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BUILDING PHARMACIST-PATIENT RELATIONSHIPS

A thesis presented in partial fulfillment of the requirements for the degree of

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ABSTRACT

Relationships between pharmacists and patients have become more important with the adoption of patient-centred care in the provision of healthcare in New Zealand. Competence standards for communication and relationship building, which have been introduced for pharmacists, highlight the importance of continuing professional development for best practice. This study explored how pharmacists built relationships with patients and how communication skills training might contribute to this process. A quantitative survey method including both closed and open questions was used to elicit the views of pharmacists and this was analysed using an interpretive process. Pharmacists were found to build relationships using a friendly and respectful approach with appropriate questioning and listening techniques and checking for understanding. It took time to build relationships, but they were seen as essential. Learning to build relationships happened during everyday practice over time. Focused study with experiential methods was seen as helpful by some respondents, although transfer of this learning to practice in real life was found to be challenging. The literature supported these findings including the recognition of difficulty with implementing changes into practice.

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FRONTISPIECE

"This pharmacy is in a central city area which formerly supported seven other pharmacies within two blocks of us. I have followed the lead of my preceptor to continue to build strong relationships and we are now serving the great grand-children of customers we had when I was an apprentice in a number of cases, which is most unusual for a central city pharmacy. Relationship building has been the key element in our survival where seven other pharmacies have failed. Customers travel right across town to reach us. A large proportion of our clients reside in a suburb where my brother closed a pharmacy five years ago. These clients pass at least two other pharmacies to come to us. This is all about relationships."

CHAPTER 1:
BUILDING PHARMACIST-PATIENT RELATIONSHIPS

Introduction

While relationships with patients have always been important for pharmacists, recent developments in the pharmacy profession focus even more closely on relationship building as a key factor in healthcare delivery. The potential health benefits of active partnerships with patients have been recognised and efforts have been made to promote this aspect of pharmacy practice. Effective communication and relationship building have been itemised in the new competence standards for the pharmacy profession, and continuing professional development courses now include these topics as authentic and legitimate study goals.

The focus of this thesis was to examine how pharmacists went about building relationships with their patients and how they learned to do this effectively. It also sought to discover how training programmes, such as communication skills courses, contributed to this learning.

This question arose because attendance at communication courses currently available from the New Zealand College of Pharmacists was poor, and the usefulness of these courses was questioned. As a pharmacist and the programme manager in the College, I have the task of organising these courses. My experience includes pharmacy practice and post graduate study in both community pharmacy and education, and spans Australia, Wales and New Zealand. Some pharmacists that I spoke with in New Zealand in 2006 expressed their doubts about the benefits of these courses. On the other hand I also spoke with several pharmacists who found such courses very helpful for their practice of pharmacy. Part of this study was to understand why opinions about these courses differed and which elements of the courses were considered to be of value.

Background

On an international scale, the delivery of healthcare has been undergoing significant and fundamental change. As an integral part of the health sector, the pharmacy profession has been challenged to keep abreast of these developments and it is important to explain these changes in the context of pharmacy practice. Relationship building has become recognised as a fundamental aspect of effective healthcare and the subtle developments being encouraged in the nature of the pharmacist-patient relationship need to be understood.

The first changes in healthcare described in this introductory chapter relate to the philosophy underlying the delivery of healthcare, and the terminology needs to be clarified and explained. The old system was referred to as the 'biomedical model', while the new system has been founded on 'evidence-based medicine' and 'patient-centred care'. Next, I discuss pharmacy services and the recent market changes in health and pharmacy practice, which are significant drivers for pharmacists to carry out more patient oriented work. Next, pharmacist roles are outlined in order to clarify the impact of these overarching changes to the everyday working environment of pharmacists. Relationships with patients develop according to the type of service being provided, and the skill or ability of the pharmacist might need to be refined accordingly. Some issues arose with the power balance within the relationship, and these ideas are introduced at this point. Following this, the discussion moves to the rise of public safety as a controlling factor, and this explains the increased focus on communication and relationship building within the new competence standards from the Pharmacy Council. Next, the discussion outlines the development of pharmacist training courses in communication and relationship building for both the compulsory pharmacy syllabus for new university graduates and the optional continuing education programmes provided by the College for experienced pharmacists. This chapter concludes with an overview of the research and an outline of the structure of the thesis.

