College of Pharmacy
Communication Skills.

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Patient-Centered Communication in Pharmacy Practice

Overview

- In order to meet their professional responsibilities, pharmacists have become more *patient-centered* in their provision of pharmaceutical care.
- Pharmacists have increase their potential to improve patient care through efforts to reduce medication errors and improve the use of medications by patients.
- Using effective communication skill is essential in the provision of patient care
- A study by Weingart (2005) found that, while 27% of patients experienced symptoms they attributed to a new prescription, many of these symptoms (31%) were not reported to the prescribing physician.

Why is patient-centered communication so crucial to a professional practice?

- A 36-year-old man was prescribed a fentanyl patch to treat pain resulting from a back injury. He was not informed that heat could make the patch unsafe to use. He fell asleep with a heating pad and died. The level of fentanyl in his bloodstream was found to be 100 times the level it should have been.
- A patient prescribed Normodyne for hypertension was dispensed Norpramin. She experienced numerous side effects including blurred vision and hand tremors.
- Thus, even minimal communication between the pharmacist and patient about the therapy would have prevented this medication error.
- The changing role of the pharmacist requires practitioners to switch from a ***"medication-centered practice"*** to ***"patient-centered care".***
- Pharmacists must participate in activities that enhance patient adherence and the wise use of medication.
- Patient-centered care depends on your ability to
  - develop trusting relationships with patients,
  - engage in an open exchange of information,
  - Involve patients in the decision-making process regarding treatment, and to help patients reach therapeutic goals that are understood and endorsed by patients as well as by health care providers.
- ***Effective communication is central to meeting these patient care responsibilities in the practice of pharmacy***

Pharmacists' Responsibility in Patient Care

- The incidence of preventable adverse drug events and the cost to society associated with medication-related morbidity and mortality is of growing concern. The Institute of Medicine (IOM) report on patient safety concluded that medication-related errors are among the most prevalent errors in medical care.
- The potential of pharmacists playing a pivotal role in **reducing** the incidence of both **medication-related errors** and **drug-related illness** is also receiving increased attention. So, there is a societal need for pharmaceutical care, {which they define as "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life}
- The quality of the interpersonal relationships pharmacists develop with patients depends upon effective communication.

Importance of Communication in Meeting Your Patient Care Responsibilities

- Establishing trusting relationships with your patients is not simply something that is "nice to do" but that is essentially peripheral to the "real" purpose of pharmacy practice.
- The quality of the patient–provider relationship is crucial.
- The purpose of the relationship is to achieve mutually understood and agreed upon goals for therapy that improve your patients' quality of life.
- Your goal, for example, is changed from providing patients with drug information to a goal of ensuring that patients understand their treatment in order to take medications safely and appropriately.

What is Patient-Centered Care?

- The pharmacist must be able to:

1. Understand the illness experience of the patient
2. Perceive each patient's experience as unique
3. Foster a more egalitarian relationship with patients
4. Build a "therapeutic alliance" with patients to meet mutually understood goals of therapy
5. Develop self-awareness of personal effects on patients

Understanding Medication Use from the Patient Perspective

- Models of the prescribing process that are ***"practitioner-centered***" have primarily focused on decisions made and actions taken by physicians and other health care providers.
- The patient is "acted upon" rather than being viewed as an active participant who makes ongoing decisions affecting the outcomes of treatment.

Encouraging a More Active Patient Role in Therapeutic Monitoring

- Pharmacists, could do more to help enable patients and their families to take a more active role in monitoring response to treatment.
- The information a patient provides you as part of therapeutic monitoring is essential to ensuring that treatment goals are being met.
- While **Hemoglobin HB** values may provide the comfort of a "scientific" basis for therapeutic monitoring, for many chronic blood such as anemia, treatment of depression and pain, for example, have only patient self-report as the basis of evaluation of response to therapy.
- Many other conditions such as asthma, angina, gastroesophageal reflux disease, epilepsy, and arthritis rely heavily on patient report of symptoms.
- The patient report of symptomatic experience is critical to monitoring, and have the beneficial effects on patient outcomes of increased patient involvement in self-monitoring of physiological indicators of treatment effectiveness.
- E.g./Certainly, patient self-monitoring of blood glucose has become standard practice in managing diabetes.
- Programs to increase patient participation in monitoring of coagulation therapy along with protocol-based patient management of warfarin dosing have led to reduced incidence of major bleeding in patient monitoring intervention groups.

A Patient-Centered View of the Medication Use Process

- ***A patient-centered*** view of the medication-use process focuses on the patient role in the process. The medication-use process for patients begins when the patient perceives a health care need or health-related problem. This is experienced as a deviation from what is ***"normal"*** for the individual. It may be the experience of ***"symptoms"*** or other sort of life-style interruption that challenges or threatens the patient's sense of wellbeing.
- This interpretation is influenced by a host of psychological and social factors unique to the individual, These include:
  - the individual's previous experience with the formal health care system;
  - family influences;
  - cultural differences in the conceptualization of "health" and "illness"; knowledge of the problem;
  - health beliefs which may or may not coincide with accepted medical "truths";
  - Psychological characteristics; personal values, motives, and goals.
  - Family members who offer their own interpretations and advice.

- The patient at this point may take no action to treat the condition either because the problem is seen as minor or transitory or because the patient lacks the means to initiate treatment.
- Once the health care provider reaches a professional assessment or diagnosis of the patient's problem she or he makes a recommendation to the patient. If the recommendation is to initiate drug treatment, the patient may or may not carry out the recommendation. Failure to initiate prescribed therapy may be caused by economic constraints, a lack of understanding of the purpose of the recommendation, or failure to "buy into" the treatment plan. This evaluation results in patients continuing to take the medications, patients altering their drug treatment regimens, or patients discontinuing drug therapy.
- It is inevitable that, as patients begin drug treatment, they will ***"monitor"*** their own response. The problem that exists is that patients often lack information on what to expect from treatment on what to look for that will give them valid feedback on their response to the medication. Lacking this information, they apply their own ***"common sense"*** criteria. Patients may interrupt the treatment process by failing to contact you and other providers when follow-up is expected. Of the patients who do contact their providers, some will communicate their perceptions, problems, and decisions regarding treatment. Other patients may contact providers and *not* convey this information. This follow-up contact occurs during revisits with a physician or refills of prescriptions from pharmacists.

Reasons to Encourage Patients to Share Their Experience with Therapy

1. They have unanswered questions
2. They have misunderstandings
3. They experience problems related to therapy
4. They "monitor" their own response to treatment
5. They make their own decisions regarding therapy
6. They may not reveal this information to you unless you initiate a dialogue

Principles and Elements of Interpersonal Communication

Overview

Interpersonal communication is a common but complex practice that is essential in dealing with patients and other health care providers. Consider Case Study **1**

Case study 1

George Raymond, a 59-year-old man with moderate hypertension, enters your pharmacy holding an unlit cigar. You know George. He has been told to quit smoking and go on a diet. **He also has a long history of not taking his medications correctly**. He comes to pick up **a new prescription**—an antibiotic for a urinary tract infection. **Although he knows you personally, he is somewhat hesitant as he approaches the prescription area. He looks down at the ground and mumbles**, "The doctor called in a new prescription for me, and can I also have a refill of my heart medication?"

Components of the Interpersonal Communication Model

1-Communication encompasses a broad spectrum of media, for example, mass communication (TV, radio), small-group communication (discussion groups), and large-group communication (e.g. lectures).

2-This course will focus on **one-to one interpersonal communication that occurs in pharmacy practice.**

3-This specific form of communication (**interpersonal communication**) is best described as a **process in which messages are generated and transmitted by one person and subsequently received and translated by another**.
A practical model of this process is shown in Figure 1.

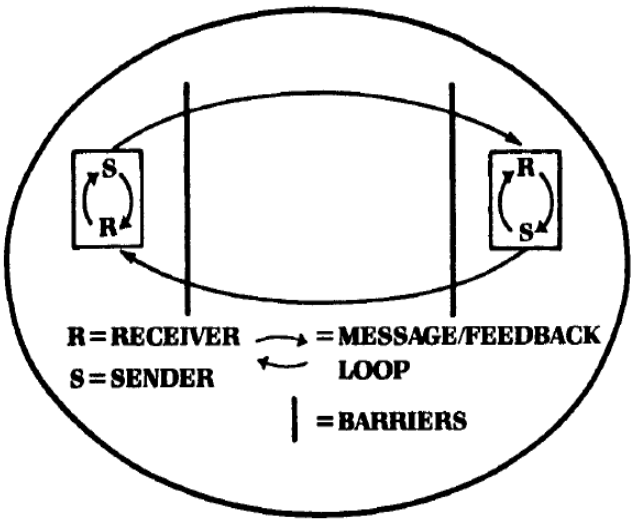

FIGURE 1. The interpersonal communication model.

The model includes five important elements: **sender**, **message**, **receiver**, **feedback**, and **barriers**.

1-The Sender

In the interpersonal communication process, **the sender transmits a message to another person.** In the example described above, the initial sender of a message was Mr. Raymond.

2-The Message

-In interpersonal communication, the message is the element that is transmitted from one person to another. Messages can be thoughts, emotions, information, or other factors and **can be transmitted both verbally (by talking) and nonverbally (by using facial expressions, hand gestures, and so on).** For example, Mr. Raymond's **verbal message** was that he wanted **his new prescription** and that he would like to have his prescription for **heart medication refilled**.

-At the same time, he also communicated nonverbal messages. Did you recognize any of these nonverbal messages? **By looking down at the ground and mumbling rather than speaking clearly, he might have been expressing embarrassment, shyness, or hesitancy to talk with you.** He might have felt embarrassed, perhaps because he had not been taking his heart pills regularly. **The nonverbal component of communication is important. Research has found that most of the message is transmitted through its nonverbal component.**

> **The most important thing in communication is hearing what isn't said.**
> **Peter Drucker**

3-The Receiver

The receiver (you in the above example) receives the message from the sender (Mr. Raymond). As the receiver, you "decode" the message and assign a particular meaning to it, which **may or may not be** Mr. Raymond's intended meaning. In receiving and translating the message, **you probably considered both the verbal and nonverbal components of the message.**

4-Feedback

Feedback is the process whereby receivers communicate back to senders their understanding of the senders' message.
In the example, you were first a receiver of information from Mr. Raymond; when you responded to him with a statement, such as "So you want your medication refilled?" you became a sender of feedback to Mr. Raymond.
Feedback can be simple, such as merely nodding your head, or more complex, such as repeating a set of complicated instructions.

During the communication process, most of us tend to miss the feedback. As receivers of messages, we fail to provide appropriate feedback to the sender about our understanding of the message. On the other hand, as senders of messages, we fail to ask for feedback from the receiver or in some cases ignore feedback provided by others.

The model we have presented is useful because it is easy to understand, but it does oversimplify the communication process. **In any interpersonal communication situation, individuals at any point in time are simultaneously sending and receiving messages**.

For example, in the scenario described above, the initial spoken message was sent by Mr. Raymond: "The doctor called in a new prescription for me, and can I also have a refill of my heart medication?" **However, at the time that he was speaking to the pharmacist, he was observing the pharmacist's nonverbal behaviors and so was receiving messages from the pharmacist as he was sending the oral message**. He observed whether the pharmacist was **paying attention**, whether he was **smiling**, whether he was **understood t**he spoken messages with nods of his head, and so on.

The communication is transactional and the interaction includes both verbal and nonverbal messages.

5-Barriers

Interpersonal communication is usually affected by a number of **barriers**. These barriers affect the accuracy of the communication exchange. For example, if a **loud generator** in your pharmacy while you were talking to Mr. Raymond, it would have been even more difficult to understand what he was trying to communicate. Other barriers to your interaction with Mr. Raymond might include a **safety glass partition between you and Mr. Raymond**, **telephones ringing**, or Mr. Raymond's **inability to hear you due to a defective hearing aid.**

Personal Responsibilities in the Communication Model

As a sender, you are responsible for ensuring that the message is transmitted in the clearest form, to the other person. To check whether the message was received as intended, you need to ask for feedback from the receiver and clarify any misunderstandings.

A-Thus, your obligation as the sender of a message is not complete until you have determined that the other person has understood the message correctly.

B-As a receiver, you have the responsibility of listening to what is being transmitted by the sender and you should provide feedback to the sender by describing what you understood the message to be.

In this counseling situation, what is the pharmacist doing correctly? What needs to be improved?

Many times, we rely on our assumptions that we understand each other and thus feel that feedback is not necessary. However, practice has found that without appropriate feedback, misunderstandings occur. Of concern is that, as pharmacists dealing with patients, physicians, and other health care providers, we cannot afford these misunderstandings. These misunderstandings might result in harm to the patient.

To become more effective, efficient, and accurate in our communication, we must include feedback in our interactions with others.

Research has found that when pharmacists communicate effectively with patients, patient outcomes improve.

In Search of the Meaning of the Message

In the interpersonal communication, the sender delivers the message, and the receiver assigns a meaning to that message. **The critical component in this process is that the receiver's assigned meaning must be the same as the meaning intended by the sender**. **In other words, we may or may not interpret the meaning of the various verbal and nonverbal messages in the same way as the sender intended**.

In the encounter with Mr. Raymond, he may have been embarrassed or hesitant to talk with you, or then again, he may not have been. He may have been looking down at a coffee stain on the new tie that his wife gave him. Thus, the message that you received might not have been the one Mr. Raymond intended to send.

Words and their context

- In general, individuals assign meaning to verbal and nonverbal messages based **on their past experiences and previous definitions** of these verbal and nonverbal elements. **If two persons do not share the same definitions or past experiences, misunderstanding may occur**.
- Different words mean different things to different people based on the definitions learned. For example, "football" to an American means a sport using an oval ball, but "football" to a European means a sport using a round ball (soccer).
- An example of this misunderstanding occurs in health care when we speak in medical terminology that may have different (or possibly no) meaning to our patients. The following example illustrates this potential misunderstanding.
- In the beginning exercise, let us assume that you wish to inform Mr. Raymond that his urinary tract antibiotic will be more effective if taken on an **(empty stomach).**
- **Empty stomach in pharmacy practice means at least 1 hour before meal or at least 2 hours after meal**. Thus, the meaning of your important message may not have been received accurately by Mr. Raymond. Thus, patients may assign a meaning to our message that is different from the one intended. The following actual situation illustrates this point
- Let us assume that you wish to inform Mr. Raymond that his urinary tract antibiotic will be **more effective if taken with sufficient fluid** to guarantee adequate urinary output.
- You relate that intent in the following manner, "This medication should be taken with plenty of fluids." The message is received and decoded into words and symbols in the mind of Mr. Raymond.
- These words or symbols may or may not have any particular meaning to him.
- Perhaps **he does not even know what "fluids" refers to**; perhaps he is uncertain whether you consider milk to be a fluid; or perhaps he associates the word "plenty" with a small glass of orange juice at breakfast rather than the 8-ounce glass of water you had in mind.
- Thus, the meaning of your important message may or may not have been received accurately by Mr. Raymond. It is the assignment of meaning to those words by Mr. Raymond that is important.

Case Study 2

A 9-month-old baby is admitted to the hospital with a severe infection. The pharmacist spoke with the mother upon admission and learned that about 1 week ago her son had developed a minor bacterial infection and received an antibiotic, which she gave him for 4 days until the infection appeared to be cleared up. When asked why she stopped the antibiotic, the mother stated that she was just following the directions on the prescription label: "**Take one-half teaspoonful three times a day for infection until all gone**." The mother stated that she gave the medication until the **infection was all gone**. Unfortunately, the **intended message was that the antibiotic should be given until the liquid was all gone** (which would have been

about 14 days—long enough to treat the bacterial infection). The mother assigned a meaning to the message on the prescription label that was not accurate; and thus, she stopped giving the antibiotic, a super-infection developed, and the baby was hospitalized.

In this example, **the pharmacist did not ask for feedback** from the mother to know how she was going to give the medication to her son.

Congruence between verbal and nonverbal messages

The meaning of the message may be somewhat unclear if the receiver senses incongruence between the verbal and nonverbal messages. **That is, the meaning of a verbal message is not consistent with the meaning of a nonverbal message**.

See the "Examples of Incongruent Messages" box. In each of these examples, the verbal message obviously does not match the nonverbal message, and the receiver may be confused about the true message intended by the sender.

To avoid this incongruence, as a sender, you must be aware of the nonverbal messages as well as the verbal messages.

As a receiver, you must point out to the sender that you are receiving two different messages.

Examples of Incongruent Messages

• A **red-faced agitated man comes into the pharmacy, raises a fist**, and loudly proclaims, **"I'm not angry**, I'm just here to ask about a prescription error."

• A patient hand a pharmacist a prescription for a **tranquilizer**, then **bursts into tears**. The pharmacist asks if anything is the matter, and the patient responds, "No, **I'm okay, it's nothing at all**."

In reality, the final message is not what is said, but what the receiver perceives was said. The following section discusses how to prevent potential misunderstandings.

Preventing misunderstanding

In the previous situation involving the baby's antibiotic prescription, the label read, "Take one-half teaspoonful three times a day for infection until all gone."

Unfortunately, the mother interpreted the message incorrectly. In this situation, the meaning could be clarified relatively easily by rearranging the position of the last two prepositional phrases (. . . three times a day **until all medication is finished**) or rearranging the wording (. . . **until the medication is all gone**).

However, minimizing misunderstandings is many times more difficult in other situations.

We often assume that the receiver will interpret our message accurately.

Using feedback to check the meaning of the message

Predicting how a person will translate a particular message is difficult. **Using a** technique **described earlier (providing feedback to check the meaning of the message) may alleviate some communication misunderstandings.**

See **case study 3** for an illustration of the harmful effects of not asking for feedback from the patient on how they intend to take the medication.

Case Study 3

A patient being seen in an anticoagulation clinic mentioned to the pharmacist that he had developed several bruises on his hands and legs. The pharmacist immediately checked the patient's INR value and found it 6, which was well above his targeted 2–3 range. The pharmacist asked whether the patient had changed his diet, lifestyle, or drug regimen. **The patient said no, but that he was given another medication during his last clinic visit**. The pharmacist then went back to the patient's record and noticed that the patient had been receiving 4 mg daily of the anticoagulant drug for some time, but his dose was reduced to 3 mg during the last visit to adjust his INR. The pharmacist suspected what the issue might be and asked the patient, "**Did you stop taking the 4 mg tablet?"**

The patient replied, "No, nobody told me to, so I have been following instructions and taking both tablets!!" Thus, he was taking 7 mg per day rather than the intended 3 mg.

Unfortunately, relying on our intuition is not as effective as obtaining feedback to measure understanding. See the accompanying box for examples of how to ask for feedback.

Statement or Question That Elicit Feedback

"just to make sure that I didn't leave anything out, please tell me how you are going to take your drugs"

The receiver can also alleviate some misunderstanding by offering feedback to the sender. After receiving the message, the receiver should indicate in some way what she understands the message to be.

So when the pharmacist is primarily the "receiver" when he is obtaining information from patients on their symptoms or current therapy, the pharmacist should provide feedback to verify his understanding.

When the pharmacist is primarily the "sender," as when he is giving information on a new prescription, then the patient should be asked to summarize key information presented as a way of providing feedback that the pharmacist's message was understood accurately.

Case Study 4

A patient returned to the pharmacy complaining of side effects apparently caused by his medication. The patient's records indicated he was given 30 nitroglycerin patches. Both the pharmacist and the physician told him to "**apply one daily**." The patient opened his shirt to reveal 27 nitroglycerin patches firmly adhered to his chest!!.

In case study 4, the patient applied one patch each day (but did not perceive the intended message that he should remove one). He followed his perception of the instructions.

Unfortunately, no one asked him how he was going to use the patches (in other words, did not ask for feedback on his perception of the instructions). If the pharmacist had verified the patient's understanding, the patient would have been spared the resulting embarrassment and possible side effects.

Misperceptions like the one above occur frequently in pharmacy practice, and most pharmacists have a story to tell about how patients misuse medication based on their misperceptions.
The outcome of these situations may be relatively harmless, but some can be serious. For an example, see case study 5.

Case Study 5

young woman suffering from vaginal candidiasis was given the usual 15 nystatin **vaginal tablets** and was told by the pharmacist to "**use one tablet daily** for two weeks." She returned to the pharmacy after two weeks in severe discomfort with a complaint that "**those nystatin tablets taste terrible**!".

In case study 5, **the patient assigned the wrong meaning to the word "use" and used the medication the way she typically uses medications—by taking them orally.**
In general, people develop their perceptions based on their past experiences, background, and values.

People of different backgrounds, values, and experiences may assign meanings to messages that are different from those intended by the sender.

One skill that minimizes perceptual differences is to use terms and concepts that are familiar to the patient. It is very easy for patients to misunderstand when you use medical terminology or professional jargon. For example:

1-احد الزملاء وعندما سأله المريض عن فائدة احد الأدوية الفوارة الموصوف له جاوبه بقوله : **يجعل الإدرار قلويا .**

2-احد الزملاء وعندما سأله المريض عن الفرق بين ابرة الكلافوران وابرة السيفترايكسون الموصوف له جاوبه بقوله : **كلاهما من الجيل الثالث . وهي ترجمة حرفية لـ**
Third generation cephalosporins

3-احد الزملاء وعندما سأله المريض عن سبب وجوب ابتلاع حبة اسبرين الاطفال كاملة وعدم قسمها اوطحنها جاوبه بقوله : **لأنها مغلفة معويا . وهي ترجمة حرفية لـ**
Enteric coated

4-احد الزملاء وعندما سأله المريض عن سبب الامتناع عن تناول كبسول تتراسايكلين مع الحليب ومشتقاته في نفس الوقت جاوبه بقوله : **لأنه يكون معقدا . وهي ترجمة حرفية لـ**
Complex formation

Many times, using "**lay language**," **which is familiar to patients, rather than medical terminology**, which is familiar only to health care professionals, **can enhance understanding.**

Perceptions of individuals

Our perception of the message is also influenced by our perception of the individual sending the message. How we perceive the sender affects the interpretation of the message. We respond using our perception of that individual as our reference point because we tend to be influenced by a person's cultural background, status, gender, or age.

