for reflection and space for you to consider any future learning needs.

6.1 Consultation models – application to practice

Which models have you identified and applied to practice?

Preferred consultation skills model/s to apply	I have applied this to my practice…. (provide example)	Other key points I will adopt in my practice (include target date)	Reflection (This worked well for me because… Next time I will improve by…….)	Future learning needs
Calgary-Cambridge				
Pendleton				
Neighbour				
BARD				
Other				

6.2 Key consultation skills – application to practice

What have you done to improve your skills?

Key skills I have identified as part of my professional development	I have applied this to my practice…. (provide example) It may help to include specific phrases you have introduced to your consultation	Further key points I will adopt in my practice (include date)	Reflection. (This worked well for me because… Next time I will improve by…….)	Future learning needs
Initiating the session ● Preparing for the consultation ● Establishing initial rapport ● Establishing the reason for the consultation				
Gathering information ● Questioning ● Listening				
Explanation and planning ● Providing evidence-based advice and information ● Discussing options and potential outcomes of options				
Closing the session ● Offering a safety net ● Verifying and agreeing a plan				
Providing structure				
Building the relationship ● Demonstrating empathy ● Building rapport throughout ● Increasing patient involvement in consultation ● Using open body language				

6.3 Taking a patient-centred approach – application to practice

What have you done to develop in the following areas?

Additional skills to develop patient-centred approach	I have applied this to my practice…. (provide example)	Further key points I will adopt in my practice (include date)	Reflection (This worked well for me because… Next time I will improve by…….)	Future learning needs
Understanding the patient's perspective of their medicines and/or health				
Analysing own behaviours during the consultation and identifying areas for change (body language and attitudes towards patients)				
Engaging the patient in shared decision making				
Working in partnership with the patient				
Taking a holistic view of the patient				

6.4 Adopting a health coaching approach to the consultation

What have you done to develop in the following areas?

Health coaching method adopted to practice and/or key skills	I have applied this to my practice…. (provide example)	Further key points I will adopt in my practice (include date)	Reflection (This worked well for me because… Next time I will improve by…….)	Future learning needs
GROW model				
Four Es model				
Other model identified				
Supporting patient to take responsibility for health/medicines				
Supporting patients in identifying their own goals				

Summary

Now you have completed this learning programme you should have a sound understanding of the consultation skills and techniques you can apply to practice. You have reflected on how effective your existing consultation skills are and identified specific areas to develop that are personal to you. What will be your next step? Will you put this programme away and move on to something else? Developing effective consultation skills can take years of practice and reflection and is something that should be ongoing throughout your professional career. There are many other ways in which you can develop your skills, such as observing others in practice and receiving feedback from colleagues and patients. Now you've got this far why not continue your journey to excellence by visiting the *Consultation skills for pharmacy practice* website at:
www.consultationskillsforpharmacy.com

Intended outcomes	
By the end of this section you should be able to:	Can you?
▶ reflect on your learning to date	☐
▶ consider a series of action plans to put your learning into practice.	☐

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