Changes In Healthcare

The style of healthcare delivery that dominated the 20th century, referred to as the 'biomedical model', is now becoming outmoded. It initially developed at the same time as molecular and chemical sciences and resulted in the focus of medicine being oriented to biochemistry and pathophysiology (disease states) (Roter & McNeilis 2003) rather than towards patients as people. This model placed the health professionals and their specialized knowledge in a position of power over patients. Didactic instructions were issued as orders to be obeyed and two-way communication with patients was not valued. The patients were 'pathologised' or identified according to their disease state or treatment regimen, rather than having their humanity recognised. A person might be referred to as a diabetes case or a heart failure case, or perhaps as an insulin script or digoxin script. Pharmacy services involved preparing the doctor's prescriptions, and medicines were labeled as "The Tablets" or "The Mixture" with no indication of what they might contain. This was privileged information that was withheld from the patient. Patients were expected to be totally accepting of and compliant with all instructions, despite being kept uninformed. If patients showed poor compliance to a regimen, they were considered to be at fault and blamed accordingly. There was no consideration that the health provider could be a factor contributing to treatment failure. While this style of health delivery is in decline, I have heard that some practitioners still appear to work with this approach.

The new system embraces what is called 'evidence-based medicine', and requires health professionals to follow practices that are supported by research evidence showing that they are the safest, most cost-effective ways of treating patients. Some definitions focus on the need to integrate the best research evidence with clinical expertise and patient values (Taylor 2002). In the area of medicine compliance, research showed that about 50% of prescriptions written were not taken effectively (WHO 2003). This result was considered so significant that the underlying reasons were examined and this work revealed a myriad of contributing factors. These were categorised into five dimensions - socio-economic, health system, condition, therapy and patient factors. It is now recognised that patients do not always do what they are told, and have a whole range of ideas, concerns and expectations related to their health beliefs. The pharmacist needs to discover what these are in order to determine what information and care the patient

needs to be given. For example, a patient with diabetes might be resistant to using insulin injections because her mother had died shortly after commencing insulin therapy. If the pharmacist found this out early in an interview, discussion might be much more constructive than if this were never known.

This need to consider the patient viewpoint was one of the prime factors driving the evolution, on an international scale, of 'patient-centred care' in the late 1990s as a concept to be adopted internationally for the delivery of healthcare. The definition of this 'patient-centred' approach has been widely debated but was generally held to include an exploration of the patient's concerns related to the patient's world, finding common ground, mutual agreement on management and health promotion, and enhancing a continuing therapeutic relationship (Stewart 2001). Some of this research shows that patients who take a greater role in managing their illness and their treatment have greater improvements in their health. This was affirmed by research carried out in the US where pharmacist-patient relationship quality was positively related to patient-centredness and participative interpersonal communication (Worley 2006). Patient-centred care was supported on a national level in New Zealand with the Minister of Health stressing the importance of a focus on people (rather than providers) in the delivery of health care in the New Zealand Primary Health Care Strategy (King 2001). This current approach opposed the previous reductionist 'biomedical model', which is now considered to be poor practice.

Pharmacy Services

The provision of healthcare in New Zealand is being affected by market forces operating within the community and health services are becoming commodities that may be purchased in defined units. In keeping with this economic philosophy, the national District Health Board organisation, DHBNZ, has created a National Framework for Pharmacy Services to define the funded services that pharmacists could provide. There are new roles for pharmacists to review medicines and to educate patients, as well as the traditional baseline dispensing service. Medicines Use Reviews (MUR) was the first of the newly funded services to be implemented by District Health Boards. This provides a welcome opportunity for pharmacists wishing to perform these MUR reviews, although on the other hand, the District Health Boards now have an expectation that there will be

sufficient pharmacists ready to make this new service widely available to all who wish to participate. As a result there is now pressure on pharmacists to attend the NZ College of Pharmacists MUR training course in order to become accredited for MUR.