These perceptions are further influenced by any *bias we have or stereotypes we hold of certain groups of individuals.*

The following statements illustrate this point:

"People who are mentally ill do not comply with their medication regimens."

"Elderly people can't hear well and always talk too much."

"People who talk slowly have a learning disability."

وفي العراق توجد الكثير من مظاهرstereotypes مع الاسف الشديد

We do not see the person as a unique individual but as a representative of a particular group (e.g., elderly, overweight, or mentally ill). We erect "perceptual barriers" to the communication process not based on fact but on our inferences **based on stereotypes**. Unfortunately, these barriers inhibit true communication between individuals.

Misunderstandings will often take root when people from differing backgrounds do not talk to one another.
Be willing to talk openly and with a constructive attitude.

Unfortunately, **the people we deal with on a daily basis may have perceptions of pharmacists that interfere with our ability to communicate with them.**

Their perceptions may not be based on reality but on **their stereotypes of pharmacists**. Patient perceptions are influenced by their past experiences with pharmacists, by what others have said about pharmacists, or by what they read in magazines and newspapers. **For example, patients may perceive us as uncaring, busy people who are concerned only with filling prescriptions and taking their money**.

These stereotypes influence what they say to us and how they listen to us. **If they perceive us as professionals, they will listen to what we tell them about their medications.**

By the same token, if nurses, physicians, and other health care providers do not perceive us as professionals, they will not value the information we provide.
Part of improving communication with others is to determine what their perceptions of pharmacists are and then try to alter those perceptions if they are unfounded.

Summary

The interpersonal communication model reveals that you must recognize that interpersonal communication is more than merely speaking to others, or offering the instructions to the patients.

You must make sure that the messages you transmit to others are received accurately.

Reference

1-Robert S. Beardsley, (ed.); Communication Skills in Pharmacy Practice, 5th edition.

College of Pharmacy

Communication Skills

Nonverbal Communication

Beyond words: the power of non-verbal communication

1-The most important thing in communication is hearing what isn't said.
Peter Drucker
2-The body never lies.
Martha Graham
3-The pharmacist may learn more about the illness from the way the patient tells the story than from the story itself.

Background

1-Words are not the only way by which pharmacists communicate. **Interpersonal communication involves both verbal and nonverbal expression**.

2- Nonverbal communication can be defined as a **message or messages that are conveyed without using language**.

3-This lecture describes the various components of nonverbal communication and discusses how it plays an important role in effective patient-centered communication.

Nonverbal versus Verbal Communication

1-The importance of nonverbal communication is underlined by the findings of behavioral scientists, **who have reported that approximately 55% to 95% of all communication can be attributed to nonverbal sources** [(1)].

2-Various interpretations may present for the same nonverbal message and come from the different social, cultural, and other background variables of the senders and receivers. **However, within a given society, groups of nonverbal cues or "cue clusters" generally result in interpretations that are usually universally agreed upon**.

3-**When analyzing nonverbal communication, avoid focusing on just one cue**. Look at all the nonverbal cues that you are receiving and use verbal communication to fully understand the meaning of the nonverbal behavior.

4-Nonverbal communications are unique for three reasons.

A-**Verbal communication is discrete with clear endpoints** – we know when the message has come to an end. In contrast, **non-verbal communication is continuous** – it goes on for as long as the communicators are in each other's

presence. **We cannot stop communicating non-verbally– even when people are together in silence, the atmosphere is filled with messages**.
So you are constantly providing "nonverbal messages" to those around you by your dress, facial expression, body movements, and other aspects of your appearance and behavior.

B-**Nonverbal communication is difficult, if not impossible, to "fake" during an interpersonal interaction**. Verbal communication is mostly under voluntary control whereas non-verbal communication operates beyond our conscious awareness.

C-**Your nonverbal communication must be consistent with your verbal communication**. This lack of congruence between your verbal and nonverbal messages may result in less than successful interpersonal communication.

Elements of Nonverbal Communication

Non-verbal communication can also be defined as all forms of human communication apart from purely the words used. Using this definition, the term non-verbal includes mainly:

1-Paralanguage (how something is said)
2-Body language
3-The physical environment (environmental nonverbal factors)

A-Paralanguage (how something is said)

The paralanguage includes the vocal characteristics as:

1-Tone: ***tone in particular can convey more meaning that actual words*** e.g.
Changes in the level and range of pitch convey information about the feeling of the person speaking.

"Thank you for asking question" said in a harsh voice contradict the words and indicate that is not meant. The same words in a warm tone show sincerity.

-The human voice communicates much to the receiver. This is especially true when the communication takes place over the telephone.

2-Speed: ***the speed of speaking must enable the listener to understand.***

For good communication, **the pharmacist should provide the clear message at a speed which give the patient time to think about what is being said**. This will help the patient to **understand and remember** the message more easily.

3-Volume (how loudly we speak): many people speak with wide variation in volume, depending on the situation.

The volume must be adjusted to the circumstance and emphasize key words.

A-It may be necessary to **speak more loudly to patients with hearing problems**.
B- It may be necessary to speak l**ess loudly to patients when we speak about an embarrassing subject**.

B-Body language

The body language in turn, includes:
1-Eye contact:
the maintenance of eye contact during communication may indicate an interest in the subject in western cultures. However, **Orientals tend to decrease eye contact during communication and will often look at the floor when speaking**.

By maintaining eye contact with the patient, **pharmacists are more likely to pick up nonverbal cues regarding whether the patient understands them**. Many patients will say they understand something when they actually do not. Patients? facial expressions, such as a crinkled eyebrow, often reveal confusion, misunderstanding or uncertainty. These important cues are often missed by pharmacists when they do not take the time to maintain eye contact.

The amount of eye contact used should be in response to the patient. If the patient reacts uncomfortably to your direct eye contact, looking away occasionally may be a good idea (**it is generally true that direct eye contact may have negative consequences in when we speak about an embarrassing subjects**).

2-Facial expression:
the facial expression of pharmacist should be encouraging and welcoming. As well as **pharmacist should be able to read the meaning of patient's facial expression regarding the level of comprehension and receptiveness**.

The 53 muscles of the face offer an almost infinite range of expression

Facial expression may send a message that you did not intend to transmit**. This is especially damaging when your facial expressions are not consistent with your verbal expressions**. For example, if you say, "Go ahead I am listening, tell me about it!" but your eyes are distracted by something else in the pharmacy, you may be communicating mixed messages.
In these situations, people would tend to believe your facial expression and other nonverbal messages more than the verbal aspects of your communication.

The right word may be effective, but no word was ever as effective as a <u>rightly timed pause</u>.

Mark Twain

3-Body posture:

In addition to facial expression, body position can be somewhat distracting. **Most patients will judge your willingness to talk to them based on their perception of your body position**. For example, a closed stance with folded arms or a body position that is slouched forward or tilted to one side may be communicating reluctance on your part to talk with them.

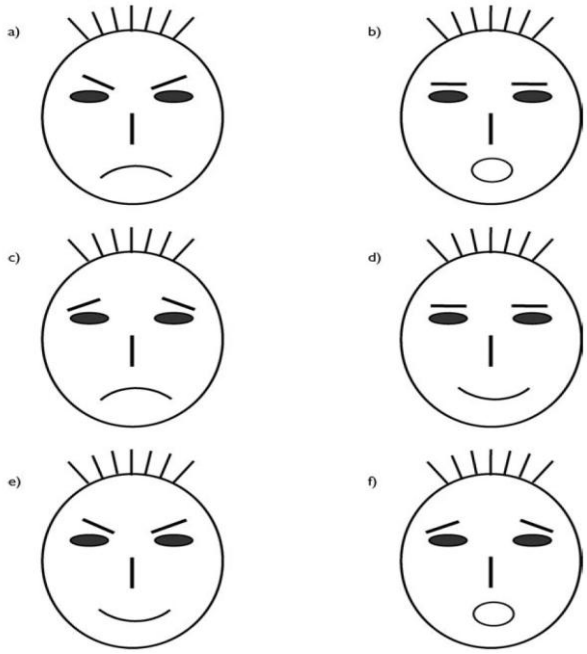

Figure six basic emotional expressions

leaning towards the person who is talking or sitting in a relaxed fashion, with a full-frontal appearance to the other person can encourage good communication.

A closed posture occurs when you have your arms folded in front of your chest, legs crossed at the knees, head facing downward, and eyes looking away from the patient. If you hold this posture during an interaction, the other person may respond in a similar noncommunicative manner or may break off the interaction altogether.

What nonverbal messages is the pharmacist sending? The patient?

Communication from a closed posture may shorten or halt further productive interactions. **Sometimes it is appropriate to use a closed posture, for example, when you want to limit the interaction with an overly talkative person**.

4-Physical contact (touch):

1-**A light, tender, sensitive touch is worth a ton of brawn**.
Peter Thomson
2- Touch seems to be as essential as sunlight.
Diane Ackerman

Of all non-verbal behavior, touch is among the most powerful and the most problematic: powerful, because any intended physical contact between two human beings can have a considerable

emotional impact; problematic, because it can be misinterpreted or experienced as a culturally offensive act [**physical contact is governed by social and religious rules, which vary between cultures**]. In some cultures, physical contact between adults in public is rare, even taboo.

3- Too often we underestimate the power of a touch, a smile, or a kind word all of which have the potential to turn a life around.
Leo Buscaglia.

In cultures where it is permitted, touch can be a compassionate and healing act which gives comfort and strength to those in pain or distress; touch can make contact between two people at a level beyond words.

The guiding hand on an elbow, the comforting touch on a shoulder, the reassuring holding of hands, picking up and hugging a distressed child – all so obvious, natural and humane.
[A sympathetic touch on an arm can say far more than any number of words].

5-Personal space (distance):

1-The distance between two interacting persons plays an important role in nonverbal communication. The structure and use of space, is a powerful nonverbal tool [(1)].

2-Behavioral scientists have found that the quality of interactions can vary depending upon the distances between the communicators.

3- **The distance should create some privacy (too far apart would cause talking that was audible to others), while at the same time, not creating discomfort**. Our patients will give us nonverbal cues when we are standing too close.
[Patients usually indicate nonverbally whether they feel comfortable with the distance by either stepping backward or leaning forward].

4-In many cultures, **0.5-1 m is usually sufficiently close to allow friendly and meaningful communication**. Preserve the most protected space (less than 0.5 m from their bodies) for others with whom they have close, intimate relationships.
When someone else enters into this space (intimate zone) during a conversation, people may experience anxiety and perhaps anger.

5-A crowded elevator is the best illustration of the need to maintain intimate space. People in a crowded elevator will do almost anything (to the point of standing like statues) to avoid touching one another. If by chance two people in this situation do have bodily contact, they usually apologize, even though neither person had an opportunity to avoid the trespass of space.

6-**The type of instructions that you need to give to the patient will also affect the distance**. For sensitive issues, such as explaining the use of a rectal or vaginal

medication, you may need to enter the patient's private zone, especially if others are around.

6-Gesture:
Hand gestures in particular are useful when emphasizing a point or to help to describe something and can greatly enhance communication and improve understanding.

مثال ذلك تحريك اليد صعودا ونزولا عند قولنا للمريض رج الزجاجة قبل الاستعمال وهكذا الحال مع الكثير من التعليمات حيث يمكن تعزيز فهم وتذكر المريض للتعليمات بتعزيز الكلام بحركات اليد المنسجمة مع محتوى الكلام...

7-Clothing:
The clothing we choose to wear can communicate a great deal about us. Are the clothes in style? Are they ironed or wrinkled? Do the colors go together? How does the pharmacist distinguish him or herself from the rest of the staff in the pharmacy? **Does the pharmacist wear a professional coat that indicating this is a pharmacist**?

وأن من ابرز الأشياء التي تعطي (مظهر المهني ونقصد به الصيدلي) هو ارتداء الصدرية في الصيدلية وهو جانب عنصر مهم من عناصر المظهر المهني ولكن ومع الأسف الشديد قلة من الزملاء الصيادلة من يلتزم به رغم التعليمات النقابية بهذا الخصوص...حتى إن صحفيا كتب مقالة في الصحيفة وعنونها (أين الصيدلي) اشتكى فيها من صعوبة تعرفه على الصيدلي في الصيدليات خصوصا إذا كان فيها أكثر من شخص والسبب واضح.

C-The physical environment (environmental nonverbal factors)

1-Never go to a doctor whose office plants have died.
Erma Bombeck
2-I was going to have cosmetic surgery when I noticed that the doctor's office was full of portraits by Picasso.
Rita Rudner

There are many things in the environment which will have a some potentially very powerful impact. These are part of the broad category of non-verbal communication [communication beyond words].

Relationships with patients will be eased and enhanced, confidence and trust will be stimulated in an **environment that is welcoming, comfortable and attractive**.

Dirt, clutter, and general untidiness carry negative nonverbal messages. These messages influence patient perceptions about your professional role and your level of interest in serving your patients.

In the pharmacy, a host of physical, non-verbal elements send strong positive or negative messages (communicate) to patients, visitors and colleagues:

• **Layout and arrangement of rooms or physical space.**

Case Study 1
Patient: Fifteen minutes? Just to throw a few pills in a bottle? I just had to wait almost an hour and a half at the doctor's office.
Pharmacist: **I know that you have waited a long time today**. I will get your medicine to you as quickly as I can. I do have two other patients ahead of you and I want to be accurate with everyone's medicine. **I do appreciate your patience**.

• Tidiness and cleanliness.

• Comfort of seating.

• Temperature, humidity and freshness of atmosphere.

• Lighting levels, color schemes, decorative elements (such as plants and pictures).

•The visibility of library references books will enhance the professional image.

• Privacy: an **area where the patient and pharmacist cannot be overheard** is very important to ensure confidential communication and this **may be only a corner in the pharmacy away from the customers' cue**. Privacy allows the pharmacist to give accurate and complete information and allow the patient to ask even potentially embarrassing or stupid questions.

[In some pharmacies (even in Iraq) there is a private consulting area. This may indicate to your patients that you are interested in counseling them in a private manner].

Many pharmacies sell many items that are not health-related. These may include, cosmetics, greeting cards, household items (e.g., paper towels, toilet paper, glass cleaners, etc.), candy, etc. Does selling these items confuse the patient about what the pharmacist's primary intent is as a healthcare provider? Is the selling of these items consistent with the health image the pharmacist is trying to convey? Pharmacists may need to reconsider the items they sell and the effects of those items on the image conveyed.

D-Time-Consciousness:

Many patients are extremely time-conscious. Even a fifteen-minute wait, which is fairly common in many pharmacies, is viewed with impatience. Therefore, it is important to **convey value in the wait** in order to reduce this negative view of waiting. **This may be done by either providing services worth waiting for (such as counseling) that most others don't provide or provide as well, or this may be done through compassion and empathy.**

Notice in this situation that the **pharmacist acknowledges the patient's complaint but does not take responsibility for the problem, nor does the pharmacist attempt**

to solve it. The pharmacist is caring and compassionate, but also not willing to engage the patient in a debate.

Mirroring

1-**When two (or more) people are in some kind of harmony, their non-verbal behavior is often mirrored**: they may be sitting in similar poses (may be one ankle resting on the knee, or an arm loose on the arm of a chair); they may move or make the same gesture at the same time.

2-Knowledge of this is also professionally important. **If a patient is imitating your body posture, then you may assume that they are on at least a similar wavelength to you and amenable to some degree of open conversation**. In order to demonstrate the same degree of openness to what a patient is saying, you can mirror their behavior.

3-**A tense patient may be influenced unconsciously to relax and imitate you, by your adopting a relaxed body posture**, but if their tension is mirrored in your posture, and you don't recognize the imitation, then progress may not be easy.

Distracting Nonverbal Communication

1-**One of the most distracting nonverbal elements is lack of eye contact**. It is frustrating to talk to somebody who is not looking at you. Unfortunately, many pharmacists unconsciously do not look at patients when talking to them. Their tendency is to look at the prescription, the prescription container, the computer screen, or other objects while talking.

This behavior may indicate to patients that you are not totally confident about what you are saying or that you really do not care about speaking with them. **Not looking at the patient also limits your ability to assess whether the patient understands the information**. In other words, lack of eye contact limits your ability to receive feedback from the patient about the messages that you are giving.

Good eye contact is also essential for effective listening. If you do not look at patients while they are talking, they may get the impression that you are not interested in what they are saying. Using good eye contact does not mean that you continually stare at patients, because that may make them feel uncomfortable as well. **The key is that you spend most of the time looking at them**.

2-**Another potentially distracting nonverbal element is facial expression**. This is especially damaging when your facial expressions are not consistent with your verbal expressions. For example, if you say, "Go ahead I am listening, tell me about it!" but your eyes are distracted by something else in the pharmacy, you may be communicating mixed messages. The patient hears you say that you are interested, but your nonverbal behavior communicates otherwise. **In these situations, people would tend to believe your facial expression and other nonverbal messages more than the verbal aspects of your communication**.

3-In addition to facial expression**, body position can be somewhat distracting**.
For example, a closed stance with folded arms or a body position that is slouched forward or tilted to one side may be communicating reluctance on your part to talk with patients.

4-Another potential distraction to communication may **be your tone of voice**. An inappropriate tone of voice may create an entirely different meaning from the one intended.

Detecting Nonverbal Cues in Others

1-Up to this point, this lecture has focused on your own nonverbal communication.
The following section examines nonverbal messages provided by others and describes how to better detect these messages.

2-**Assessing the meaning behind the nonverbal messages of others is difficult, because we tend to interpret nonverbal cues based on our own personal backgrounds and experiences**. We "filter" these messages based on our personal orientation and experiences. The meaning of the nonverbal messages that we receive **may or may not be the meanings intended by the sender**.

Case Study 2
During his first experience in a community pharmacy, a pharmacy student (John) was assigned the task of receiving new prescriptions from patients.
One day, Mr. Stevens approached the prescription counter to have his prescription for levodopa refilled. John, who did not realize that Mr. Stevens had Parkinson's disease, **noticed that his hands were shaking** and commented, "**I see you are a bit nervous today. What's the matter**?"

John observed a nonverbal message (rapid hand movement) from Mr. Stevens and assigned a wrong meaning to it. **John should not have jumped to the conclusion based on just one nonverbal cue** but should have noticed that Mr. Stevens' head was also moving and that he walked with a shuffled gait characteristic of Parkinson's disease.

3-Another example occurs when **elderly patients move closer to you or may put a hand to their ears**. What message might these nonverbal cues indicate? Possibly, **they may indicate that they are having difficulty in hearing**. You may also observe hearing aids, glasses, and other devices that may indicate possible communication difficulties.

Dealing with Sensitive Issues

1- It is interesting to note that a study found that **embarrassment was the most common reason why consumers did not approach their health care provider**.

2- A wide variety of embarrassing issues could exist within practice, including **incontinence**, **sexual dysfunction**, **depression**, **menopause**, **hemorrhoids**, **contraception**, and **breast or prostate cancer**.

3-As a pharmacist, you should be prepared to recognize situations that may be sensitive areas for patients. **You should be comfortable discussing such matters in a nonthreatening way and in a nonverbal environment that conveys confidentiality and privacy.**

Overcoming distracting nonverbal factors

1-As mentioned earlier**, the first step in improving interpersonal communication is recognizing how you communicate with others**. In the nonverbal area, this self-awareness **involves being constantly aware of your nonverbal behavior**.

2-Once you have discovered what aspects you need to change to become more effective, the next step is a difficult one: **finding strategies to overcome these distracting elements.** Several suggestions have been already made about how specific nonverbal elements can be improved.

One thing that should be mentioned here is that **potentially distracting behaviors can be overcome by using nonverbal elements that project different messages**. For example, you may find that you naturally cross your arms while talking to others. You can overcome this nonverbal element by using other nonverbal elements, such as smiling, using a friendly tone of voice, or moving closer to the patient. **The total message received by the patient is the combination of all these nonverbal cues, both positive and negative, and not just one isolated component.**

Another example is that if you have a soft voice and you sense that the patient cannot hear you, then you should lean toward the patient, or move the patient into a quieter section of the pharmacy.

[**The key to this process is to first recognize distracting nonverbal elements and then try to overcome them**].

Summary

Because nonverbal communication contributes significantly to the meanings of messages between pharmacists and others, it is important for you to keep the following in mind:

1-Certain nonverbal behaviors are **universal**; however, many are **culturally specific**.

2- **Nonverbal behavior is more powerful than verbal**. If the spoken word contradicts nonverbal behaviors, the observer will believe the nonverbal messages.

3-The practice **environment have important effects on communication** with patients.

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College of Pharmacy
Communication Skills.

Assertiveness

Overview

Assertive pharmacists **take an active role** in patient care.
1-These pharmacists **initiate communication** with patients rather than wait to be asked questions.
2-Assertive pharmacists also **convey their views** on the management of patient drug therapy to other health care professionals.
3-Finally, assertive pharmacists **try to resolve conflicts** with others in a direct manner but in a way that conveys respect for others.

Defining Assertiveness

What is assertiveness? Assertiveness is perhaps best understood by comparing it with two other response styles: **passivity** and **aggression**. These three styles of responding are described below.

A-Passive behavior

1-This response is **designed to avoid conflict at all cost**.
2-Passive or nonassertive persons **will not say what they really think out of fear that others may not agree.**
3-Passive individuals "hide" from people and wait for others to initiate conversation.
4-**They put the needs or wants of other people above their own**.
5-**They worry about how others will respond to them and have a high need for approval**.
6-Passive persons may see themselves as **victims** who are subject to the **manipulation** of others.