Looking at health provision from a central government perspective, pharmacists are considered to be underutilised on a national level, and the current Minister of Health urged pharmacists to take on the new patient oriented services in order to take advantage of their knowledge (Budgen 2007). This was a fair comment, given that today's pharmacy degree programmes at universities produce pharmacists with excellent clinical knowledge of modern medicines. However, because dispensing was the only service attracting financial reward before the Framework, pharmacists understandably spent much of their time building income by dispensing. Now that the new patient oriented MUR services are being funded, pharmacists have been given the financial support they need to be able to develop these new roles.

Pharmacist Roles

The major role of a pharmacist is to dispense medical prescriptions for patients. While this is mainly a technical task involving the packing and labeling of medicines, it also requires a few minutes to check the safety of the prescribed medicines for this patient, to give advice about the medicines and how best to take them, as well as determining whether the patient has understood correctly. Pharmacists also supply non-prescription medicines over the counter of the pharmacy. In this role the pharmacist must enquire about the customers' needs and provide information to enable them to make an informed choice about their purchases.

The new role that is currently being developed across the country for Medicines Use Reviews (MUR), involves a formal and structured consultation between a pharmacist and a patient in a private area. Patients are offered the service according to eligibility criteria specified by each District Health Board, usually involving chronic illness and several regular medicines or potential risk for medicines related problems. MUR fits well with the definition for patient-centred care outlined above, with development of the pharmacist-patient relationship as an ongoing feature. MUR asks the question "Does this patient understand their medicines?" The pharmacist interviews the patient using

reflective questioning to find out how they take their medicines, what they think they are for and how they are getting on with them. If the patient wants to be reminded, wants to know more, is confused or has forgotten or misunderstood what the doctor had said, the pharmacist explains. As the relationship develops, it may be possible that the pharmacist finds out new things because the patient did not wish to trouble the doctor with details they did not consider relevant. At the beginning of the interview for MUR, the patient's consent is gained for the review including the sharing of information with their doctor, as it is intended that the role of the doctor should be supported with feedback from the interview, as well as supporting the patient's autonomy in managing their treatment and enjoying better health. Ideally, the doctor would refer suitable patients to the pharmacist for MUR reviews, and this has been happening in the pilot sites already.

Power Issues Within These Changes

The relative power of the pharmacist and the patient was another area subject to change. The patient-centred approach to health care provision described a change in the dynamics between the patient and the pharmacist. Instead of the pharmacist issuing orders and wielding professional power, the patient viewpoint was acknowledged and patients were expected to become partners in treatment management. In theory this represented a change in the power balance, but the question was how it was changing in practice. Did patients gain power as they took more responsibility for their treatment? Were all pharmacists able to empower all of their patients? Were some pharmacist-patient relationships held in the biomedical model, unable to change paradigms for various reasons? The patient might have great faith in the advice and still prefer to be told what to do. The situation might involve choices in treatment approaches and this may require some joint decisions as to which alternative would suit a particular person and their lifestyle. As a simple example, the pharmacist could explain that if a patient with high blood sugars chose to exercise or eat less in order to lose some excess weight they might be able to reduce their medicines in future. The pharmacist could then ask if the patient would be prepared to introduce some extra activities into their daily routine by the next visit and the patient might think they could. This patient was being given the power to choose how to manage their condition. The subtle change was in the wording of the conversation, such that choices were offered as opposed to orders being categorically imposed.

Patient Safety And Competence Standards

Today health professionals are required under the Health and Disability Services Consumer Rights to communicate with patients and to provide all the information required for them to make an informed choice. These Rights represent a situation where the person previously referred to as a 'patient' is now a 'consumer' of health care. The health professionals who were previously at the top of the medical hierarchy, are now service providers required by regulatory authorities to meet certain standards and deliver care according to market factors and budgeted targets. Health care has become a commodity and the patient a purchaser with buying power. As consumers driving market forces, they have a right to expect a high standard of service and in many cases this hinges on good relationships and communication with health providers.