[It is this view that is damaging to their self-esteem]

B-Aggressive behavior

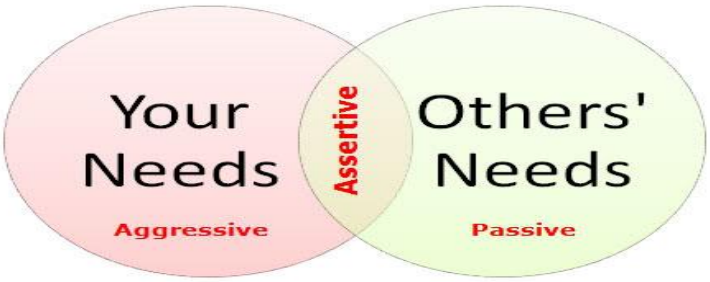
1-**Aggressive people seek to "win" in conflict situations by dominating or intimidating others.**
2-Aggressive persons **promote their own points of view but are indifferent or hostile to the feelings, thoughts, or needs of others.**
3-Such individuals are easily angered and have a low tolerance for frustration
3-Thus, aggressive individuals may "win" certain interpersonal battles in the short term, **but their behavior often leads to negative long-term consequences.**

[For example, patients who do not feel they are treated with respect in a community pharmacy **may not return to that pharmacy** and may tell friends about their negative experiences.

Employees who feel helpless and undervalued **can damage the goals of their employer** in a variety of indirect ways].

4-**Aggressive approaches do not build trusting relationships**, which is a key element in working with patients and others in professional practice.

C-Assertive behavior



1-Assertive behavior is **the direct expression** of ideas, opinions, and desires. The intent of assertive behavior is to communicate in an atmosphere of trust. Conflicts that arise are **faced and solutions of mutual accord are sought.** Assertive individuals initiate communication in a way that conveys their **concern and respect for** others.

The goal of communication is to stand up for oneself and to solve interpersonal problems **in ways that do not damage relationships**. Assertiveness requires that **you respect others as well as yourself.**

2-Too often, our goals in communication are defined in terms of **what we want others to do rather than what we will do.** For example, **we might say that we want physicians to appreciate the role of the pharmacist in patient care.** Redefining this goal would have us **focus on what specific things we can do to improve our working relationships with physicians**. If we tell others our goals in providing a good pharmaceutical care services and show them by our behavior what we want to achieve, many will come to respect our position.

ويكون ذلك بممارسة الصيدلي لدوره العلمي بجوانبه المختلفة (كالتثقيف الدوائي للمرضى والاشتراك مع الطبيب (في المستشفى خصوصا) في اختيار الدواء المناسب للمريض وإبداء الآراء العلمية المستندة على قاعدة علمية رصينة في مختلف المسائل التي تواجهه في المستشفى والمساهمة في إيصال المعلومة الصحيحة للطبيب والاشتراك في الحلقات والندوات والمؤتمرات العلمية وغيرها كثير ...كل ذلك يجعل الطبيب وغيره يحترم ويقدر دور الصيدلي ....أما الاكتفاء بكتابة طلبية الأدوية وتوزيعها على المرضى ...ومن ثم نطلب من الطبيب تقدير واحترام دور الصيدلي...فلا يجدي نفعا)

3-Other example, you may wish that your boss, who tends to be **very negative during evaluations of staff**, was more supportive of your work. However, **just hoping** that he would be more positive in his evaluations will not resolve this issue. **You must take active steps to change how you respond to his criticisms** rather than waiting for his to change her approach

سيتم التعرف على كيفية التعامل مع الانتقاد لاحقا في المحاضرة

Theoretical Foundations

Usually, the people respond passively or aggressively **because they have irrational beliefs that interfere with assertiveness.** These beliefs involve:

1-Fear of rejection or anger from others and need for approval (**everyone should like me and approve of what I do).**
2-**Over-concern for the needs and rights of others** (**I should always try to help others and be nice to them).**
3-**Perfectionist standards** (**I must be perfectly competent**. If I am not, then I am a failure. **Others must also be perfectly competent** and deserve to be severely criticized if they are not.)

[In the passive person these beliefs create anxiety that leads the individual to try (unsuccessfully) to avoid the inevitable conflicts that arise in relationships.

In aggressive person these beliefs lead to angry, aggressive behavior, with frequent "blaming" of others for normal human failings].

Assertiveness Techniques

There are a number of communication techniques or strategies that are useful in responding to situations that tend to be conflict-ridden.

A-Providing feedback

Many times, you must tell people that you are upset by what they did. **When you choose to convey negative feedback to others, use techniques to make the communication less threatening.** Criteria for useful feedback include:

1-Feedback focuses on a person's behavior rather than personality.
2-The feedback must be specific rather than general. It focuses on behavior that has just occurred and avoids dragging in past behavior (e.g., "**you always do**------ ").

3-Feedback focuses on problem solving. The focus is on problem solving rather than turning the conflict into a "win/lose" situation that damages the relationship.

The entire focus should be on **attacking problems** or issues, **not people or personalities.**

For another example, rather than saying (**you should not prescribed ciprofloxacin** because Mr. Jones is **taking theophylline** and the two drugs interact)

But say (**This patient** cannot take **ciprofloxacin because he is already taking theophylline and there is a serious drug interaction**. I suggest we use co-trimoxazole))

4-**Feedback is provided in a private setting**.

تعمدني بنصحك في انفـــراد .... وجنبني النصيحة في الجماعة
فإن النصح بين النـاس نـوع .... من التوبيخ لا أرضى استماعه

Feedback uses "I" statements that take the form "When you [do or say] _____, I feel ___." For example, "**When you are late for work, I feel frustrated**" is less damaging

than “You’re irresponsible. You don’t care about the patients who are waiting and the co-workers covering for you when you’re late.”

B-Inviting feedback from others

1-At the same time, **we need to invite feedback from others about us in order to improve our interpersonal communication skills.**

2-Your ability to **encourage feedback from others** (**even when it is negative)**, to hear criticism **or suggestions without anger**, and to **admit when you have made a mistake**, encourage people to be honest in their communications with you.

3- For example, as a pharmacist, you should routinely assess patient satisfaction and invite feedback on your services. As a manager, you should let employees know that you welcome suggestions from them on how to improve pharmacy operations.

C-Setting Limits

1-If we **have difficulty in saying "no" to any request, then we feel overwhelmed** and, often, angry at others for "taking advantage" of us.

2-**Saying "no" or setting limits may be particularly difficult if you believe that the other person must agree that you have a good reason for saying "no."** Whether you give reasons or not does not change the fact that **you have the right to make the decision on how you will spend personal time.**

3-Remember: **being assertive in setting limits does not mean that you stop saying "yes" to requests. You will no doubt continue to help others.**

D-Making Requests

1-When we ask for what we want from others, **we must trust that others will be able to respond to our requests in an assertive manner, including saying "no."**

2-Thus, **we must not overreact when someone turns down our request in an assertive way.**

E-Being Persistent

1- Often when you said “no,” people will try to coax you into changing your mind. **If you continue to repeat your decision calmly, you can be assertive without becoming aggressive and without giving in.**

F-Ignoring provocations

1-You as a pharmacist may receive an **aggressive comments (provocations)** for example, from patients who are angry or feeling helpless or from other pharmacists who feel unfairly criticized.

2-Ignoring the aggressive comments of others and focusing exclusively on solving underlying problems can do much to keep conflict from escalating to the point that relationships are damaged.

G-Responding to criticism

For some of us, criticism is particularly devastating because we typically hold two common irrational beliefs:
(1) **That we must be loved or approved of by virtually everyone we know**, and
(2) **That we must be completely competent in everything we do and never make mistakes**.
Since such perfectionist standards are impossible to achieve, we are constantly faced with feelings of failure or unworthiness.

****

Now let's examine a few typical situations in pharmacy practice and determine what might be the most assertive way to respond in relationships with patients, physicians, employees, employers, and colleagues.

Assertiveness and Patients

1-**Certain activities distinguish assertive pharmacists from passive ones**. For example, **passive pharmacists** seem to **hide behind the counter**, and generally avoid interaction with patients unless asked specific questions. In this way, **passive pharmacists are able to avoid the potential conflicts inherent in dealing with people**.

2-**Assertive pharmacists come out from behind counters, introduce themselves to patients, provide information on medications, and assess the patient's use of medications and problems with therapy**.

3-**Encouraging patients to be more assertive** is also an important skill in improving your communication with them. Even normally assertive patients may experience enough anxiety in communication with pharmacists. You as a pharmacist may encourage patients to be more assertive by **allowing them to ask questions about their therapy that they want to ask.**

4-**A particularly difficult situation that you will face in pharmacy practice is responding to an angry patient**. While no one likes to hear criticism, there are ways of dealing with criticism in a rational, assertive manner.

> A-When you hear criticism from patients, it is important to **keep in mind that some (do not assume all) patient anger arises from frustrations about being ill** (and the life stresses they are experiencing), and not from you.

B-**When patients are reacting primarily to the stresses of being ill; it is most helpful for you to understand what it is like for them and to respond empathically**. An empathic response when patients react with dismay at the cost of their medications will probably be more helpful than an attempt to justify the cost.
Saying, "**You're right. These medications are expensive. Are you worried about whether you can afford them?"** shows that you understand the patient's worry and allows you to assess whether the concern about cost is a real problem of inability to afford treatment or a way of expressing feelings of frustration.

C-Another skill that is useful in responding to patient criticism **is to get patients to turn criticism into useful feedback**. For example, if a patient tells you that your pharmacy does not seem to care about the customer, **it is important to find out specifically what is causing the problem**. Asking "**What specifically is it that upsets you?" may give you feedback that would be useful in improving your pharmacy operation.**

D-There will be times with angry patients **where you will need to stand up for yourself. If a patient persists in aggressive behavior in spite of your efforts to focus on understanding and problem solving**, you will want to set limits without becoming aggressive. You can ***calmly*** tell an angry patient "**I want to hear your point of view, but, when you are ready to talk without yelling and swearing, I will listen."**

Assertiveness and Other Health Care Professionals

When problems in patient medication therapies arise, consultations with physicians or nurses are often required. **If you have determined that you need to speak directly with the prescribing physician, you will be most effective if you are persistent with receptionists and nurses in your request**. Messages transmitted through third parties may not be the most effective means of communication. Such persistence might sound something like this:

CASE STUDY 1

Pharmacist calling a receptionist in a physician's office
Pharmacist: This is **Ameer Hasan**, the pharmacist at **AL-Yasameen Pharmacy**. I'd like to speak to Dr. **Ahmed Saleem** please.
Receptionist: He's with a patient now. What is it you wish to speak to him about?
Pharmacist: **I** am concerned about Mr. **Amjad's** prescription for metformin. I will need to speak to Dr. Ahmed about it. Please have him call me as soon as he comes out from the patient examination.

Receptionist: It might be quicker if you tell me what the problem is. **I** could talk to Dr. Ahmed and get back to you.
Pharmacist: Thank you, hut in this case I would like to talk to Dr. Ahmed directly.
Receptionist: He's very busy today.

Pharmacist: 1 knows he has a busy schedule but I must speak with him as soon as possible. Please ask him to call.

1-The pharmacist (**Ameer Hasan**) in this communication **was assertive**. **He showed respect for the receptionist and yet was <u>persistent</u> in stating his request**. He did not argue about the issue of which method of communication was quicker. **He <u>calmly</u> restated his request without anger or apology**.

Now, let's say you have managed to get through to the physician. **Compare the following introductory comments by a pharmacist:**

A-Dr. Ahmed, this is the pharmacist at AL-Yasameen Pharmacy. I'm sorry to bother you—I know you're busy—but I think there's a problem with Mr. **Amjad's** prescription for metformin.

B- Dr. Ahmed, this is Ameer Hasan, the pharmacist at AL-Yasameen Pharmacy. I'm calling about a problem Mr. Amjad is having with his prescription for metformin.

In (A), **the pharmacist did not introduce himself**, **which makes him an anonymous** rather than a professional with an individual identity. Also, in (A), he **"apologizes" for calling, which makes him seem unassertive.**

Here are several ways the pharmacist could precede:
A-**Did you know that Mr. Amjad is still having diarrhea from the metformin? Do you want to change his prescription?**

B- **I spoke with Mr. Amjad today. He reports that he continues to have diarrhea after three months on the medication. He is now reluctant to leave the house because of the diarrhea. The effect on his life is so serious that we may want to consider switching him to another drug like Glimepiride which is less likely to cause diarrhea**.

Response (B) is better.

-The pharmacist is **<u>not putting the physician on the spot</u>** by asking him if he knew there was a problem.

-Instead, he **<u>presented the problem</u>** that concerned him and **<u>suggested alternative</u>** medications that could possibly resolve the problem (The **<u>focus is on problem solving rather than win the situation</u>)**.

2-When identifying potential problems with a physician prescription:

A- **You should be prepared to <u>identify alternatives to try to resolve the problem</u>**. In order to do this with confidence, **you should have <u>checked</u>**

references before making the phone call or sending the written communication. This will increase your effectiveness in making a recommendation.

B-**Once you are sure of your facts; you must be persistent** in pushing for a therapeutic change that is required.

C-Be sure that you should use **the medical terms** and **speak to the physician as a fellow health professional**.

D-Focus on the goal you share with the physician, **which is to help the patient**.

E-Physicians may not accept recommendations and may, in fact, seem ungrateful to some of your interventions and you may not receive feedback that your efforts have been successful. **Perhaps the next prescription the physician writes will show a change**, even though the initial response to you indicated that a change would not be made.

F-It is important to keep in mind that consulting with physicians if problems arise or asking questions if something seems to be a problem **must be done in spite of what the physician's reaction might be.** To fail to consult a physician because of anticipated resistance **reduces your professional role significantly**.

6-While pharmacists seem to fear that physicians will not respond positively to therapeutic recommendations; **the research evidence suggests just the opposite**. Research indicates that, **when pharmacists make suggestions to physicians for important therapeutic changes in a patient's drug treatment, in the vast majority of cases, pharmacist recommendations are accepted and implemented by physicians.**

7-When patient safety is compromised, it is the professional responsibility of the assertive pharmacist to persist in trying to prevent or resolve problems. **More than one-half of health care workers in one study reported seeing colleagues making mistakes, yet less than 10% reported saying anything about what they observed.**

Assertiveness and Employees

Please consider the following situation. The manager of a hospital outpatient pharmacy has observed lately **that one of the pharmacists has been creating problems**.
The manager's major concern is that **the pharmacist is sometimes rude and abrupt with patients**. Today, the manager overhears the pharmacist respond with obvious annoyance to a patient who expressed confusion about how to take her medication.
The manager decides to **talk privately** with the pharmacist and **provide feedback** about his behaviour.

CASE STUDY 6.2

Manager speaking with staff pharmacist
Manager: I overheard your conversation with Mrs. Raymond this afternoon when you became impatient with her for not understanding instructions. I was upset because I didn't think you treated her with respect. I want you to treat patients with courtesy and not get so impatient and judgmental with them.
Pharmacist: Well, she wouldn't pay attention when I was explaining the directions. I just got fed up.
Manager: I know that patients can be irritating, but I want you to treat them with respect.
Pharmacist: Well, we were so busy then that I just didn't have time to explain the directions slowly.
Manager: I know you were feeling rushed today, but even then, I want you to be more courteous.
Pharmacist: Well, it would certainly be easier to take time to be nice if you'd get enough pharmacists in here to cover the workload.
Manager: Those things may be true, but right now I want to resolve the problem in the way you communicate with patients when you are irritated or hurried. I want you to agree to treat patients with respect, regardless of how busy we get. Will you do that?
Pharmacist: That's easier said than done.
Manager: Will you do it?

1-Pharmacy managers are responsible not only for how they communicate with patients, but also how other pharmacists and support personnel treat patients. **They must make clear to all employees what is expected in the way of patient care.**

2-In the previous scene, **the pharmacy manager used a number of assertive techniques** in his conversation with the pharmacist.

A-The pharmacy manager used appropriate feedback techniques. **He told the pharmacist what he had observed about a specific behaviour and what he wanted changed <u>without attacking the pharmacist as a person</u>**. The manager did not label the pharmacist as being rude. Focusing feedback on what a person does is much less destructive than making personal judgments about him as a person. Such feedback also lets him know exactly what must be changed to improve his performance

B- He **calmly <u>repeated</u> these expectations in spite of the pharmacist's excuses**. He would not let himself be dragged off the point.

C-**He <u>did not become anger</u> when the pharmacist attacked his performance as a manager (Ignoring provocations)**. He might also have said, "I would like to discuss any ideas you might have about improved the training of techs another time, but right now I want to talk about the way you counsel patients." This would have let the pharmacist know that he was willing to listen to specific, constructive suggestions but not before the current problem was resolved.

D-**The manager discussed the situation <u>privately</u>** and **soon after the incident occurred**. He made "I" statements to provide feedback and define expectations, including "I overheard your conversation," "I was upset," and "I want you to treat patients with courtesy." Because of these "I" statements, the communication was less damaging to the relationship than if the manager had labelled or judged the pharmacist as a person ("You are rude" or "You were rude") or if he had over-generalized based on what he observed ("You always …… when we get busy here"). **Dealing with the problem <u>immediately</u> was also much more effective than waiting** until the problem had become so serious that more drastic action was required.

Many of the same guidelines that are useful in giving negative feedback apply as well to **praise**. A personal statement, such as telling a pharmacist, "**I really appreciate your willingness to stay late tonight to help out**" is more meaningful than a general statement (e.g., "You're a good pharmacist").

In addition, **<u>if positive feedback is an ongoing part of the relationship</u>** rather than something that only gets written on job performance evaluation forms, it is more effective. **Too often, employees feel that the only time they get any feedback from their bosses is when they have <u>done something wrong</u>, which makes it much harder to accept the negative comments**.

Finally, **your willingness to accept even negative feedback from employees** (if it is constructive) **can create an atmosphere of mutual respect**. In the example above, the pharmacy manager conveyed **both an assertive and empathic message** when he said, "I **know you were feeling rushed today, but even then, I want you to be more courteous**." He let the pharmacist know that **he understood the feelings of frustration** and at the same time insisted that certain standards be met in patient care.

Assertiveness and Employers

1-**It is necessary to be assertive not only with your employees, but with your supervisors as well.** We may be faced with a situation where we receive a negative evaluation or criticism of our performance by a supervisor.

2-For some of us, our first response to criticism is to **counterattack**. The attitude is, "So what if I did make a mistake……..". In contrast to these aggressive responses, for more passive individuals, the initial response to criticism is to apologize

excessively, and give excuses. **Neither a passive nor aggressive response fosters problem solving**.

3- Even when you agree with the judgments made by someone criticizing you and think you were wrong, **you must separate the foolish or careless thing you did from yourself as a person.**

The following are **five responses** that are helpful in various types of situations where criticism is levied.

1-Getting Useful Feedback

If the criticism is vague, it is necessary first to find out exactly what happened that led to the criticism. **Therefore, before reacting to any problem that may be present, first be certain that you understand the exact nature of the problem**. If a patient says that people in your pharmacy don't care about customers, find out exactly what happened that was upsetting and led to this conclusion. In order to know how to improve your service, you must have **specific feedback** that points out what changes might be indicated.

2-Agreeing With Criticism

If you consider the criticism you receive to be valid, the most straightforward response is to acknowledge the mistake.
In any case, avoid "Yes, but. . ." responses that try to excuse behavior but lead to increased annoyance on the part of the other person. “Yes, I am late for work a lot, but the traffic is so bad" usually leads to an escalation of the conflict ("You'll just have to leave home earlier!"). **If you made a mistake or were wrong, acknowledge that**.
When you acknowledge mistakes and apologize for them, people have difficulty maintaining their anger.
However, if you **continue to make the same mistakes**, the **apologies will seem manipulative** since you **have not taken steps to prevent the problem** from reoccurring.

3-Disagreeing With Criticism

If you consider criticism unfair or unreasonable, it is important to state your disagreement and tell why. For example, you came in late to work this morning and your boss is anger. During his attack, he says, "**You're always late**……."
It is important to say to him: "**You're right, I was late this morning, and for that I apologize**. **But it is not true that I am always late**. I know I was late one day last month but that is the only other time I can recall being late in the two years I have worked here.
Not speaking against something you consider to be an injustice or untruth leads to loss of self-esteem.

4-Fogging

Fogging involves acknowledging the truth or possible truths in what people tell you about yourself while ignoring completely any judgments they might have implied by what they said.

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CASE STUDY 6.3

Supervisor: You spent a lot of time talking with that patient about a simple drug.
Pharmacist: You're right. I did.
Supervisor: The other pharmacists spent much less time than you when talking about this simple drug**.**
Pharmacist: You're probably right. They may not spend as much time as I do **on patient education about the drugs.**

Such a response allows you to look at truths about your behavior *without* accepting the implied criticisms. A fogging response differs from agreeing with the criticism. Agreeing with criticism includes acknowledging that you were wrong.

5-Delaying a response

If the criticism takes you by surprise and you are confused about how to respond, give yourself time to think about the problem before responding. Few conflict situations call for an immediate response. **If you are too surprised or upset to think clearly about what you want to say, then delay a response**. Tell the person: "I want time to think about what you've told me, and then I'd like to sit down with you and try to clear up this problem.

Assertiveness and Colleagues

The techniques for assertiveness with employers can also help you be more assertive with your colleagues.

For example, **a pharmacist who works with you in the hospital calls and asks you to serve as chairman of a new committee**. You are interested in the committee but are not sure you have the time to chair it. Which of the following responses would you choose?

A-"Well, I'd really like to. I don't know. I think I could if it doesn't take too much time."
B-"Why don't you ask Jim? He'd be good. If you can't find anyone else, maybe I could do it."
C-"I've given enough time to this organization. Everyone always comes to me. Let someone else do some work for a change."

D-"I'm interested in the committee, but I'm not sure I have time. Let me think
about it tonight and I'll call you in the morning with my decision."

Response (d) seems most honest and assertive.
[We typically feel that we must respond immediately to situations that arise. **Often the best response is to delay a response**. **It gives you time to decide what it is you really want to do].**
When you are facing a decision or when you are embroiled in a conflict, it is often best to say, "**I want time to think. I'll get back to you**." It is, of course, essential that you do get back to that person when you say you will and resolve the issue.

Response (a) is a **wishy-washy** "yes." The problem with such a response is that you may say "yes" but never take responsibility for your decision. **The "yes" response, in this situation, was given because you found it difficult to say "no."**

Response (b) suggests that, if no one else will do it, you will feel that you must do it. **You feel responsible for solving the president's problem** by identifying someone to chair the committee. **If he cannot find someone else, you will then feel obligated**.

The response **(c) is an aggressive response**.

Let's now imagine a situation where the colleague **tries to coax you into changing your "no" response to a "yes" response** to his request to chair the committee.

CASE STUDY 6.4

The colleague: You would be perfect for the job. It is extremely important and I must have someone who knows the issues and stays on top of things.

Pharmacist: I appreciate that, but I won't be able to chair the committee this year.

The colleague: I'll help with the workload. It shouldn't take more than an hour or so a week.

Pharmacist: That may be true, but I'm not willing to chair the committee right now.

The colleague: Why not? Perhaps there is something we can do to resolve the problems you seem to think will come up in chairing the committee.

Pharmacist: The decision is really a personal one. I won't be able to chair the committee at this time.

In this instance, the pharmacist calmly repeated his "no" response without despite the other pharmacist's efforts to coax him into changing his mind. If the pharmacist had

chosen to do so, he might have given an explanation for his decision, but he is not "**obliged**" to do so.

The danger for passive people in giving an explanation is that they seem to believe that the others must agree that the decision is "justified" before they feel they have the right to say "no."

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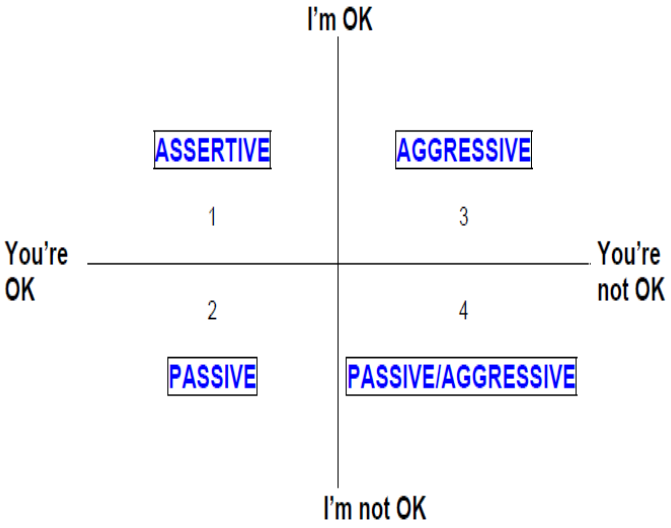
Summary

Quadrant 1

If I am ok and you are ok, then I am being assertive. When you are being assertive, people like you and respect you because you accept others in spite of their faults. You will have confidence, self esteem even though you are not perfect.



Quadrant 2

If I am not OK, but you are OK, then I am being passive. When you are being passive, the other person may benefit. However, your viewpoint will be ignored, and people won't respect you. This can then affect your performance at work.

Quadrant 3

If I am OK but you are not OK, then I am being aggressive. Aggressive people have a tendency to behave in a superior manner. They tend to dismiss people and thus, people do not trust them. Using aggressive behaviour leads to under performance in others in the longer term.

College of Pharmacy
Communication Skills.

Communication strategies to Meet Specific Needs

Overview

1-Communication skills in pharmacy practice can be especially difficult in situations in which patients have special communication needs (**older adults**; persons with **hearing**, **sight**, or **literacy deficiencies**; patients with **disabilities**; **terminally ill** patients; patients with AIDS; patients **with mental health problems**; patients from **different cultural background**s and persons taking care of patients (**caregivers**).

2-These groups require special strategies to ensure effective communication.

1-Older adults

Several factors make it imperative for you to be sensitive to interactions involving older adults.

1-**The number of elderlies in society is increasing**, and the **elderly consume higher amount of medications** compared with other age groups (Poly pharmacy).

- Although **some elderly patients** may appear to be weak, they may not be forgetful or hearing impaired. However, we make certain assumptions based on our perceptions of the elderly as a group of patients.
- The key is to assess how they **are responding to our educational efforts.** We should watch for nonverbal signs.
- Asking **open-ended questions** can also provide feedback about the patient's ability to communicate.

2-Unfortunately, the **aging process sometimes affects certain elements of the communication process in some older adults**. These potential communication problems are:

A-Learning

1-**Some older adults learn at a slower rate than younger persons**. They have the ability to learn, but they process information at a different rate.

2-In addition, short-term memory, and recall, may be diminished in some elderly patients

3-**The rate of speech and the amount of information presented at one time must meet the individual's ability to comprehend the material**.

4-A good approach with some older adults is **to break down learning tasks into smaller components.** When given the opportunity to learn at their own speed, most elderly people can learn as well as younger adults.

3-Another important step is to **encourage feedback from patients** as to whether they received your intended message by asking them to repeat instructions.

B-Generation differences

1-Potential communication barriers between you and older patients may be attributable to the **generation gap**.

2-Thus, **some older adults may have different beliefs and perceptions about health care** in general and about drugs. Some behaviours, such as **sharing medication**, may seem inappropriate to you, **but such actions may be common in elderly**.

C-Psychosocial factors

1-Several psychosocial factors may influence your relationship with older adults. First, some older adults may be experiencing a significant amount of loss compared with people of other age groups. For example, their friends may be dying at an increased rate, or they may have retired from their jobs.

2-Thus, their reaction to certain medical situations, such as ignoring your directions or complaining about the price of their medications, may be responses of becoming less active, or of dying.

3-They may become angry at you or other health care providers. They may also turn to self-diagnosis and self-treatment or to the use of other people's medications.

D-Vision

If you work with elderly patients, you need to realize that the aging process may affect the visual process. **Written messages for persons with visual deficiencies should be in large print.**

E-Hearing

1-Aging may affect the hearing process. Auditory loss in various degrees of severity is seen in more than 50% of all older adults.

2-Many individuals **with hearing deficiencies, including some older adults, rely on speech reading (**watching the lips, facial expressions, and gestures) to enhance their communication ability (For speech-reading to be most effective, **you should position patients directly in front of you when communicating**).

3-To improve communication with hearing-impaired patients, **try to position yourself about 3 to 6 feet away; never speak directly into the patient's ear** because this may distort the message. **Wait until the patient can see you before speaking**.

4-It is also important to **slow your rate of speech somewhat so that the person can differentiate the words**. Remember **not to shout when speaking**, since shouting may

offend some people. Talking in a somewhat **higher volume and at a slower rate** of speech will help most individuals.

5-Finally, be aware of **environmental barriers, such as loud background noises** or which make communication difficult for the hearing impaired.

F-Speech

1-In pharmacy practice, you may need to interact with people who have some type of speech impairment. A common speech deficiency is **dysarthria** [**difficulty in speaking words clearly**]. Diseases such as Parkinson's disease, as well as strokes and accidents, can cause dysarthria. In dysarthria, **speech may be slurred or otherwise difficult to understand**.

2-To overcome speech barriers, many patients **write notes to their pharmacist or use sign language as a means of communicating**. Some pharmacists have responded to this need by providing writing pads for patients.

G-Aphasia [Inability to generate or comprehend spoken language].

1-A group of patients with related speech difficulties are those who suffer from aphasia after a stroke or another adverse event. Aphasia is a complex problem that may result, to varying degrees, in the reduced ability to understand what others are saying and to express oneself.

2-Fortunately for some patients, their communication ability can be improved after extensive therapy. However, improvements are often seen in small increments.

3-Aphasic patients usually **have normal hearing acuity; shouting at them will not help. T**heir problems are due to lack of comprehension.

4-You need to be **patient with these individuals when discussing their medications**. Also, **it takes longer to communicate with them**, since they may hear the word but may not immediately recall the meaning of it.

5-It is best to let them try to communicate. If they are unsuccessful after a few attempts, **help them by supplying a few words in multiple-choice fashion and let them select the word they desire.**

7-Many times it is **best to counsel other people who are caring for aphasic patients**, but do not exclude patients from communication

2-Patients with Disabilities

A-Wheel chair bound patients

1- **Access issues are important when caring for wheel chair bound patients**. Unfortunately, many pharmacy practice settings, including hospital and community sites, are not readily accessible to these individuals. Entrances are often not wide enough, counters are too high, and pharmacists may not be visible to wheel chair bound patients.

2-When talking with patients in wheelchairs, it is important to realize that you may be talking down to them. **So, it is best to talk on the same eye level.**

3-Patients appreciate any efforts **to minimize the distance between you and them** without causing increased attention to the fact that they are in a wheel chair.

B-Learning disabled patients

1-Patients with learning disabilities are especially challenging. **You may have to repeat key information to make your point.** In addition, you should **not get frustrated if the patient does not seem to get the main points.**

2-For many patients, you may also have to work **with the patient's caregiver to make sure that information is transmitted correctly and used appropriately**. If the patient and caregiver are both present, make sure that you speak to the patient, not just to the caregiver, to get them involved with the situation as much as possible.

3-Patients with mental health problems

1- Some pharmacists may also be **unwilling to distribute written information to patients** receiving psychotropic medications for fear that patients may misinterpret the information. Another related concern is that many psychotropic medications are used for **non-mental health disorders**, such as imipramine for bed-wetting or diazepam for muscle spasms. Thus, the written material may not be relevant to the patient's condition and may only cause alarm.

2- **Patients with mental illness may be reluctant to interact with pharmacists for a variety of reasons.**

- First, they may have a poor self-concept and may be insecure about interacting with others.
- They may also realize that they have a condition that makes other people uncomfortable. Thus, this societal stigma about mental illness makes them avoid social interactions.
- In some cases, patients may be fearful about dealing with other people, especially health care professionals. Thus, your attempts to communicate may find initial patient resistance.

3- The presence of mental illness should not stop you from trying to interact with these special patients. **Asking open-ended questions (e.g., what has the doctor**

told you about this medication?) are good tools to determine cognitive functioning. That is, are they able to comprehend what you are saying? If not, you may have to communicate through a caregiver.

4-Patients with Low health literacy

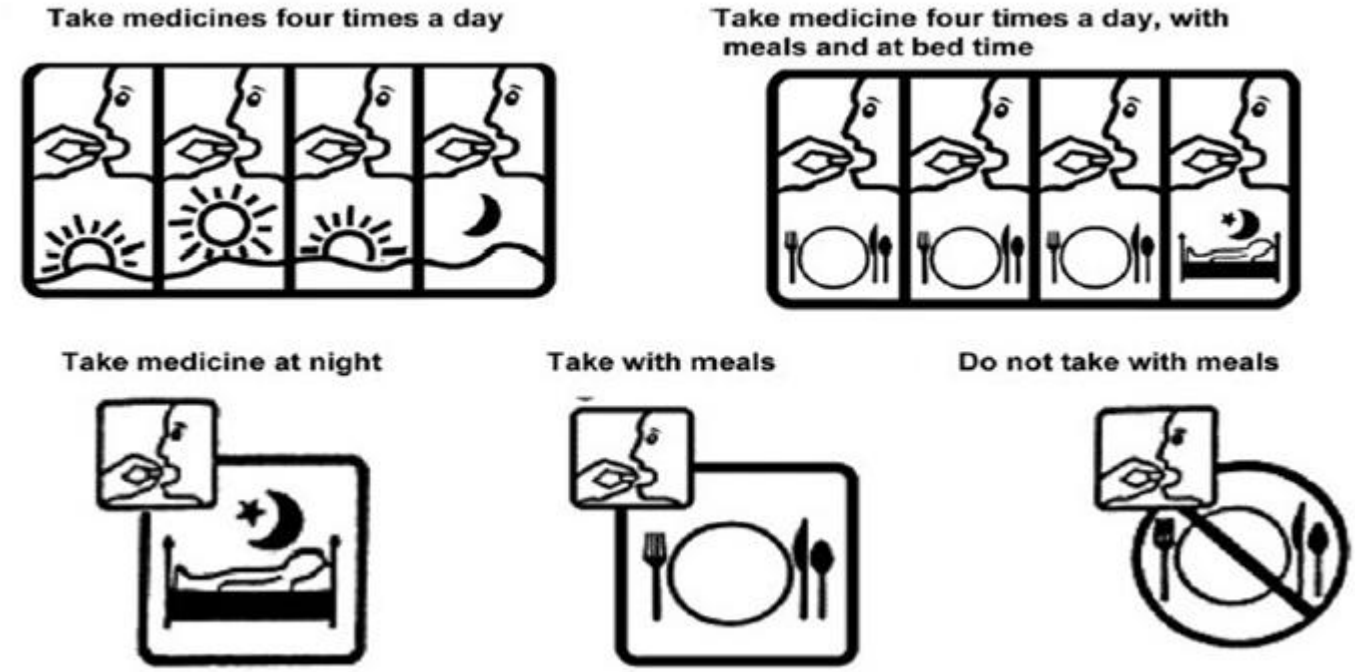
1-Health literacy is the ability to "read, and understand the healthcare information".

2-Persons with limited ability to read information are frequently **embarrassed** and **fail to disclose this fact to health care providers.** Due to the strong **stigma** associated with reading problems, many patients **will make excuses or try to conceal that fact that they have trouble reading.**

3-Many patients with literacy issues have average IQs and function well in daily life, so **detection is difficult**.

4-Poor health literacy is directly linked to patient safety. **If patients cannot understand the material, then they are in danger of medication errors.**

5- Providing pictures can improve understanding of key medication instructions. The United States Pharmacopeia (USP) has developed **81 pictograms that illustrate common medication instructions and precautions**. These graphic images can be used by health care professionals when communicating with **low literate or non-Arabic -speaking patients**.



5-Terminally ill patients

Most individuals, including pharmacists, find it somewhat **difficult to interact** with terminally ill patients. People typically feel uncomfortable discussing the **topic of death** and are uncertain about what to say; they do not want to say the "wrong" thing or upset patients. Yet most terminally ill patients need **supportive relationships** from family members, friends, and pharmacists.

Pharmacists are becoming increasingly important in the care of terminally ill patients owing to the **complex nature of cancer therapy and pain management** and to their increased involvement on **oncology teams** in hospitals and other institutions. More important, pharmacists may be the **only** health professionals in their community who are **readily accessible** to patients and families

The following communication strategies should be used when working with terminally ill patients

A. Most strategies require **"meeting the patients where they are"** in relation to their understanding of their condition and their stage of adjustment. For example, a patient may be denying the existence of his illness, or he may be angry or depressed about his situation. You would approach these two situations differently.

B. The key is to **ask open-ended questions**, such as "How are you doing today?" or "How are things going?" to determine patient willingness to discuss the situation with you. You should not assume that patients do not want to talk about it. Even if patients do not respond initially, they at least realize that you are willing to talk and may open up at a later time.

C. Before interacting with terminally ill patients, be **aware of your own feelings about death** and about interacting with terminally ill patients. Being aware of your feelings will help you assist these patients. You should realize that you can handle some situations

D. Many terminally ill patients **realize they make other people feel uncomfortable**. Thus, they tend to avoid certain interactions. However, if you can express your uneasiness or your frustration about not knowing how to help them at the same time that you express your concern for them, patients will typically feel more comfort and more willing to express their own feelings.

6-Caregivers

1-Caregivers can be people who take care of older adults with chronic conditions, parents who take care of children during acute or chronic illnesses, family members.

2-Caregivers need to **understand the patient's condition and treatment.**

3-Since you cannot communicate directly with patients [and thus cannot determine whether they received your intended message], the **written information about the medication is essential.**

4-Many pharmacists use medication **reminder systems** (i.e., drug calendars, weekly medication containers) to **help caregivers keep track of medications**.

5- **When dealing with caregivers, certain areas should be addressed**.

A-Caregivers need to understand the patient's condition and treatment and how to communicate specific instructions to the patient.
B-Caregivers must also understand how to monitor patient therapeutic response to a specific medication
C-How to monitor for adverse drug events, and how to report any suspicious events.
D-They should be instructed about the importance of good nutrition and fluid intake for certain types of patients.
E-They must be reminded about the refill status of medications and when their physicians need to be contacted.
F- Caregivers should be encouraged to contact you if they have any questions or if the patient has specific question.

6-**Many times, caregivers have special needs themselves**. They may be under a lot of stress trying to care for the patient at home. **Serious depression** has been found in almost **one-fourth of the individuals caring for the home-bound elderly**.

College of Pharmacy
Communication Skills.

Communicating with Children about Medicines

Overview

Children are **important consumers of medicines**. Communication with children typically involves **three people**: the **pharmacist**, the **child**, and the **parent** of the child.

Need for Educating Children and their Parents about Medicines

1-Studies showed that pharmacists reported **considerable contact with children and their families** and that **most pharmacists reported filling prescriptions for children *daily*.**

2-Unfortunatly, these studies also showed that **most of pharmacists do not communicate directly with children.**

3-When parents come in to purchase drugs for their children, **it is important to educate the child as well as the parent about the medicine**. In addition to educating the child, an advantage to communicating directly with the child is that ***you are more likely to speak at a level the parent will understand***

at a level that is appropriate for level of the child لان تكلمنا المباشـر مع الطفل سـيجعلنا نتكلم

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4-These studies also showed that most **children reported that they would like to ask the doctor or pharmacist a question about medicine but they reported never doing so**.
Therefore, pharmacists need **to encourage children to ask questions about their medicines.** The easiest way to do this is to say to a child "**Nearly everyone who gets a medicine has questions about it. I bet you have questions, too. Can you tell me a question you have about your medicines**?"

5-As a pharmacist, you need to make sure that the **parents** also are informed about their children's medicines to prevent errors.

General Principles for Communicating with Children

The following general strategies for communicating with children about medicines:

1. **Tell the parent** that you are going to talk with the child.

2. Attempt to communicate at the **child's developmental level**. Therefore, start at the beginning :(**Ask children open-ended questions** rather than closed –ended questions **to get an idea about the cognitive level and knowledge)** (e.g.,

Through some simple questions such as "**Why do you need to take this medicine**?**)**.

3. Ask the **child whether he or she has questions for you**. (Note: you can lead into this by telling the child a simple question that another child asked you.)

4. Ask the child to **repeat what you say.**

5. Pay attention to **nonverbal communication**. (**Nonverbal communication is very important to children**. If you think about it, much of the communication between children and parents is nonverbal (e.g., hugs, sounds, gestures). Therefore, when you interact with children, you need to be aware of your facial expressions, tone of voice, and gestures.

6-Try to **get down to their level** so you will not be "talking down" to them.

7. Don't give up. **If you fail the first time, try again the next time.**

Understanding the Cognitive Developmental Level of a Child

1-Children **progress through four stages** as they develop cognitive skills. The four stages of cognitive development are:

A-The first stage: This stage lasts **from birth to roughly 2 years of age.**
Learning about medicines is not really possible in this stage.

B- The second stage: This stage lasts from about age 2 to 7 years.
At this age, it is important to begin educating children **in simple terms:**

Communication Strategies for Different Stages of Cognitive Development
The second stage (AGE 2 TO 7 YEARS) Sample educational message: 1-The medicine you'll get will **go into your body** and make your throat feel better. 2-It will work only if you take it 3 times every day. 3-**Your mom will help you** know when to take the medicine and when to stop taking the medicine.

C- The third stage: This stage lasts from about age 7 through 12 years.
During this stage, children begin to understand that disease is treatable and preventable.

Communication Strategies for Different Stages of Cognitive Development
The third stage (Age 7 To 12 Years) Sample educational message: 1-This medicine will go into your body to help **fight off the germs** that are causing the infection in your throat. 2-The medicine will work only if you take it 3 times **a day for the next 10 days.** 3-If you don't take it this way, **the infection might come back**. So, keep taking the medicine, even if you think you're feeling better.

D-The fourth stage: This stage typically is from age 13 through adulthood.

In general, you can typically **give teenagers educational messages that would be equivalent to what you would give an adult.**

Communication Strategies for Different Stages of Cognitive Development
The fourth stage (Age 13 Years to Adulthood) Sample educational message: 1-The medicine you're getting will **help your immune system** fight **off bacteria** that are causing your infection. 2-The medicine used to treat these bacteria **is an antibiotic.** 3-You have to **take it every 8 hours**—that is, 3 times a day—for the next 10 days. 4-keep taking the medicine even if you think your throat is better. If you don't do this, there is a chance you will be **reinfected**.

College of Pharmacy
Communication Skills.

Medication Safety and Communication Skills

Overview

As discussed in earlier lectures, effective communication skills are essential in assuring that patients understand how to take their medications correctly and in assuring patient safety.

Case Study 9.1

Brenda Anderson, a 78-year-old female, visited her physician for a refill of her "Blood thinner"—warfarin 5 mg. Based on her recent lab work, Brenda's physician told her to take one-half a tablet daily for 4 days and then 1 tablet daily thereafter. Her physician wrote a prescription for: warfarin 5 mg.
SIG: 2.5 **mg** q d x 4 d; 1 tab q d. #30.
John Coleman, the pharmacist who filled Brenda's prescription, typed 2.5 **tablets** daily for 4 days and then one tablet daily on the prescription label.
While at home, Brenda forgot what her physician said and followed John's instructions. Thus, she took 2.5 tablets (**5 times the amount that was intended**!). Going into her fourth day of this treatment, Brenda died of massive hemorrhaging. This situation is based on an actual experience.

- Take Mrs. Anderson's situation in Case Study 9.1 as an example—was this death related to a system failure or a **pharmacist's personal error?**
- John, the pharmacist who filled the prescription, obviously misinterpreted the directions (21/2 tablets rather than 21/2 mg), so it is easy to just **blame him**. However, although John is **responsible** for this error, he may not be **entirely culpable**. Being a **refill prescription**, John might have rationalized that he did not need to talk to Mrs. Anderson because she had been taking this drug for a **long time** and knew how to take it. In addition, **system errors** may have led to John's misinterpretation. Possibly he was too stressed out and was **working too fast** (his technician called in sick and thus he was **short of staff**). Possibly his ability to see clearly was hindered by **inadequate lighting in the pharmacy.**
- Possibly the **physician's handwriting** was not clear, thus "mg" looked like "tab." The physician could have written the prescription **more clearly**. He wrote the directions in an unorthodox way (21/2 mg rather than 2.5 mg). Thus, John's eyes saw the 21/2 and inferred that it related to how many tablets should be given. Physicians typically use fractions when indicating how many tablets.