The importance of relationships and interpersonal communication to the caring process was recognised by the Pharmacy Council of New Zealand in the development of the Competence Standards for the pharmacy profession. These standards included a number of elements concerning communication, which made them mandatory skills for registered pharmacists and effectively legitimised communication skills as an essential area for continuing professional development for pharmacists. The additional standards developed for MUR specifically included building relationships with patients.

A key feature of this work by the Pharmacy Council was that communication was not dealt with as a discrete activity, but was spread throughout the standards in various different contexts. Given that these were intended to be measurable activities that a pharmacist might be assessed against, they were linked to practical rather than theoretical situations. This was reflected in the literature in a comment about the difficulty of defining communicative competence in a theoretical construct and how a practical situation might be easier for assessment (Greene & Burleson 2003). Appendix One contains a list of the pharmacy competence standards and elements that relate to communication and relationships with patients.

There were a few pilot studies for MUR reviews and the general practitioners whose patients accessed the service, were favourably impressed by the results. Following this success, the Pharmacy Council wished to ensure that this quality was standardised and

maintained in order to sustain the MUR service in the long term. Consequently, the Pharmacy Council stipulated an accreditation programme to inform pharmacists of best practice and prepare them for success.

Pharmacist Training Courses And Communication Topics

Training to become a pharmacist in New Zealand today involves a degree course followed by an intern year in a workplace setting. The degree at the University of Auckland has been available since 2000, while the degree at the University of Otago was introduced in 1963 (University of Otago 2007, University of Auckland 2007). Between 1960 and 1991, it was also possible to qualify by completing a diploma course that was available at the Central Institute of Technology in Petone, Wellington (Abbott 2000). Many pharmacists practising in New Zealand today trained through this diploma route.

The content of pharmacy training has also undergone changes of an evolutionary nature. Before the 1980s communication was not included in the curricula. The earliest teaching in interpersonal techniques focused on questioning and listening skills and this began in the Otago courses with the introduction of Pharmacy Practice as a vocational topic in the 1980s (University of Otago 2007). It was generally referred to as communication skills and this title persisted as other subtopics were developed and included. Even though the importance of relationships and partnership building was recognised within the concept of patient-centred care, pharmacy courses still tended to refer to this type of training as communication skills training. This research project reoriented this arrangement and placed communication as an aspect of relationship building, rather than the other way around.

It is important to note that the older pharmacists practising today were trained before communication became part of the curriculum, and therefore relationship building was not covered during their compulsory training. Those qualifying from the 1980s received gradually increasing amounts of communication training. By the 2000s, pharmacy students were being taught communication during all four of their undergraduate years at university. They started at a basic level in workshop settings, and this was extended over subsequent years, with consolidation of the skills during regular practice tutorials

using conversations with simulated patients. The key position of communication and rapport in pharmacy was stressed from the first year, and by the fourth year teaching and assessment about counselling, relationship building and patient-centred care was also included in the curriculum. Occasional days out in the workplace (both community and hospital) provided more experience in communication and patient care in real settings (Parore 2007).

Since the introduction of the compulsory intern year prior to registration as a pharmacist, each new graduate spent a year in the workplace with various assignments and training days. Communication and relationship building were included in training and assessment during this intern programme. One key assignment was the patient-centred care plan (which involves communication and relationship building) and one training day was devoted to communication, including topics such as personality styles and the effect this could have on individual interactions with other people.