- **Patient issues** also might have influenced the tragic outcome. Possibly Mrs. Anderson did **not remember** what her physician told her about how the medication was to be taken. If she had remembered, she would have **detected the error** as soon as she read the prescription label and John could have remedied the situation easily.

Let's **analyze** how poor communication entered into this situation.

- First of all, the **physician** could have **written down his instructions** for Mrs. Anderson during her office visit, but he chose to **rely on her memory** instead. The physician could have written the prescription **more clearly**.
- **John** could **have called the physician** about the instructions once he noticed that the dose was written in an unorthodox manner **(21/2 vs. 2.5)**. John could have carved out time to **counsel Mrs. Anderson** and to ask her how she was supposed to take the medication. In addition, John could have **double checked** to see whether she understood that she had to change regimens in just a few days. This **discussion** may have caused Mrs. Anderson to remember her physician's original instructions.

Introduction to Medication Safety Issues

1- The definition of **medication error** is "Any **preventable event that may cause or lead to inappropriate medication use or patient harm** ".

2-What would happen if 100 Boeing 747 jetliners crashed each year? (About 40,000 lives lost)? Terrible and unimaginable! Yes, but between **44,000 and 98,000 Americans lose their lives to medication errors each year**. **The annual cost of medication errors in the United States has been estimated to be more than $140 billion.**

3- Impact of medication errors:

- Medication errors not only cause **physical harm** to patients, but also undermine **patient confidence** in the health care system. Patients may perceive medications in a different light and may not trust information provided by health care providers. These perceptions may directly **affect patient adherence with prescribed therapy** or may stimulate the use of **alternative therapies**.
- Medication errors also cause **tension between health care providers**. Finger pointing may occur, and perceptions of professional competence may be altered. When situations are **not** handled appropriately, **trust evaporates and future interactions do not evolve in a positive way.**

Types of Errors: Possible Causes and Potential Solutions

A-Errors Involving Communication with Health Care Providers

Many errors occur in the process of physicians communicating instructions to pharmacists and in the pharmacist's ability to interpret these instructions.

Prescribers might not convey their messages clearly; and **pharmacists might not have an opportunity to provide feedback regarding their interpretation and understanding of these messages**. This is true for **both written as well as verbal communication.**

Common issues involving **verbal** communication include:

1. Distractions and noise that interfere with clear transmission and receipt of the message
2. Heavy accents and language differences
3. Use of terminology that **other health care providers** do not understand
4. Speaking **too rapidly** for the listener to clearly comprehend
5. Medications that sound alike when spoken (Zantac vs. Zyrtec)
6. Numbers that sound alike (15 vs. 50; 19 vs. 90)

Although **written communication** is often preferred over verbal communication to minimize errors, there are several issues that inhibit effective written communication as well. Examples of written communication issues include:

A-**Poor handwriting**.

B-**Medication names that look alike when written out** (Celexa vs. Celbrex or Bisoprolol 10 mg and Buspirone 10 mg).

C-**Misplaced zeroes** and decimal points in dosing instructions (.5 vs. 0.5; 1.0 vs. 10)

To minimize the above stated issues:

A-In general, pharmacists **should be able to contact physicians at any time to clarify issues regarding patient therapy.**

B-Pharmacists should also **review the possible issues, for example: The lighting within the pharmacy area may not be adequate**.

وبالتأكيد فان مشروع الوصفة المطبوعة (الالكترونية) سيحد من هذه المشكلة فيما لو كتب له النجاح

C-communication between pharmacy and nursing staffs must be clear to assure **safe administration of the medication**. For example, is the medication **labeled** clearly? Are **doses** appropriate? Are the instructions for **delivery method (IM, IV)** and **administration times clearly** articulated? It is also critical to have access to the most up-to-date ***drug information references*** for health care providers, preferably in an electronic format, so that the most current information is used.

B-Errors Involving Communication with Patients

1-Common issues involving **verbal communication** include:

- Inability of patients to understand pharmacists (accent, medical terminology, language and cultural differences, etc.)
- Hearing and vision impairments
- Environmental barriers (noisy pharmacy, no access to pharmacist

2-Common issues **involving written communication** with patients include:

- Patient's inability to read or comprehend material
- Lack of effective patient education material
- Inability to read label (sight impairments)

3-Fortunately, **many errors could be discovered during the pharmacist–patient counseling interaction** and are corrected before patients leave the pharmacy. Patients need to know what the medication is used for, how to take it, and other essential information. The pharmacist can use the "**show and tell**" technique of showing the medication to the patient and saying what the medication is used for and how they are taking it [**Unfortunately, this does not occur all the time in Iraq**].

4-Case 9.3 showed **how effective pharmacist–patient counseling interaction might aid in discovering an error where a physician prescribed a wrong drug to a patient**.

Note: Indocin is an analgesic drug to relief pain while Imodium is a antidiarrheal drug.

CASE STUDY 9.3

A patient enters Morgan's Pharmacy and presents a prescription for:

Indocin 25 mg SIG: 1 cap bid prn #20

After filling the prescription, the pharmacist counsels the patient as follows.

Pharmacist: What exactly are you taking Indocin for?

Patient: I'm taking it for diarrhea.

Pharmacist: Diarrhea, huh? Did your doctor and you discuss the need for a pain medication?"

Patient: No, just diarrhea. I feel fine otherwise.

Pharmacist: Well let me double-check something here; I will be right back.

The pharmacist then calls the prescribing physician to inform him about the patient's statement. The physician says: "Oh my goodness, I meant to prescribe Imodium, I must have been thinking about another patient I just saw in clinic with back pain. Thanks for calling about this one. Please change the prescription to Imodium 2 mg." This situation is based on an actual experience.

When Errors Occur

What do you do when an error occurs? How do you handle the embarrassing situation of telling someone that you made an error? What do you do when an injury or death has occurred (as in Case Study 9.1)?

Difficult questions to face, but as revealed in this section, **effective communication skills can help remedy these situations. Put another way, weak communication skills can certainly make situations worse**. You should be aware that legal counsel must be consulted if there is a chance of litigation surrounding the event.

[This lecture focuses only on the communication skills related to the discovery and disclosure of medication errors].

General Strategies to Enhance Patient Safety

- To be most effective, reporting mechanisms should not be punitive, but instructive. People should not lose their jobs or be penalized (except in cases of dereliction of duty or criminal activity) when errors occur.
- Industries found out the hard way that penalizing employees actually increased potential errors by decreasing the number of reported errors and by eliminating any opportunity to remedy structural or procedural deficiencies.
- Many errors are related to system issues rather than people issues. Thus, people must feel comfortable identifying, documenting, and reporting errors in a constructive environment.
- The organization's philosophy and culture should be nonpunitive, which is difficult at times.

- A delicate balance exists between holding personnel to a high level of quality and professionalism and at the same time recognizing that some errors will occur and that employees are not to be punished when errors are reported.

A-Initial Discovery

When an error occurs, **you must make sure that the patient is not harmed or does not continue to be at risk.** The first general response to finding an error might be:

والاستجابات التالية من الصيدلاني تعتبر خاطئة عند الاكتشاف بأن خطأ ما قد ارتكب في صيدليته مع احد المرضى

• **Avoidance:** "I didn't make the error; the new pharmacist made the error it is not my responsibility to get involved."

• **Blaming someone or something else:** "The physician's poor handwriting was the problem."

• **Rationalizing that the error was not important:** "It is not big problem if you take two capsules from this drug rather than one capsule."

B-Initial Contact with Patient

1-If the patient is in the pharmacy; **go with him or her to a quiet area where other people cannot overhear.**

2-During the initial contact, **you should make a simple, but clear statement that you are extremely sorry for the error**. **You should not place the blame on other people** ("the evening pharmacist made the error"), or the fact that you were too busy. If you found the error, you need to take the responsibility for trying to resolve it. If a technician مساعد الصيدلي made the error, you, as the pharmacist in charge, should not transfer blame to him or her since the error occurred **under your watch.**

3-When patients learn about a particular error, t**hey typically want to hear a brief description of exactly what happened and the short-term consequences of the error** ("this dose might increase your chances of having diarrhea").

- They also want to **be reassured** that you are trying to resolve the situation immediately.
- Patients need to perceive that you are **genuinely concerned** about the error and are taking immediate steps to deal with it.
- If they perceive that an appropriate level of concern is **not apparent**, they may be **more prone to litigation**
- During the initial contact, you should make a simple, but clear statement that you are extremely sorry for the error.
- You **should not place the blame** on technology ("the computer didn't catch the error"), other people ("the evening pharmacist made the error"), or the fact that you were too busy.

4-**Do not minimize the importance of the error either**, "Luckily, no harm was done. Taking the 1 mg strength of this drug instead of the 2 mg wouldn't have hurt you."

5-Some errors can be remedied relatively easily ("please bring the prescription into the pharmacy and we will give you the new prescription" while others might be more complex and may take time to resolve ("I need to discuss this situation with your physician before making a decision about what needs to be done").

6-Finally, you **should thank the patient for bringing the error to your attention**, "Thank you for checking your medicine and telling us immediately that you had a concern."

7-Even when patients think an error has occurred **but has not** (e.g., a different looking generic was dispensed), yo**u should thank them for reporting the possible error.**

C-Contacting Other Health Care Providers

1-**You should alert physicians or other health care providers if they were involved with the original error** (wrong drug prescribed, prescribing two interacting medications, etc.).

2-Once again, you may be tempted to avoid contacting others since you may be embarrassed. **However, if you do not report it and they find out through the patient or some other means, then they may not trust your professional competence in the future**.

بالنهاية مهم جدا ان تعرف ان ***الصيدلية ليست مخزن للادويه والصيدلي ليس حارس المخزن***. الصيدلي ليس صراف ادويه فقط. لاتقول هذه وصفه الطبيب كتبها والمسؤوليه هو يتحملها لان المسؤوليه مشتركه هو يوصف وانت تتاكد ان الوصفه ليس فيها اخطاء بعدها تصرفها. في حال وجدت خطا طبي بالوصفة لازم تتواصل مع الطبيب اذا كنت تعمل في مستشفى او مركز صحي. اما اذا كانت وصفة بها خطا طبي والصيدلية خاصة اشرح للمريض الخطا واطلب منه ان يتواصل مع الطبيب. ساعطي مثال ادناه:

قبل فتره طبيبه كتبت وصفه لمريضه حامل ومن ضمن الادويه كان (Methotrexate).
الوصفه تم صرفها لمريضه حامل في الشهر الثامن والمعروف الدواء ممنوع يصرف للحوامل. الطبيبه بالخطا كتبت الدواء مثل المثال الموجود اعلاه بالمحاضره. المريضه مارجعت للطبيبه اخذت الوصفه وراحت اخذت الدواء لمدة 20 يوم قبل اكتشاف الخطا

علما ان الصيدليه تقريبا تصرف وصفات الدكتوره النسائيه فقط لايوجد طبيب ثاني في المجمع و90% من المراجعين نساء حوامل.
يعني لو بس الصيلي سال المريضه ليش تاخذ الدواء شنو عندها؟ واكيد كان مبين عليها حامل بالشهر الثامن ماكان صار هذا الخطا الطبي.

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Communication Skills.

Barriers to Communication

Overview

1-Take the following. You want to complain to your pharmacist that your cough still does not improve. While you are telling him about your problem, the pharmacist continues to look at paper on the counter. You continue to speak. However, he rushes over to the phone, paper in hand, and starts talking to another person without even looking up. While on the phone, he winks at you and says, "Go ahead, I'm still listening. Keep telling me about your problem."

How do you feel now—frustrated, angry… Why? Probably because you feel you can't communicate with this person. **He is not listening to you even though he says he is.**

2-Within the communication process, numerous barriers exist that may disrupt or even eliminate interpersonal interaction.

3-Minimizing communication barriers typically requires a two-stage process:
First, **you must be aware that they exist.**
Second, **you need to take appropriate action to overcome them**

4-Some barriers are easily removed, while others are more complex and require multiple strategies to minimize their impact.

A-Environmental Barriers

1-The environment in which communication takes place is critical in pharmacy practice, and distractions within the environment often interfere with this process.

2-One of the most obvious barriers in most community practice settings is **the height of the prescription counter** separating patients from pharmacy personnel.

A-These prescription counters exist primary to provide a private area in which the staff can work.

B-Unfortunately, in some situations, **high prescription counters**, **or glass partitions separate patients from the pharmacist and thus discourage patient–pharmacist interaction and** give the patients impression that the pharmacist does not want to talk to them.

C-Many pharmacies provide areas where the **counter is lower** to facilitate pharmacist–patient interaction. **Ideally, you and the patient should both <u>be at eye level</u> to enhance verbal and nonverbal communication.**

3-**Crowded, noisy prescription areas** also inhibit one-to-one communication.

A-These noises interfere with your ability to communicate with patients. In addition, other people may be within hearing range, which limits the level of privacy (which is important when patients want to talk about personal matters).

B-Many community pharmacists have tried to address these issues. Some have private or semiprivate counseling areas or rooms. **Privacy does not necessarily mean having a private room. Even in a noisy environment, privacy can be achieved by moving away from a busy prescription area and lowering your voice to achieve**.

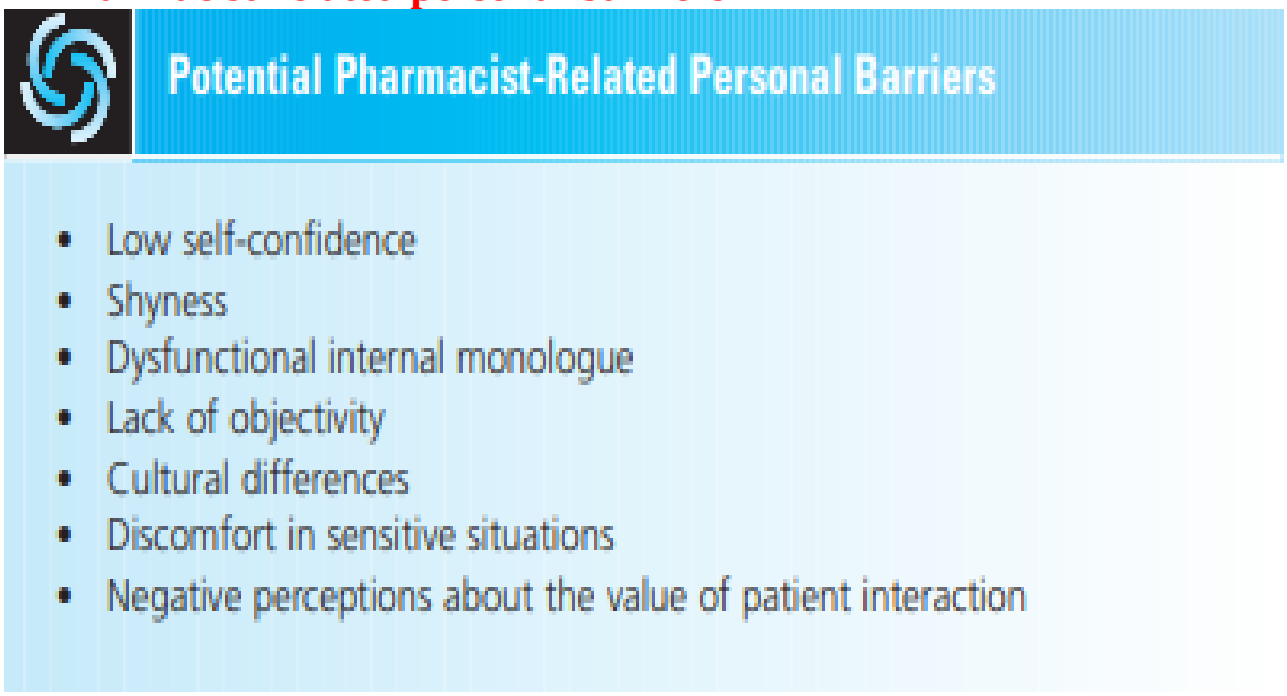
C-The pharmacist should reduce the number of products for sale near the counseling area to reduce the number of customers nearby, and reduce the distractions.

4-The first step in removing environmental barriers is discovering them. **One approach might be to view things from the other person's perspective. What images do others have when they enter your pharmacy?** How easy is it for others to access you to have a dialogue? Is there a comfortable waiting area and counseling area?

The next time you enter a community pharmacy, check for the following:
1-Does it appear that the pharmacist wants to talk to patients?
2-Is the prescription area conducive to private conversation?

B-Personal Barriers

A-Pharmacist-related personal barriers



Lack of confidence in your personal ability to communicate effectively may influence how you communicate. If you believe that you do not have the ability to communicate well, you may avoid talking with others [Many people feel that an effective communication style is something you are born with. **Unfortunately, people do not realize that communication skills can be learned and developed. However, like other skills, they require practice**]. So, **you must remember that there are no expert communicators**: no one communicates perfectly 100% of the time. **However, you must still strive to improve your communication skills by constant practice.**

Another personal barrier to communication for some pharmacists involves the **degree of personal shyness**. Individuals with high levels of shyness tend to avoid interpersonal communication in most situations, including interactions with patients, physicians, or other health care providers. Overcoming this barrier requires time and effort and, many times, professional assistance**. Resolving personal shyness is a more complex process than overcoming other types of communication barriers**. Techniques, such as **systematic desensitization** have been successful in resolving personal shyness for some 'persons.

Another personal barrier to communication **is the internal conversation you may have within yourself while talking with others**. For example, while you are listening to someone, you may be thinking to yourself about "**How can I get rid of this person?**". **This internal conversation may limit your ability to listen effectively as you focus on your own thoughts rather than on what the other person is saying**. It is essential to become aware of this habit because it can inhibit your ability to listen.

Another personal barrier involves the pharmacist's **negative perceptions about the importance of patient communication.**
Many pharmacists believe that talking with patients is not a high-priority activity. They may perceive that patient do not want to talk with them. Thus, they are reluctant to approach patients. **If they do not value patient interaction, then they will not be eager to participate in patient counseling activities.**

Another barrier is the pharmacist's desire to answer every phone call, which may give the impression to the patient that the pharmacist does not want to talk to him or her.
Another barrier is that many pharmacies have **reduced the number of staff members who can assist pharmacists**. Sufficient staff support should provide more time for the pharmacist to offer enhanced patient care, including patient counseling.

B-Patient-related personal barriers

A-Patient perceptions of pharmacists:

If patients perceive you as not being knowledgeable or trustworthy, they will tend not to ask questions or listen to your advice. On the other hand, if patients perceive you as being knowledgeable, they will tend to seek out information. Also, if they **perceive that you do not want to talk with them,** they will not approach you. Therefore, you may need to alter negative patient perceptions by actually **counseling them effectively.**

B-Patients' perceptions of their medical conditions:

1-Some patients may believe that their conditions are relatively minor requiring no further discussion with the pharmacists. Thus, they may not seek out information from the pharmacist.

2-Some patients may be overly anxious about their conditions and therefore will avoid talking about.

3-Some patients may feel that their physicians would have told them everything about their conditions and their medications. Therefore, there is no need to talk with pharmacists.

4-Many patients think that all the important information is stated on the prescription label.

C-Time Barriers

1-**Choosing an inappropriate time to initiate conversation may lead to communication failure. The timing of the interaction is critical, since both parties must be ready to communicate at a given time.** For example, a woman who just came from a physician's office after waiting for three hours with two sick children may not be interested in talking with you or anyone else. The most important thing on her mind is to go home, get her kids to bed, and then relax. You may feel that this is not a convenient time to talk to the mother.

A possible solution might be to give her **basic information to get the therapy started** [and then (if possible) contact her at a later time (e.g. via phone) when both of you may be more relaxed and ready to communicate].

2-In any situation, you **should assess nonverbal messages from patients** for assurances that communication is well timed (do they appear to be listening to you?). At the same time, you must be aware of situations where people are trying to talk with you, but you are not listening appropriately.

D-Administrative Barriers

- Most community practitioners are not paid directly for educating or communicating with patients.
- Counseling services are not included as part of pharmacies' business plans.
- Therefore, many pharmacy managers perceive the task of talking with patients as an expensive service and not a high priority.

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Communication Skills.

Helping Patients Manage Therapeutic Regimens

Introduction

- Numerous reasons exist for why adherence is less than optimal.
- Reasons for non-adherence to regimens include patient perception of medications and the perceived value of following treatment plans as prescribed. Patient perceptions of the severity of the illness, the value of treatment, and confidence in their own ability to adhere determines the likelihood of adherence. Many patients are afraid of taking medications, while some may rely too heavily on medications and take more than prescribed.
- Simplified dosing regimens, particularly once a day dosing, has been found to be associated with higher rates of adherence.
- Negative patient mood, including depression and anxiety, has been found to be associated with nonadherence in a number of disease states.
- Nonadherence can be divided into **two broad categories:**

– **Inadvertent nonadherence** typically involves forgetting to take medications at prescribed times

– **Intentional nonadherence** involves decisions a patient has made to alter a medication regimen or to discontinue drug therapy (permanently or temporarily). For example, a patient may decide to stop taking a medication due to an uncomfortable side effect or skip doses of a medication that should not be taken with alcohol before going to a party.

False Assumptions about Patient Understanding and Medication Adherence

1. Do not assume that physicians have already discussed with patients the medications they prescribe.

2. Do not assume that patients understand all information provided.

3. Do not assume that if patients understand what is required, they will be able to take the medication correctly.

4. Do not assume that when patients do not take their medications correctly that they “don’t care,” “aren’t motivated,” “lack intelligence,” or “can’t remember.”

5. Do not assume that once patients start taking their medications correctly, they will continue to take them correctly in the future.

6. Do not assume that physicians routinely monitor patient medication use and will thus intervene if medication problems exist.

Techniques to Improve Patient Understanding and remembering

The following strategies can assist in your patient education efforts.

1-**Emphasize key points.**
Telling patients beforehand "**Now this is very important**" helps them remember what follows.

2-Give reasons for key advice.
When reasons for advice are provided, patients are more likely to perceive the advice as important. For example, take the dose of the statins (cholesterol lowering drugs) at night because the synthesis of cholesterol is higher at night.

3-Any **information that patients can mentally picture is more easily remembered**. Use visual aids, photographs, or demonstrations.

4-Provide key information at the beginning and end of the interaction. Patients concentrate on the initial information given and also remember the last items discussed.

5-End the encounter by giving patients the opportunity to provide feedback about what they learned. You should ask patients to summarize critical points of information so that you can make sure you communicated clearly and patients understand accurately.

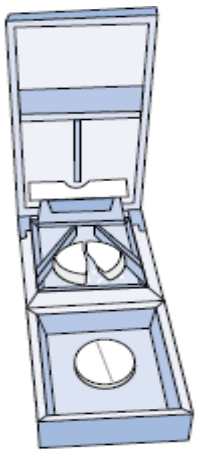
6-Supplementing oral instructions with written information is an essential part of patient counseling.

Techniques to Establish New Behaviors

A number of simple suggestions from you when patients are beginning a new regimen can help get them started on the right track. These strategies can make it easier for patients to establish a new routine of taking medications.

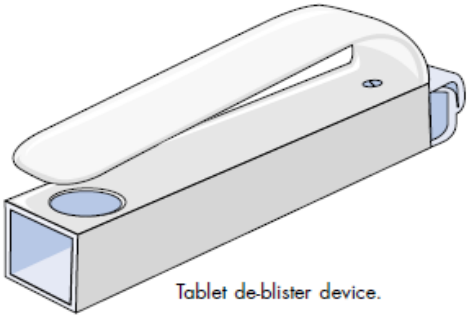
1. **Help patients identify ways to integrate new behaviors with current habits.**
2. **Provide appropriate compliance aids.**
3. **Suggest ways to self-monitor.**
4. **Monitor medication use.**
5. **Make proper referrals.**

Medidos tablet dispenser with seven days of the week and each day split into four compartments, breakfast, lunch, dinner and bedtime.

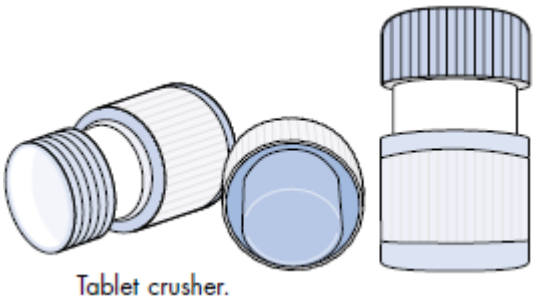


Tablet splitter.

Tablet bottle opener.



Tablet de-blister device.



Tablet crusher.

Techniques to Facilitate Behavior Change

- Behavior change is difficult. It is difficult to establish a new habit such as beginning a medication regimen, to change old habits such as overeating, and to stop existing habits such as smoking. The more complex and multifaceted the behavior change required, the more difficult the change will be.
- For chronic diseases such as diabetes, the changes prescribed by health providers involve **establishing new behaviors** (drug therapy and daily blood glucose monitoring), **changing old habits** (diet and exercise), and **ceasing other behaviors** (drinking alcohol). In addition to the distress of discovering that you have a chronic disease, the sheer number of changes you are asked to make can seem overwhelming.
- Individuals who are **forced** to change habits or start long-term therapy often are ambivalent about the changes they are asked to make. They are usually able to see the **benefits of changing** their behaviors, but they also have **a reinforcement history and hold existing beliefs that support their current habits**. There are likely to be **downsides or perceived costs** associated with both changing behaviors and with maintaining the status quo. The result is **ambivalence.**
- Ambivalence regarding changing behavior exists when patients feel that they *want* to make changes to **improve their health** but at the same time they also *resent* changing behaviors they have found comfort from in the past. They thus

feel **contradictory feelings**. Ambivalence is a state of contradictory emotions at the same time related to the same situation. The ambivalence does not mean that patients are unwilling to change but that they feel conflicted between wanting to change and wanting to stay the same. The goal of the pharmacist is to help patients move from being **ambivalent to being willing to begin the process of change.**

Theoretical Foundations Supporting Behavior Change

Miller and Rollnick (2002) developed a conceptual foundation and intervention strategies, known as ***motivational interviewing***, to help people make changes in the direction of better health. They identified three components of motivation to change:

(a) **willingness**, which is indicated by the amount of discrepancy patients perceive between current health status and goals they have for themselves,

(b) perceived ability or the amount of self-confidence that patients feel in their ability to initiate and maintain behavioral change (also known as **self-efficacy**), and

(c**) readiness**, which is related to how high a priority is given to these behavioral changes. Often patients will want to delay a commitment to initiate change because other stressors in their lives make changing their own behaviors seem daunting.

According to the social cognitive theory of Albert Bandura (1986), **behavior change** requires that an individual believe that

(a) "engaging in a particular behavior change will lead to an outcome I desire" (**outcome** expectancy), and

(b) "I am capable of carrying out the behavior change" (**self-efficacy** expectancy). Outcome beliefs are persuasive.

1-If patients do not believe that taking **antihypertensive medications** will really affect their quality of life or longevity, they will probably not be willing to initiate treatment.

2-If smokers believe that the research linking smoking and premature death is exaggerated or somehow does not apply to them personally, they are unlikely to stop smoking.

3-For abstinence from **alcohol,** self-efficacy may involve confidence in ability to adhere to abstinence even at a holiday party, which is a high-risk situation. Confidence in ability to overcome temptations to relapse even in high-risk situations is a key component of self-efficacy beliefs. If patients have tried and failed to maintain changes in the past, this can result in doubts about their own self-efficacy.

4- For use of a **metered dose inhaler (MDI) for albuterol** in treatment of asthma, self-efficacy may involve confidence in ability to use the MDI at a party or in a classroom if the need arises.

STAGE 1: PRECONTEMPLATION

- In this stage, persons **do not intend to** change their behavior or implement new behaviors. They may be uninformed about the benefits of change or may minimize the risks to their health of continuing their current practices.
- Brief, **simple advice** with reasons can be given in a nonjudgmental or non-dictatorial way. From then on, the pharmacist must listen to patients and understand concerns expressed.

STAGE 2: CONTEMPLATION

- The contemplation stage is one where individuals are **"think about" changing** their behavior—not immediately but **within the next six months** or so.
- Interventions at this stage can best be focused on getting patients to describe the "pros" to making changes and to explore what might help them overcome barriers they perceive. It is best to **have patients make the arguments themselves** on the desirable aspects of initiating a change in behavior.
- If a patient says that he knows it would improve his health if he stopped smoking, but that he is "not ready" to quit immediately, asking how he will know when it is the right time can help the **planning process** without sounding argumentative.

STAGE 3: PREPARATION

- In the preparation stage, the individual is ready to implement a change program or initiate a new regimen almost immediately (**within a month**). These individuals have reached a decision in favor of change.
- Reinforcement from pharmacists can help them carry out these decisions. In addition, teaching patients strategies to help them be successful in initiating change is important.

STAGE 4: ACTION

- The action stage is the initial period in changing a behavior. This stage is thought to incorporate the **first six months**. During this initial period of change, the desire to go back **to old habits** makes the potential to relapse of concern.
- Providers can use some of the strategies identified in the "Motivational Interviewing Strategies" section below to help **"inoculate" against relapse.**

- In addition, continued **positive reinforcement** for the small successes, for the "progress" being made in reaching goals is extremely helpful.
- Attention should be given to the ***triumphs experienced rather than only to the problems encountered and the slips*** that occur.

STAGE 5: MAINTENANCE

- The new behaviors have become more integrated into lifestyles and routines.
- Patients gain more confidence in their abilities to maintain changes. However, for certain changes, such as abstinence from addictive substances, dangers of relapse continue **indefinitely.**
- In any stage, ***regression to an earlier stage can occur***. In fact, for many key changes, including diet, exercise, smoking, alcohol consumption, and medication adherence, relapse at some point in the change process should be considered ***the norm rather than an unexpected aberration.***

Applying Motivational Interviewing Principles and Strategies

Motivational Interviewing focuses on techniques to help motivate patients to move through the stages of change. Some of the principles and techniques of Motivational Interviewing are summarized below.

1. Motivating Patients to Change.
2. Express empathy
3. Develop discrepancy
4. Roll with resistance
5. Support self-efficacy
6. Elicit and reinforce "change talk"

EXPRESS EMPATHY

1. Convey to patients that you understand the difficulty of change.
2. You are not judgmental even when patients are unwilling to begin or unable to maintain changes.
3. Reflective listening and acceptance of patient feelings and struggles are core conditions for the helping relationship.
4. Pressuring patients to change increases resistance to change rather than helping to initiate and maintain change.

Example: Your patient is a 50-year-old woman who has had type 2 diabetes for 1 year. She is 5'2", says she weighs 220 pounds, reports her self-monitored glucose to be "about" 200, and the last lab report shows HbA1c to be 9.

Patient: I know that my diabetes is a serious problem. I have read that diabetes can kill you or make you go blind. I certainly want to stick around to see my grandkids grow up.

Pharmacist: Your grandchildren are important to you and you want to be there for them. [Empathic response]

Patient: Absolutely. It's just so hard to do everything—diet, exercise, take medications, test my blood.

Pharmacist: So even though you want to make changes, you feel overwhelmed. [Empathy for ambivalent feelings]

DEVELOP DISCREPANCY

1. Help patients identify the discrepancy that exists between their current behaviors and their stated values or goals.
2. Let patients present the arguments in favor of change.
3. As Miller and Rollnick (2002) note, "People are often more persuaded by what they hear themselves say than by what other people tell them"

Diabetic patient: I know I have to get my blood sugar down. And I really want to lose weight. But I just can't stick to that diet. I love fried chicken and biscuits and gravy and sweets too much to cut them out.

Pharmacist: It sounds like you resent having to cut down on the foods you love. But, it also sounds as if you would like to lose weight and get your blood sugar levels down.

Patient: I would like to lose weight. I know it is not good for me to be so overweight.

Pharmacist: So you have the goal of losing weight but you know that the foods you eat are preventing you from reaching your goal. [Reflection of discrepancy between goals and current behaviors]

ROLL WITH RESISTANCE

1. Arguing with patients about the necessity of behavioral change may cause them to argue the other side (remember, they feel ambivalent) and point out why change is not feasible right now.

2. Resistance will also be increased if pharmacists seem to be blaming patients for not "adhering" to regimen demands, seem to be in a hurry for patients to make progress, or imply that they know better than patients how to proceed.
3. We must accept the fact that decisions to change inevitably come from patients.
4. Reinforce the patient's role as the key problem-solver.
5. If you see patients arguing with you, it is time to change the way you are responding.

Diabetic patient: I wish people would quit nagging me about my diet.

Pharmacist: You're right. It really is up to you whether or not you change your eating habits.

Patient: I know my kids mean well.

Pharmacist: So you think your kids nag because they are worried about your health?

Patient: Everyone in my family is overweight. It is in my genes.

Pharmacist: There is some evidence of a genetic tendency to be overweight. Diabetics who have been heavy all their lives but do lose weight often try many different strategies until they find something that works for them.

SUPPORT SELF-EFFICACY

1. Reinforce patient statements that reflect positive attitudes and optimism about ability to change.
2. Encourage patients to talk with others who have overcome obstacles to change and have discovered strategies that worked for them. Observing how others overcome challenges can be a powerful way of learning. This is one reason support groups can be helpful to some individuals.
3. However, the most important learning comes from one's own "mastery" experiences where one makes changes in line with goals.
4. This is why it is so important to help patients define small steps for change that they feel confident they can achieve.

Pharmacist: What have you tried before that has been successful in changing diet or exercise habits?

Patient: I did start a diet and exercise program when I first found out I was diabetic. I lost 25 pounds. But I only stuck with it for 3 months.

Pharmacist: Twenty-five pounds is a lot. Those 3 months show you can be successful. We can work on strategies for maintaining the changes for longer if you

are ready to do that. How were you able to make the changes that you made the last time?

IMPLEMENT "RELAPSE PREVENTION" PROGRAM

- Mark Twain reportedly said "It's easy to stop smoking. I've done it hundreds of times." In fact, few people are able to maintain change the first time they try.
- A number of factors have been found to be related to relapse or backsliding into old patterns of behavior. These include:

1. Emotional distress, particularly anxiety, depression, worry, boredom, and interpersonal conflict.

2. Social pressure.

3. Guilt and self-blame for lapses or one-time slips.

4. Overconfidence (I can smoke one cigarette and stop again).

5. Frequent temptation (meeting the same drinking buddies after work at a bar, keeping a pack of cigarettes on hand to prove I can resist).

6. Desire for immediate gratification ("I deserve a drink after a hard day," "Changing should not be this hard," "It takes too long to notice weight change").

To help patients prevent relapse—a more permanent regression to an unhealthy behavior pattern—the following steps are recommended:

• Help patients identify the high-risk situations in which they are most vulnerable to lapsing into old habits.

• Help patients identify what might help them to cope with a similar situation in the future.

• Help patients have a plan in place ahead of time to go back to the new behavior without feeling guilty.

• Help patients recommit to goals of change.

Listening and Empathic Responding

Listening to patients trying to understand their thoughts and feelings is crucial to effective communication. The understanding you have must be

A/conveyed back to patients so they know you understand

B/you must genuinely care about patients and not be afraid to communicate your concern to them.

C/Patient feelings must be accepted without judgment as to being "right" or "wrong."

Listening Well

The skills of **"effective communication,"** involved first the skills of speaking clearly and forcefully, in having an effect on others based on what we say.

However, an equally critical part of the communication process, and perhaps the most difficult to learn, **is the ability to be a good listener.**

You have experienced a sense of satisfaction and gratitude when you have felt that another person really listened to what you had to say and understood your meaning.

Skills that are useful in effective listening include 1.SUMMARIZING, 2.PARAPHRASING, 3.Empathic responding

The following examples, adapted from the section on paraphrasing, should illustrate the difference.

Patient #3: I don't know about my doctor. One time I go to him and he's as nice as he can be. The next time he's so rude I swear I won't go back again.

Pharmacist #3:

Paraphrase: He seems to be very inconsistent.

Empathic Response: You must feel uncomfortable going to see him if you never know what to expect.

Q/What are two other attitudes or messages in addition to using empathic responses must be conveyed to the patient if trust is to be established???

First, you must be **genuine in the relationship** to established trust with the patient.

E.g./it may be necessary to tell a patient that you "***do not have time right now*** "set an appointment when you are not so busy. (The fact that you were **direct and honest** about your limits will do less to harm the relationship)

E.g. if you had said, ***"I'm listening,"*** while nonverbally conveying hurry or impatience. (The fact of incongruence between what we say and how we act sets up barriers that are difficult to overcome).

Second, another essential condition is ***respect for and acceptance of the patient as an autonomous, worthwhile person***. (If you convey an **ongoing positive** feeling for patients, they may be **more open** with you since they **do not fear** that they are being judged).

E.g./They will more likely tell you that they are having **trouble taking their** medications or that they **do not understand regimen** directions if they know that you will not think them **stupid or incompetent. Why????????**If we think that another will judge us negatively, we feel less willing to reveal ourselves. **What to do?????** Acceptance and warmth, allow patients to feel free to be more open in their communication with you.

EMPATHY AND EFFECTIVE COMMUNICATION

Empathy has many positive effects.

1. It helps patients come to trust you as someone who cares about their welfare.

2. It helps patients understand their own feelings more clearly. Often their concerns are only vaguely perceived until they begin to talk with someone.

3. In addition, an empathic response facilitates the patient's own problem-solving ability.

EMPATHY CAN BE LEARNED

There is a widespread belief that empathic communication skills are not something one can learn. The belief is based on the notion that you either are an empathic person or you are not. **As with any new skill, being an empathic listener must be practiced before it becomes a natural part of how we relate to others.**

Nonverbal Aspects of Empathy

Your nonverbal behavior is at least as important as what you say. Establishing **eye contact**, leaning toward them with **no physical barriers** between you, and **having a relaxed posture all** help to put the patient at ease and show your concern.

As an example, put yourself in the role of a community pharmacist**. Your patient, Mr. Raymond, talks about his physician:**
"I've been to Dr. Johnson because I heard he was a good doctor. But he just doesn't seem to care.
I have to wait endlessly in the waiting room. Then when I do get to see him, he was so fast that I don't have a chance to talk to him. I get the feeling he doesn't have time to talk to me."

The following are examples of different responses of the pharmacist:

		Type of response
A	**"You have to understand that Dr. Johnson is a very busy man."**	**Judging response**
B	**"Tell him how you feel about the way he treats patients. Otherwise, find a different physician"**	**Advising response**
C	**"I'm sure you just happened to see him when he was having a bad day. I bet if you keep going to him, things will improve."**	**Falsely reassuring response**
D	**"How long do you usually have to wait before you get in to see him?"**	**Quizzing or probing response**
E	**"Let me talk with you about the new prescription you're getting."**	**Distracting response**
F	**"You seem to feel there's something missing in your relationship with Dr. Johnson—that there isn't the caring you would like."**	**Understanding response**

إن كل إجابة من الإجابات أعلاه تمثل نوعا مختلفا من الإجابات وهنا سنأتي على مناقشة كل نوع:

1-Judging response: in which we tend to judge or evaluate another's feelings as "right" or "wrong." (Responses [**A**]**)**

Any message from you that indicates **that it is appropriate for you to judge patient's feelings as "right" or "wrong" will** indicate **that it is not safe to confide in you.**

2-Advising response: We must, as pharmacists, give patients advice on their medication regimens. That is part of our professional responsibility. **However, the advising role may not be appropriate in helping a patient deal with emotional or personal problems.** [The best source of problem solution resides within the patient].

Even when the advice is reasonable, ***it is not a decision that patients have arrived at themselves.*** In the example with Mr. Raymond, your advice in response [**B**] gives a quick "solution" to what is a complex problem in the eyes of Mr. Raymond.

3-Falsely reassuring response: Response [**C**] is a falsely reassuring response **that predicts a positive outcome you have no way of knowing will occur.**

Another example is telling a patient who is facing surgery "Don't worry, I'm sure your surgery will turn out just fine".

4-Quizzing or probing response: Another type of response to feelings is a quizzing or probing response. **However, asking questions when the patient has expressed a feeling can take the focus away from the feeling and onto the "content" of the**

message. It also leads to the expectation that, if enough information is gathered, a solution will be forthcoming.

Often patients simply want to be able to express their feelings and know that we understand. Asking Mr. Raymond how long he has to wait for an appointment (Response [**D**]) does not convey an understanding of the essence of his concern, which was his perception of a lack of caring from his physician.

5-Distracting response: Many times, we respond by changing the subject (response [**E**]). Raymond gets no indication from you that his concerns have even **been heard**, let alone ناهيك عن understood.

6- **GENERALIZING RESPONSE:** It is try to reassure patients is by telling them "I've been through the same thing and I've survived." This response may take the **focus away from the patien**t experience and onto your own experience before patients had a chance to talk over their own immediate concerns. It also can lead you to stop listening because **you jump to the conclusion** that, since the patient is feeling the same way you felt.

7-Understanding response: Contrast each of the other responses to Mr. Raymond with response [**F**] "**You seem to feel there's something missing** in your relationship with Dr. Johnson—that there isn't the caring you would like."

Only in this response **give an indication that you truly understand Mr. Raymond's feeling**. A patient who feels discouraged or angry often needs simply to know that others understand.

Problems in Establishing Helping Relationships

A certain pharmacist attitudes and behaviors are particularly damaging in establishing helping relationships with patients. These include:-

1. Stereotyping
2. depersonalizing
3. controlling behaviors

Stereotyping: If you hold certain stereotypes of patients, you may fail to listen without judgment. For example, if a pharmacist has a negative stereotype of people who use analgesics, especially opioids, he may view all patients using opioids as "drug abuser".

او النظر الى كل مريض يريد شراب السعال المسمى توسيرام والمحتوي على الكودائين على انه مدمن

Communication problems may exist because of negative stereotypes held by health care practitioners that affect the quality of their communication. What image comes to mind when you think of:

an elderly patient?

. . . a welfare patient?

. . . a chronic pain patient?

. . . a noncompliant patient?
. . . an illiterate patient?
. . . a “hypochondriacal” patient?
. . . a dying patient?
. . . a “psychiatric” patient?

If you hold certain stereotypes of patients, you may fail to listen without judgment. **For example,** if a pharmacist has a negative stereotype of people who use analgesics, especially opioids, on a chronic basis, he may view a patient who complains about lack of effective pain control as “drug seeking” rather than as someone who is not receiving appropriate and effective drug therapy.

Depersonalizing: Unfortunately, there are a number of ways communication with a patient can become depersonalized. If an elderly person is accompanied by a young person, for example, we may direct the communication to the young and **talk about the patient rather than with the patient.**

Controlling: In most situations, there is an unequal power in relationships between health care providers and patients and there is tendency of providers to adopt an “authoritarian” style of communicating. Patients are “told” what they should do and what they should not do. Decisions are made, often with very little input from the patient on preferences, or concerns about treatment. We must actively encourage patients to ask questions and discuss problems they perceive with treatment so that the treatment decisions will be a shared decisions.

College of Pharmacy
Communication Skills.

Interviewing and Assessment

Overview

1-Patient assessment is an important aspect of patient care. **Determining what patients understand about their medications**, **how they are taking their medications**, **how well their medications are working**, **and problems they perceive with their** therapy are key elements to ensuring positive health outcomes.

2-**Interviewing** is one of the **most common methods used in patient assessment**. This lecture focuses on ways of improving patient assessment and the interviewing process.

Introduction

1-Pharmacists often must obtain information from patients as part of the patient assessment process. It ranges from simple requests, such as asking whether a patient is **allergic to penicillin**, to complex problems, such as determining **whether a patient is taking a medication properly**.

2-One of the first steps in the patient assessment process should be to determine not only **what medications patients may take** but also what **patients already know about their medications and their health-related problems.**

3-Determining how much patients know is necessary because **patient education strategies vary depending on the depth of understanding patients already possess**.

4-Patients who are **very familiar with their medications** have **different needs** than those **who know relatively little**. It is **inefficient to repeat information that patients already understand**. You provide the information you think is important for a particular patient.

Components of an Effective Interview

The interviewing process contains several critical components that should be Mastered.

A-Listening

1-When we think about **skills of communication** we probably think first of the skills involved in *speaking clearly*. However, **an equally critical part of the communication process, and perhaps the most difficult to learn*, is the ability to be a good listener*.**

2-In the relationship between a health professional and patient, **the patient's feeling of being understood is <u>therapeutic in and of itself</u>. It helps to ameliorate the sense of isolation and helplessness that accompanies a patient's experience of illness**.
3-**Some communication habits can <u>interfere</u> with your ability to listen well.**

A-**Trying to do two things at once** makes it evident that patients do not have your full attention.

B-**Jumping to conclusions before patients have completed their messages** can lead to only hearing parts of messages.

C-**Focusing only on content** cause us to miss much of the meaning in the messages people send us.

*The "Listening Techniques for the Interview Process" are shown in the table 1.

Table 1: Listening Techniques for the Interview Process
• **Stop talking.** You can't listen while you are talking. • **Get rid of distractions.** These break your concentration. • **Use good eye contact** (i.e., look at the other person). This helps you concentrate and shows the other person that you are indeed listening. • **React to ideas, not to the person.** Focus on what is being said and not on whether you like the person. • **Read nonverbal messages.** These may communicate the same or a different message than the one given verbally. • **Listen to how something is said.** The tone of voice and rate of speech also transmit part of the message. • **Provide feedback to clarify any messages.** This also shows that you are listening and trying to understand

B-Probing

1-Another important communication skill is learning to **ask questions in a way that elicits the most accurate information**. This technique is called "**probing**."

2-The phrasing of the question is important. For instance, "**why" type questions can make people feel that they have to justify their reason for doing a certain thing**. It is **usually better to use "what" or "how" type of questions**. For example, people might become defensive if asked "Why do you miss doses of medication?" instead of "What causes you to miss doses of medication?"

3-In addition, the timing of the question is important. **The patient should be allowed to finish answering the current question before proceeding to the next one**.

4-In addition, **leading questions should be avoided.** These questions strongly imply an expected answer (for example, "You don't usually forget to take the medication, do you?" or "You take this three times a day with meals, right?"). These questions lead patients into saying what they think you want to hear rather than what the truth may be.

5-To conduct an effective interview, it is important to understand the differences between **closed-ended** and **open-ended questions**.

A-A closed-ended question can be answered with either a "**yes**" or "**no**" response or with a few words at most.

B-On the other hand, open-ended questions **allow people to respond in their own way** and expand their answers.

C-For example, a **closed**-ended question would be "**Has your doctor told you how to take this medication?"** The patient may only respond with a "yes" and not provide any useful information to you. On the other hand, an example of an **open-ended question** would be "**How has your doctor told you to take this medication?"**
With an open-ended question you are allowing patients to present information in their own words.

D-Closed-ended questions reduce the patient's degree of openness because you are doing most of the talking. For this reason, **closed-ended** questions are referred to as "**pharmacist-centered questions**."

E-**Open-ended** questions permit open expression and for this reason are sometimes referred to as "**patient-centered questions**."

F-You may find a **combination of open-ended and closed-ended** questions most efficient for you in your practice. **Patient encounters may be initiated with an open-ended question, followed by more directed, closed-ended questions**.

G-For example, if you want to know whether Mr. Raymond is experiencing bothersome side effects from his antihypertensive medication, you may say "**What things have you noticed since beginning this medication?"**

H-If necessary, open-ended questioning can be followed by more direct questions that focus on specific side effects, such as "**Do you have trouble sleeping**?" and so on.

6-For new prescriptions, the questions "**What did your doctor tell you the medication is for?"** and "**How did your doctor tell you to take the medication**?" are suggested as a way for assessment of patient understanding of new prescriptions.

7-Open-ended questions provide an opportunity for you to assess whether or not the patient **understands the key elements of drug therapy** (shown in table-2).

Table 2: Key Elements of Drug Therapy
1–Tell the patient the **name**, **indication**, and **route** of administration of the medication: 2– Inform the patient of the **dosage regimen**: –Tell the patient **how long it will take for the drug to show an effect**:3 4–Tell the patient **how long he/she might be taking the medication:** 5–Discuss **major side effects** of the drug: 6–Discuss **storage recommendations**, ancillary instructions (e.g., shake well, refrigerate)

C-Asking sensitive questions

1-Some questions you ask patients may be particularly sensitive. Questions assessing **adherence**, or alcohol use. Assessment of effects (including side effects) of medications that relate to **sexual functioning** may also require a diplomatic approach.

2-**There are a number of techniques that can make such questions easier to ask**. Before asking a question about a sensitive topic, **let the patient know that the behaviors or problems you are asking about are common**. If you acknowledge that "**everyone**" has similar problems, it makes the issue seem less threatening. For example, say to a patient "It is very difficult to take a medication consistently, day after day. **Nearly everyone** will miss a dose of medication once in a while" before asking specific questions about adherence. Framing the question in this way can make it feel safe for patients to admit that they are having difficulty adhering to a medication regimen.

3-Another technique for reducing the threat of sensitive questions is to ask whether the **situation has ever, at any time, occurred and then ask about the current situation.** For example, asking first whether the patient has ever missed a dose of a medication and then progressing to estimates of the number of doses missed in the last week may make the information the patient provides more reliable.

4-In addressing these issues, the way **you phrase the question and your tone of voice** should be **no different for a question on alcohol consumption as for a question on use of an over-the-counter (OTC) product**.

5-In structuring the interview, **it helps to embed more threatening topics among less threatening topics and to ask more "personal" questions later in the interview**. For example, questions about alcohol consumption may be better accepted by the patient if they follow questions about caffeine consumption.

6-If patients seem reluctant to address an issue, **it helps to discuss the reason why you are asking a particular question.** A statement such as: "People often do not think of alcohol as a drug, but there are many medications that can interact with alcohol. I ask about alcohol use so that I can help you prevent problems with the medications you

take." **If patients understand the reason for a question, they are more likely to respond honestly**.

7-In any case, before asking any question, and especially one that may be sensitive, be sure that the **question is necessary and that you have a clear need for the information** in your efforts to help the patient.

D-Use of silence

1-Another skill that you must learn in order to be an effective interviewer is the art of using **silence** appropriately.

2-Many times, the patient **needs time to think about or react to the information you have provided or the question you have asked**. Interrupting the silence destroys the opportunity for the patient to think about this material.

3-On the other hand, the **pause might be due to the fact that the patient did not understand the question completely**. In this situation, the question should be restated or rephrased.

4-**Responding with empathy** is a necessary component of any communication you have with a patient قد يكون الصمت. ابلغ في التعبير عن التعاطف من الكلام.

E-Establishing rapport

Successful interviews are marked by a high degree of **rapport between the two parties**. Rapport is built mainly on mutual consideration and **respect**. You can aid this process by using **good eye contact**, by using a **sincere**, friendly **greeting**, by being **courteous during the discussion**, and by **not stereotyping** or **prejudging** the patient. Each patient must be seen as a unique individual

Interviewing as a Process

A-Type of **information**
B-Type of **Environment**
C-**Starting** the Interview
D-**Ending** the Interview

A-Type of information

1-Before the **interview begins, you should determine the** amount and type of information desired. In other words, what exactly do you want to accomplish?

2-For example, if you need to find out specific pieces of information, you will want to have more control over the interview process. This is referred to as the **directed interview approach.** However, if the outcome is unknown, you need to use a more **nondirected approach** (open-ended questions should be used more frequently).

B-Type of environment

1-Before you begin the interview, interruptions should be reduced as much as possible. A partition at the end of the prescription counter, a special room, or a consulting area can provide the **necessary privacy**.

2-Privacy also allows both you and the patient to express personal concerns, to ask difficult questions, to listen more effectively, and to share honest opinions.

C-Starting the interview

1-After considering the type of environment available and the type of information desired, you should start the interview by greeting patients by name and by introducing yourself to patients if you do not know them. This helps establish rapport with the patient.

2-You should also state the purpose of the interview. The **purpose** of the interview should be **stated in terms of the benefit to the patient**. The **amount of time** needed, the **subjects to be covered**, and the **final outcome** should be mentioned so that the patient has a clear understanding of the process.

3-For example, a pharmacist seeing a patient for the first time might say:

Hello, Mr. Pearson, I'm Jane Bradley, the pharmacist (the **introduction**). Since you are new to our pharmacy, I would like to ask you a few quick questions about the medications you are now taking (**the subjects to be covered**). This will take about 5 to 10 minutes (the **amount of time needed**) and will allow me to create a drug profile so that we can know all the medications that you are taking. This will help us identify potential problems with new medications that might be prescribed for you (**the purpose/outcome)**.

4-After the interview is started, the following suggestions will help you conduct a more efficient interview:

A-**Avoid making recommendations during the information-gathering phases** of the interview.

B-Similarly, **do not jump to conclusions** or rapid solutions without hearing all the facts.

C-Do not **shift from one subject to another** until each subject has been followed through.

D-Guide the interview **using a combination of open- and closed-ended questions.**

E-Determine the patient's **ability** to **learn** specific information in order to guide

you in your presentation of the material. **Reading** ability, **language** proficiency, and **vision** or **hearing impairments** would all influence the techniques you use in interviewing and counseling a patient.

F-Use good communication skills, especially the **probing**, **listening**, and **feedback** components.

G-Be aware of the **patient's nonverbal messages**, because these signal how the interview is progressing.

H-Depending upon your relationship with the patient, **move from general to more specific questions and less personal to more personal subjects**. This may remove some of the patient's initial defensiveness.

I-**Note-ta**king should be **as brief as possibl**e.

D-Ending the interview

1-Bringing the interview to a close is **often more difficult than starting** the interview. It is a crucial part of the interview process because a **person's evaluation of the entire interview and your performance may be based on the final statements**.

2-**People seem to remember best what was said last**. If you have provided important information to the patient, you should determine whether or not the patient understood the material correctly at the end of the interaction. For example, you could say to the patient: "**I want to make sure I have explained everything clearly. Please summarize for me the most important things to remember about this new medicine**." Other simple open-ended questions, such as "**When you get home, how are you going to take this medication**?"

3-To conclude the interview, you will want to briefly summarize the key information provided by the patient. A summary allows both parties the opportunity to review exactly what has been discussed and helps clarify any misunderstanding.

4-A summary also tactfully **hints to the patient that the interview is ending**. In conjunction with a summary, **you can use nonverbal cues to indicate to the patient that the interview is over.** For instance, you could get up from the chair or change your stance in such a way that indicates that you need to move on. A simple question such as: "I've enjoyed talking with you. Do you have any further questions?" may also be useful.

5-The ending of the interview is a good time for you to reassure the patient about a particular problem. However, **this should not be false assurance,** such as "Everything is going to turn out okay" or "Don't worry about it." Instead, you should state, "**I will try to help things get better for you**" along with specific action or follow-up you will implement.

Interviewing in Pharmacy Practice

1-Assessing the health problems a patient presents before making **an OTC recommendation** is a targeted interview. Evaluating a **patient's response to treatment** and **perceived problems** related to medication therapy during a refill visit is another example of an interview.

2-The specific questions that are asked may **vary** somewhat because the purpose of the interview varies, **but the skills** involved in gathering information from patients **remain the same**.

3-In assessing medication therapy, such as in a **medication history interview**, it is necessary to ensure that you have a complete listing of medications being taken, including **prescriptions**, **OTCs**, **herbals**, and other **complementary and alternative** medicines.

4-For each medication, an assessment is made of:
(a) the patient perception of the **purpose** of the medication,
(b) the **way** the medication is actually being used by the patient,
(c) patient perceived **effectiveness** (along with specific information on indicators of effectiveness derived from physician reports to the patient or patient self-monitoring of response), and
(d) **problems** the patient perceives with therapy.

5-Medication-related problems include not only problems with medications being taken, but **also drug therapy that is needed but is not being received** by the patient

6-So it is also important to ask patients about health problems they have been experiencing or ones that have been diagnosed but that are not currently being treated with medication. **Fears related to an imagined diagnosis** may prevent patients from seeking care. In other cases, a patient may have received a diagnosis (e.g., type 2 diabetes) that is being treated by means other than medication (e.g., **diet and exercise**).

Table. Description of Drug Therapy Problem Categories
1. The drug therapy is **unnecessary** because the patient does not have a clinical indication at this time.
2. **Additional drug therapy is required** to treat or prevent a medical condition in the patient.
3. The drug product is **not being effective** at producing the desired response in the patient.
4. The **dosage is too low** to produce the desired response in the patient.
5. The drug is **causing an adverse reaction** in the patient.
6. The **dosage is too high**, resulting in undesirable effects experienced by the patient.
7. The patient is **not able or willing to take the drug therapy** as intended.

7-Case Study -1 is an example of an interview in a community pharmacy setting. A new patient, Robert Evans, comes to the pharmacy and presents a prescription for hydrochlorothiazide. The pharmacist, Ed Robinson, initiates a brief interview with the patient.

Case Study 1

Ed: Hello. Are you Robert Evans?
Robert: Yes.
Ed: Mr. Evans, **I'm Ed Robinson**, the **pharmacist** here. I would like to sit down with you and talk **about the medications** you currently take. **This can help us identify problems you might be having with your drug therapy**. We can talk while the technician is filling your prescription. **Do you have about 10 minutes**?
Robert: Sure. I was going to wait for my prescription anyway.
Ed: Let's start with the prescription you brought in today. **What has your doctor**
told you about this medicine?
Robert: Dr. Carter told me I have high blood pressure. This isn't the first prescription for this hydrochlorothiazide (HCTZ) medicine though. I've been taking it about three
years. My old prescription ran out of refills. Dr. Carter gave me a new one today.
Ed: When were you first diagnosed with high blood pressure?
Robert: About three years ago. I don't remember what my blood pressure was but
the doc said it was high.
Ed: Are you **taking any other medications for your high blood pressure**?
Robert: No, just the one.
Ed: How well has the HCTZ medication **worked for you**?
Robert: It has done the trick. Dr. Carter says I'm doing great.
Ed: That must be encouraging to hear! Tell me, what was your blood pressure today when you saw Dr. Carter?
Robert: 125/85. I take my blood pressure myself every day and it always stays around that.
Ed: It's a great idea to keep track of your own blood pressure. How often do you
see Dr. Carter to have your blood pressure checked by him?
Robert: I see him every 6 months. At first it was every couple of months, but he
said I am doing so well now, he doesn't have to see me as often.
Ed: Tell me, **what problems have you had with this medication**?
Robert: I haven't had any problems.
Ed: Have you noticed **any side effects** or symptoms you think are related to the medication?
Robert: I haven't had any side effects. I really haven't had any problems with the
medication.

Ed: In terms of how you have been taking the HCTZ, **describe your schedule** on a typical day.
Robert: I swallow it with my orange juice when I eat breakfast.
Ed: It's sometimes difficult to take a medication every day, day after day. How often
would you say you miss a dose in a typical week?
Robert: I never miss. I fill up one of those weekly pill containers every Sunday and keep it beside the cereal in the cupboard so I remember to take it. Last time I forgot to take it was a month or so ago. I had gone to a restaurant for breakfast and
I forgot it that morning. But that hardly ever happens.
Ed: Sounds like you really stay on top of it. Are there other things you do to help
you control your high blood pressure?
Robert: Dr. Carter put me on a diet and exercise program. I've lost over 50 pounds in the past couple of years. I don't eat a lot of salt either.
Ed: You're really doing what you need to do to keep your blood pressure down. Do you have any questions or concerns about your medicine or your high blood pressure?
Robert: No. I think I've been doing fine. I've gotten used to taking a pill every day.
Ed: If any concerns do come up in the future, please let me know. Next, let me ask about other prescription medications you might currently be taking?
Robert: I don't take anything else. One drug is all I take.
Ed: I see. Let me switch to **over-the-counter products** that you can buy without a prescription.
Robert: I don't take anything. Maybe Tylenol once a year for a headache. Doc told me not to take anything for a cold without checking with him or a pharmacist. I don't like taking drugs so I don't use that stuff you can buy in a grocery store.
Ed: Any **vitamins or herbal products**?
Robert: Nope.
Ed: Do you have any health concerns or other conditions a doctor has told you about that you are not treating with medication?
Robert: None. I'm healthy except for the high blood pressure.
Ed: That's good to hear. Do you have any allergies, especially reactions to medications?
Robert: No, no allergies at all.
At this point, the pharmacist might conclude the interview by thanking the patient for taking the time to answer questions, making sure there is not another issue related to drug therapy the patient might want to discuss. Finally, he can make himself available by telephone or in person if the patient wants to discuss drug therapy or any health concerns in the future.

8-The interview was limited, focusing on information needed to assess problems

with current therapy.

Documenting Interview Information

1-The information documented in a note will assist in your own follow-up care as well as communicate to colleagues about the care you have provided to a particular patient.

2-A format for documentation that is familiar to health care professionals is the SOAP note. **SOAP** is an acronym for **Subjective**, **Objective**, **Assessment**, and **Plan**.

A-Subjective information is that **information reported by the patient** or patient caregiver, such as symptom experience or self-report of adherence.

B-Objective **information is that provided by a lab test or physical exam**. If a pharmacist, as part of an interview with a hypertensive patient, takes the patient's blood pressure, for example, this would be documented as objective information.

C-The Assessment section includes a **description of any medication-related problem identified during the interview**. For example, a problem may be lack of therapeutic response secondary to reported nonadherence.

D-Once the assessment of a problem is made, based on the subjective and objective information included in the note, **the plan** the "P" portion of the SOAP note). **should detail the actions to be taken to resolve the problem.**

Interviewing Using the Telephone

Many times, you need to collect information from patients by telephone. The following should be considered during this type of interaction:

1. **Try to smile before you pick up the telephone**. Your friendly attitude will be transmitted through the tone, pitch, volume, and inflection of your voice.

2. If at all possible, **answer the telephone within the first three or four rings**.

3. Identify the **pharmacy and yourself**.

4. Give your **full attention to the call**. Nothing is more irritating to callers than to be given the impression that they are competing for your attention.

5. Ask for the **caller's name** and **use the name** in the conversation.

6. If you must place the **caller on hold** (for a short time only) ask, "May I put you on hold while I look up your prescription?" In these circumstances, it is important that you do the following:

   a. Tell callers **why** you want to put them on hold;

b. Ask if they would mind **waiting a brief time**, or would prefer **to call back** (If appropriate); and
c. On **returning** to the telephone, say, "**Thank you for waiting**."

7. At the conclusion of the call, end it graciously (e.g., "**Thank you for calling**").

8. If possible, allow **the caller to hang up first**. This will allow the caller time to remember that extra request.

Besides receiving telephone calls, many times you must call physicians or other health care professionals to obtain additional information regarding a patient. The following suggestions may help make these calls more efficient.

1. Before making the call, be sure you **have any and all information related to the call readily available.** Prescription, patient, and other relevant information should be obtained before your telephone conversation starts.

2. Before making the call, determine **with whom you need to speak** in order to achieve your goal for calling.

3. Most importantly, before making the call ask yourself, "**Is this call necessary**?"

4. **Identify yourself, your position, and the pharmacy first**. Then, if it is not already provided to you, ask for the same information from the person who has answered your call.

5. After introducing yourself, **state in clear, concise terms the reason for your call**. Be assertive! Do not begin by apologizing ("Sorry to bother you"). You have already decided that the call is necessary.

6. If the nature of your call dictates that it will exceed more than a couple of minutes, **ask the person whether they have time to talk** with you for a few minutes.

7. **Conclude the conversation** with a sincere "**Thank you**."

College of Pharmacy
Communication Skills.

Effective patient counseling

1-Effective patient counseling is not simply the provision of information**. Information is prerequisite to compliance, but the timing and organization of the message and involvement of the patient are also critical in determining what the patient understands and remembers.**

2-The counseling checklist provided here was developed to **increase the probability that the patient will comply with the treatment regimen**.

3-It is assumed that before the pharmacist counsels the patient, he or she will first assess the appropriateness of the drug therapy.

Patient Counseling Checklist

1– Introduce yourself:
2– Identify to whom you are speaking:
3– Ask if the patient has time to discuss the medicine:
4– Explain the purpose/importance of the counseling session:
5– Ask the patient what the physician told him/her about the drug and what condition it is treating:
6– Listen carefully and respond with appropriate empathy:
7– Tell the patient the name, indication, and route of administration of the medication:
8– Inform the patient of the dosage regimen:
9–Tailor the medication regimen to the patient's daily routine:
10– Tell the patient how long it will take for the drug to show an effect:
11– Tell the patient how long he/she might be taking the medication:
12– Emphasize the benefits of the medication:
13– Discuss major side effects of the drug:
14–Use written information to support counseling when appropriate:
15– Discuss precautions (e.g., activities to avoid) and beneficial activities (e.g., exercise, decreased salt intake, diet, self-monitoring):
16– Discuss drug-drug, drug-food, drug-disease interactions:
17– Discuss storage recommendations, ancillary instructions (e.g., shake well, refrigerate):
18– Explain to the patient in precise terms what to do if he/she misses a dose:
19– Check for further understanding by asking the patient to repeat back additional key information: 20– Use appropriate language throughout the counseling session:
21– Organize the information in an appropriate manner:
22– Follow up to determine how the patient is doing:

1–Introduce yourself:
It is important for patients to know they are speaking with the pharmacist. Pharmacists should greet the patient. Extend your hand, and state your name: "Hello, I'm James Smith, your pharmacist." This begins the relationship.

2–Identify to whom you are speaking:
If you are talking to the patient directly, information is **less** likely to be confused or distorted than if you are talking to the patient's agent, who must pass the information on to the patient. In third party communication, *written information* becomes even more important than when directly communicating with the patient.

3–Ask if the patient has time to discuss the medicine:
If patients do not have time to listen, the information will be ineffective. The information should be written and/or the patient should be contacted at a more convenient time.

4–Explain the purpose/importance of the counseling session:
People listen and learn more effectively when they are given reasons for what is being asked of them. For example, patients are less likely to take tetracycline with food or dairy products if they are told that decreased absorption and effectiveness of the drug may result.

5–Ask the patient what the physician told him/her about the drug and what condition it is treating:
Find out what the patient knows or understands about his or her disease. There is *no reason* for the pharmacist to present information that the patient already has *mastered*. Generally speaking, in any effective counseling session, the patient should *speak more* than the healthcare provider. Inaccurate information should be corrected, and information that is omitted should be added.

6–Listen carefully and respond with appropriate empathy:
These skills are absolutely essential to an effective counseling session. The relationship between the patient and practitioner is a key variable in predicting compliance with treatment regimens. Listening and empathic responding are effective tools for communicating caring.

7–Tell the patient the name, indication, and route of administration of the medication.

8–Inform the patient of the dosage regimen:
While a particular dosage regimen may seem straightforward or obvious, it may be interpreted incorrectly. For example, not everyone eats three meals a day. Patients with diabetes may eat six or seven mini-meals each day. Therefore, directions that state,

"Take one tablet after meals and at bedtime," may prompt some patients to take their medications more than the intended four times per day.

9–Tailor the medication regimen to the patient's daily routine:
Making a connection between taking a dose of medication and a regular daily task will enhance compliance. This could include identifying when the patient wakes up and goes to bed or which meals the patient eats.

10–Tell the patient how long it will take for the drug to show an effect:
If patients are not told when to expect onset of action, they may believe the medication is not working.

11–Tell the patient how long he/she might be taking the medication:
Patients need to have a reasonable expectation of how long they will need to take the medication.

12–Emphasize the benefits of the medication:
Pharmacists should make every effort *to support the chosen* therapy and tell patients about the benefits of the treatment *before* they discuss potential side effects. Lack of confidence in the chosen therapy results in a higher incidence of noncompliance.

13–Discuss major side effects of the drug:
Will the side effects go away, and if so, within what period of time? Are there steps the patient can take to prevent, alleviate or manage the side effects? What should they do if side effects don't go away or become intolerable.

14–Use written information to support counseling when appropriate:
For literate patients, *written information* has been shown to *reinforce* verbal instruction.

15–Discuss precautions (e.g., activities to avoid) and beneficial activities (e.g., exercise, decreased salt intake, diet, self-monitoring):

16– Discuss drug-drug, drug-food, drug-disease interactions:
Patients generally are *not aware* that other medications, foods, or diseases may interfere with the drug they are taking or affect the condition for which they are being treated. For example, a patient with high blood pressure should be told to ask the pharmacist before taking any medicines for coughs or colds.

17–Discuss storage recommendations, ancillary instructions (e.g., shake well, refrigerate):

18–Explain to the patient in precise terms what to do if he/she misses a dose:

19– Check for further understanding by asking the patient to repeat back additional key information: To fully assess whether the patient understands the dosage regimen, you could say, "Mrs. Jones, Just to make sure **that I didn't leave anything out**, please tell me how you are going to take your medication?
The same would be done with side effects, storage conditions, etc.

20–Use appropriate language throughout the counseling session:
Language that is simple and understandable promotes compliance.

21–Organize the information in an appropriate manner:
Generally speaking, *the most important information should be provided at the beginning of the counseling session and repeated at the end*.

22– Follow up to determine how the patient is doing.

Ethical Behavior when Communicating with Patients

Overview

1-As the pharmacy practice grows, **you will find yourself in the midst of many ethical and legal problems that need resolution.**

2-Thus, you must be prepared to carefully recognize and resolve ethical issues **by understanding general and specific ethical principles** and by applying these principles to pharmacy practice.

Key Ethical Principles

1. The Principle of Nonmaleficence

Ethical Principles
• **Nonmaleficence**
• **Beneficence**
• **Autonomy versus paternalism**
• **Honesty and truth telling**
• **Informed consent**
• **Confidentiality**
• **loyalty (Fidelity)**

1-The "principle of nonmaleficence" is commonly stated as the principle of "**first of all, or at least**, **do no harm**." This principle has been used for 3,500 years, in the Oath of Hippocrates.

2-The principle of nonmaleficence requires that a health care provider **to not act in any way that causes a <u>needless</u> harm or injury to a patient**.

3-The principle of nonmaleficence can be violated in two distinct ways.

A-Pharmacists can violate this principle if they **knowingly and intentionally** cause a patient harm**.** For example, knowingly filling a prescription to which a patient has an **allergy** or filling a prescription although they knew it may have **a serious drug-drug interaction.**

وفي العراق هناك البعض من الممارسات الخاطئة التي قد يتم بموجبها إعطاء أدوية لناس يستخدموها لغير الغرض الطبي ومن هذه الممارسات : **Nonmaleficence** الصحيح لذا فانه يندرج تحت عنوان المخالفة لمبدأ

1-إعطاء دواء الـــ (**دكسون**) لناس يستخدمونه كفاتح للشهية و(**مسمن**) دون النظر إلى الأعراض الجانبية الخطيرة التي يمكن يسببها مثل هكذا استخدام.

2-إعطاء بعض الأدوية التي تحتوي على **هرمونات بانية للجسم** (**anabolic steroids**)للشباب الرياضيين الذين يرومون بناء جسم قوي مفتول العضلات دون النظر إلى الأعراض الجانبية الخطيرة التي يمكن يسببها مثل هكذا استخدام.

3-إعطاء بعض الأدوية التي تعمل على الجهاز العصبي المركزي لبعض **الناس المدمنين عليها (بقصد الحصول على حالة من الانتعاش الذهني** وغيره)ا دون النظر إلى الأعراض الجانبية الخطيرة التي يمكن يسببها مثل هكذا استخدام.

4-استخدام ما يسمى (**الإبرة الخبط**) (**فولتارين +ديكادرون**) لعلاج حالات الأنفلونزا وهو استخدام غير صحيح من ناحية عملية خبط دوائيين مختلفين في سرنجة واحدة ومن ناحية استخدام إبرة الديكادرون للغرض أعلاه.

B-The principle of nonmaleficence may also be violated **when no intent to do harm is involved.**
For example, a pharmacist misreads a prescription for Zyrtec® and fills it with Zyprexa® (sound alike drugs). The pharmacist may be found negligent in his or her actions even though the pharmacist had no intention to cause harm.

أي ان التسبب بخطأ غير متعمد (**بصرفه لدواء آخر غير المكتوب نظرا لتشابه الأسماء**) قد يعتبر أيضا انتهاكا لمبدأ عدم أذية المريض إذا كان ناتجا عن إهمال الصيدلي وعدم اتخاذه إجراءات تحول دون الوقوع في الخطأ أعلاه وهذا الأمر يمكن تجنبه كما ذكرنا سابقا **بسؤال المريض عن حالته المرضية التي شخصها الطبيب** قبل صرف الأدوية....

5-To avoid harming patients, even unintentionally, this principle require **that the pharmacist should obtained and continue to maintain an acceptable level of knowledge** as new medication, devices, and technologies become available and health information advances.
If pharmacists fail to observe these duties, patients may be harmed due to **dated knowledge**.

وبالتالي على الصيدلاني أن يواكب المستجدات العلمية الخاصة بالأدوية واستعمالاتها أولا بأول...فإذا ساهم بعملية صرف أدوية بطريقة مخالفة للمعلومات الحديثة فانه يكون قد خالف مبدأ عدم أذية المريض لأنه لم يواكب المستجدات العلمية

2. The Principle of Beneficence

1-"As to disease make two things—**to help or at least to do no harm**."
This statement from Hippocratic writings focuses on two ethical principles: nonmaleficence (**at least to do no harm)**, as discussed above, and **beneficence** (**to help)**.

2-**Beneficence** is the principle that health professionals **should behave in the best for their patients**. The purpose of dispensing medications is that they will bring benefit to the patient by improving the patient's condition (**provide benefits**).

3- The Principle of Confidentiality "protected health information."

1- **Pharmacists deal with patient-specific information that is personal and sensitive, therefore patient confidentiality and privacy must be maintained at all times**.

2-**It would be considered unethical to discuss or disclose personal health-related information** about your patient with one of **your friends** or **family members who is not a health care provider** and who **is not involved in the care of that patient.**

3-the patients must be assures that information discussed with the pharmacist will be used only by those involved in their care. **Few patients would discuss drug abuse if they thought that the information would become public.**

4-**Access to patient information must be restricted to individuals providing patient care.** Patient cases should not be discussed in public areas such as elevators, and cafeterias. Discussions about specific patient cases should be held in private settings, such as conference rooms, or other private areas.

4. The Principle of Informed Consent

1-The informed consent principle states that patients have the **right to full disclosure of all aspects of care and must give consent to treatment based on clear understandable information.**

2-**In general, consent is not required when a procedure is simple and the risks are commonly understood**. However, any provider who recommends treatment for a patient, especially if it associated with serious risks, must obtain informed consent.

3-For informed consent to successfully take place, it requires a dialogue between patient and provider that consists of:

A-**Diagnosis** of the specific condition that requires treatment(s),
B-The **probability of success** of the treatment(s)(drugs, surgery,…).
C-**Risks and complications** associated with the treatment(s),
D-All **reasonable alternative treatment**(s) or procedures and a discussion of their relative risks and benefits

4-While drug therapy is the most common type of therapy in health care, **informed consent issues surrounding drug therapy are largely ignored compared with issues involving other types of treatment, such as surgery**.

مثال على informed consent ما يلاحظ بأن بعضا من المرضى المصابين بداء الصدفيـــــــــــــة مثلا يفضلون التعامل والتعايش مع المرض وان كان غير مستجيبا للعلاج بالأدوية الآمنة نسبيا كالمراهم الجلدية على العلاج بالأدوية الكيماوية وهي الأدوية المستخدمة لعلاج الإمراض السرطانية (وتستعمل أيضا للصدفية) وذلك عندما يتم تعريفهم بان هذه الأدوية قد تسبب آثارا جانبية خطيرة خصوصا على الكبد أو نخاع العظم.. وبالتالي فأن إهمال هذا المبدأ وكتابة وصـــرف هذه الأدوية دون أعلام المريض بكافة المعلومات أعلاه قد تتعارض مع رغبات المرضى الحقيقية وقرارهم الذي قد يكون مختلفا بعد تزويدهم بالمعلومات ....

5-The central problem about informed consent is **related to communication**. Many times, in actual practice, **health care professionals focus more on "disclosure and telling" than on patient understanding of information**. Therefore, it is important for health care providers to make sure that **patients understand all they need to know to make a reasoned decision about therapy.**

و بالتالي فان كل مهارات التواصل التي تم التطرق إليها سابقا والتي تعين المريض على الفهم الجيد بحاجة إلى الاستحضار عند ما يتم تزويد المريض بالمعلومات الضرورية خلال عملية **informed consent**

5. The Principle of Autonomy versus Paternalism

1- **The paternalism is a poor practice as it fails to take into consideration the preferences of the patient.** In past times, medicine has used the beneficence principle as justification for "paternalistic" relationships with patients. **The paternalistic medical model describes the relation of professional and patient in terms of parent and child**. The professional, like parents, "knows best." makes decisions by themselves without informing the child/ patient who has minimal understanding about the choices.

2- Pharmacist actions that encourage **patient involvement in decision making** would be placed toward the "**patient autonomy". Patient autonomy is best maintained by concordance which mean coming to an agreement between patient and practitioner**.

3-**Information is very important for patient autonomy.** Patients need to be informed **in language they understand**, and in **unbiased terms** the possible treatment options as well as their risks and benefits.

4-**Unfortunately, in today's hurried medical environment, patient education is many times pushed aside**. Thus, patients often feel unprepared to make important decisions about their health care and thus give their right of autonomy to their provider.

5-**In some situations patient autonomy may be *unintentionally* compromised**. For example, some patients who are naturally shy, uneducated, or illiterate may be intimidated in the presence of anyone wearing a white coat so the patient feels he or she is powerless to make a decision.

6-In adults with **lacked autonomy** (unconscious) it is necessary to determine who is authorized to speak for the individual, while health professionals do not automatically have this authority. **Violating patient autonomy is acceptable in limited cases to ensure beneficence to the patient** [e.g., in patients who **are critically ill**, it is often the responsibility of the practitioner to make decisions that are in the best interest of the patient].

6. The Principle of Honesty and Truth Telling

1- **The principle of honesty states that patients have the right to truthful communication regarding their medical condition, the course of their disease, the treatments recommended, and alternative treatments available**.

2-But what should be done when full disclosure of every detail could prove to be harmful?

With the increased prominence of the principle of autonomy in these modern times, **full disclosure and truthfulness have become the more accepted ethical action.**

3-**Pharmacists may find themselves in the middle of an ethical dilemma concerning truth telling and therapeutic benefits**.
In some cases, the patient's pharmacist may be asked to withhold some drug information.
The prescribing provider may state that telling the patient of possible side effects or adverse reactions may actually cause the patient undue distress or even lead to the patient not taking the medication at all.
"this based on paternalistic patient benefit, **but it is contrary the principle of autonomy**"
See the case study below

Case study:
A 30 years old **female** which act in **TV advertisement** were diagnosed to have **Hodgkin lymphoma** (**type of cancer**) was admitted to hospital and treated by single chemotherapy and radiation, during conversation with her she told you that she notices a hair loss but her physician told her that it is temporary and **she asked the physician to refuse any treatment that cause loss of hair** since she planned to continue her work, and her appearance is very important in her work.
But now her physician decided to start combination therapy (called **ABVD**) **which is a best therapy for her case**, so she welcomed the idea and come to the pharmacy to fill her prescription, The pharmacist asked this patient if her doctor told her about side effects of these drug and found out that the doctor told her about most side effects **but he did not tell her that it cause hair loss.**
AT this time a pharmacist realized an ethical problem.

Ethical problems in this case:

1-Incorrect information about the use of drug because some of the drug side effects were withheld. The principle of Truth Telling was not achieved where the physician sees that benefit for the patient will be higher by withholding information about drug side effects)**.**

2-Patient autonomy not respected (since she doesn't like to lose her hair).

3-There are conflicts between Beneficence and Nonmaleficence ethical principles:

Beneficence (by treating the disease with ABVD combination therapy which is the best treatment) which made the physician withholding information about drug side effects**.**

Nonmaleficence (not using ABVD combination therapy may lead to death) **which may occurs when telling the patient side effects of the drugs.**

Judging and possible outcomes:

1- So if we choose beneficence-------- we prefer the doctor idea of using ABVD with withholding the truth [but this will have negative consequences, **since the patient confidence with pharmacist and physician will be lost at the time side effects occur (Hair loss)** and may **lead to patient noncompliance and refusal to continue with any medication**].

2-Telling the patient about side effects (the principle of **Truth Telling**) will maintain confidence of the patient but mean that the patient will refuse taking the ABVD--------- a harm will occur and subject herself to disease mortality [the principle of **nonmaleficence** was not achieved].

3-**So best thing beneficence (choosing ABVD)** but on the same side we need to discuss this with the patient and **tell him about disease consequence which may be fatal**, additionally we can tell the patient **that hair loss will be temporary during ABVD courses and hair will grow again**, she can use **a wig** (باروكة) temporarily, if the patient accepts this would be the best choice.

4-Pharmacist must put in his/her mind that **lying may harm the patient, especially if a lie was found out**, then pharmacist credibility and respect will be damaged.

5-However telling the truth is not absolute, example: **Telling the truth to a patient who may not know that his illness is likely to be fatal may be not acceptable** because telling the truth in such a case may lead a patient **to be depressed** and may seek a way to end his own life, so not telling the truth is justifiable since it is in the patient's best interests (**Beneficence**).

7. The Principle of loyalty

1- The pharmacists, at times, may experience **differing loyalties that will pull them in opposing directions**, which is difficult when one choice must be made. For example;

A-Pharmacists may promote the **use of vitamins** by patients who do not need them to enhance their financial well-being at the expense of their patients.

B-Pharmacists may refuse to confront physicians about inappropriate prescribing because they want to ensure that physicians will continue to direct patients to their pharmacies.

2-Ethically, the responsibilities of **pharmacists should be directed toward the welfare of patients** and to act in **ways that best benefit the patient**.

Refusal of Dispensing

1-Pharmacists are not required to dispense prescriptions if there is a question about the validity of the prescription. However, **Refusal of dispensing** involves refusal to fill

valid prescriptions (e.g., drug for **abortion**) if the medication's use conflicts with the pharmacist's personal beliefs [The ethical conflict is between the rights of patients to access legally prescribed medications and the ethical rights of pharmacists].

2-The pharmacists have the right to "**refuse to participate in therapies they consider to be morally, religiously, or ethically troubling".**

في الدول الغربية إن لم تقم بصـــرف الوصـــفة لأنها تتعارض مع مبادئك الأخلاقية أو الدينية (أدوية الإجهاض مثلا) فانك تكون **ملزما** بإرشـاد المريض إلى المكان الذي يسـتطيع الحصـول منه على الدواء المذكور (صـيدلية أخرى مثلا) لكن حتى هذا العمل قد يكون غير مقبول أخلاقيا باعتباره مساعدة بطريقة أو بأخرى على عمل غير أخلاقي ...وهكذا تبقى كثير من الأمور محل جدل أخلاقي وقانوني....

3-As a general rule, pharmacists who cannot or will not dispense a drug have an obligation to meet the needs of their customers **by referring them elsewhere.**

Ethics and the Promotion of Drugs

1-يمثل العمل في قطاع الترويج الدوائي والمكاتب العلمية لدعاية الأدوية مجالا واعدا ومغريا للكثير من الصـــيادلة وهذا العمل على أهميته إلا انه لا بد له أن ينضـــبط بالقواعد الأخلاقية التي تنظمه ولا يخرج عنها بتبنيه لممارسات خاطئة بين المكتب العلمي ومن يقوم بالترويج له (وهم من الصـيادلة على الأعم الأغلب) من جهة وبين الطبيب من جهة أخرى يكون ضـحيتها الأول والأخير هم المرضـــى.. وابسـط مثال على ذلك تقديم الهدايا والسـفرات والعزائم مقابل الإكثار من وصـف دواء معين قد لا يحتاجه المريض أو قد يكون غاليا مع توفر دواء مماثل بالكفاءة وبسعر انسب...
2- هذا الموضـــوع أي موضـــوع الترويج الدوائي بأبعاده المختلفة والموســعة يتم تدريســه أيضــا وبشكل أوسع ضمن مادة أخلاقيات الصيدلة في المرحلة الثالثة....

1-**Promotion** refers to all activities by manufacturers and distributors **to induce the prescription and use of drugs.** It is a part of **advertisement**. It is well known that increasing drug promotion will increases drug sells.

2-Unlike other types of advertising, pharmaceutical advertising **targets health care professionals, who influence drug selection, and not patients, the ultimate consumers of the products.**

3-**Many drug companies give gifts to Health care professionals**. Gifts ranging from low-cost items such as pens, notepads, clothing, textbooks, and meals to high-cost gifts such as (I pad, laptop …and even cash gifts).

4-Acceptance of these gifts carries ethical problems, **no matter the monetary value of the gif**t.

The cost of gifts and other forms of advertising is included in the price of medications. Therefore, spending patients' money without their knowledge is unjust

وارجو أن تبقى هذه العبارة ومعناها حاضرا على الدوام في أذهاننا ...فالكثير منا يحضر مؤتمرات وندوات علمية بحتة ....وهذه الفعاليات ترعاها شركات الأدوية ....وتقوم بتوزيع هدايا على الحضور وخصوصا الحقائب المكتوب عليها اسم الشركة مثلا ...حتى هذا العمل البسيط الذي لا يجد احد منا حرجا في استلام الحقيبة ....يعده المختصون بالأخلاق الطبية والصيدلانية عملا لا يخلو من إشكال على اعتبار إن تكلفة هذه الفعاليات تحسب ضمن تكاليف الأدوية والتي سوف يتحملها المريض دون علمه وموافقته...

فإذا كان مثل هكذا عمل ...تثار عليه مثل هكذا اعتراضات ....فما بالك بالممارسات الخاطئة التي ذكرناها أعلاه(الاتفاقات والتعاملات) .....وهذه (صورة للفقرة أعلاه) من الكتاب الذي يذكرها واسمه

Clinical Skills for Pharmacists. A Patient-Focused Approach

نضعها تأكيدا لهذه الجملة المؤثرة ...

The ethical implications of accepting gifts from the pharmaceutical industry involve issues of justness and obligations.[29] The cost of pharmaceutical gifts and other forms of advertising is included in the price of medications. Therefore some argue that spending patients' money without their knowledge or consent and without direct benefit is unjust.

5-Guidelines regarding the relationships between health care professionals and the pharmaceutical industry continue to evolve. Common practices such **as sponsoring dinner at a local restaurant, or giving gifts such as mugs imprinted with a drug name, *are no longer acceptable.***

6- **Many studies showed that gifts will affect doctors' prescribing practices**. [When these items (mugs, pens... imprinted with a drug name) **saturate the workplace**, they increase product recognition and likely **increase the probability that physicians will prescribe the advertised drug**].

7-Ethical problems for prescribing in case of physicians who accept gifts from companies include: **Increased prescribing rates,** and prescribing **of more expensive medications** at no demonstrated advantage to the patients.

وهكذا فانه حتى الهدايا البسيطة كالقلم أو ألكاس أو المفكرة التي تحتوي أسماء الأدوية قد تؤثر لا شعوريا في الطبيب وتجعله يكثر من صرف هذا الاسم التجاري بعينه...لذا يعده البعض غير مقبول أخلاقيا... فما بالك إذا كانت المسألة تتعلق باتفاق لا أخلاقي بين مندوب الشركة الدوائية وبين الطبيب يتضمن الإكثار من كتابة الدواء مقابل هدية ثمينة أو سفرة !!!

8-The guideline allows companies to offer gifts **that are primarily for patient education**
(e.g., anatomic models, educational posters) if the gift is not of substantial value and does not have value beyond the health care professional's professional responsibilities.

9-Companies can provide **modest meals with presentations if the presentation is at the health care professional's office or hospital.**