The New Zealand College of Pharmacists, established in 1990, has a mission to provide optional, part-time, continuing education accessible to practising pharmacists. If pharmacists had trained a significant time in the past this was seen as an opportunity to augment their knowledge and bring their practice up to date. In terms of communication courses, there was a two day workshop module which covered questioning and listening techniques, communication styles as well as 'motivational interviewing' (a behaviour change model for lifestyle advice such as dieting, exercising, smoking cessation) and a variety of other small topics. Consultation skills and relationship building were not included. This module has been offered every second year since 1990, however, the numbers enrolling have been declining consistently until in 2007 when there were too few to enable the course to run. Since 2002, it has been my task as programme manager to develop course content for modules such as this. A new course that was offered in 2007 was the training for MUR as mentioned above. This included specific teaching for pharmacists on empathic understanding, consultation skills and building relationships, which were seen as crucial skills for the provision of MUR consultations. Because pharmacists were required to attend this training in order to be accredited for MUR services, they did enroll; however, some still commented that they found the communication aspects of the course of little use to them, while others found them very helpful, although they did not explain which aspects were beneficial and worthwhile.

This gave rise to the research questions in this study, which were:

> How do pharmacists learn to build relationships with their patients,
> and how does communication skills training help?

Overview And Structure

The goal of this research was to examine the values, beliefs, attitudes and cultural approaches to the whole concept of building pharmacist-patient relationships, how it was achieved and how pharmacists learned to do it. It was unclear whether it was something which could be learned in courses or if it was influenced by other factors entirely. It was also unknown why there was such variation in attitudes to communication skills training.

Some insight into the underlying concerns would be of great benefit to the College in order to determine the future rationale for courses. This would also assist me in determining the best topics to include and the optimal design of methods that would enable pharmacists to develop their ability to relate to patients. It might also provide some evidence to help convince pharmacists that there were some useful techniques that could be learned and readily applied in everyday practice.

An important issue that has impacted on this research project and imposed a very tight time schedule upon the work needs to be mentioned here, as it has had a major effect on the methodology involved (see Chapter 3). I had originally set out to do a completely different project, but became worried after the first two applications to the ethics committee did not succeed. Concerned that I would not gain ethical approval in time to complete the research within the overall time allocated, I therefore decided to change direction and proceed with this research into relationship building as an alternative project, despite the associated limitations.

This thesis is structured so that in Chapter 2 there is a literature review presenting what has already been written on this topic from not only the pharmacy literature, but also the medical and nursing fields. Chapter 3 discusses the methodology supporting this study and which assumptions are being made about this research. The next section provides the details of the questionnaire method employed. Chapter 4 provides the data and

results of the survey. Chapter 5 discusses in detail the findings from the research study and the literature review. Chapter 6 provides the conclusion of the research with recommendations for further study.

CHAPTER 2: LITERATURE REVIEW

Overview

The first part of this literature review focuses on relationship building, and is structured using the three factors detailed below (interpersonal sensitivity, patient viewpoint and partnership building). The next section covers the various styles of communication and the effect of personality and culture on the development of relationships. The next section examines behaviours that blocked relationship building.

The second part of the review looks at how relationship building was learned and what resources were available. Comments in the literature about the usefulness of training courses in communication and relationship building were gathered and any useful aspects of courses were identified. Comments speaking against courses were collected with a view to understanding why training courses in communication skills were not valued.

Relationship Building

Introduction

Relationships with patients mattered. They made a difference to communication in healthcare, to the people who were involved, to healthcare and its outcomes. Relationship building was called "the cement that binds the consultation together" (Silverman et al 2005 p117) and referred to relationship-centred care that brought a personalised, partnership-oriented approach to medical care.

In their book *Skills for Communicating with Patients,* Silverman et al (2005) referred to a model for structuring consultations that was known as the Calgary-Cambridge Guide. Although this model was originally developed for doctors, the New Zealand College of Pharmacists adopted it as 'best practice' for pharmacists carrying out Medicines Use Reviews (MUR) and used it in the training currently provided for pharmacists wishing to become accredited for MUR.

The Calgary-Cambridge Guide identified the objectives to be achieved in consultations (Silverman et al 2005). This framework outlined the five stages within the consultation, and described two tasks that occurred as continuous threads throughout the interview, namely building the relationship and structuring the interview. Seventy one separate details were listed in the expanded framework and all contributed to a successful consultation. I identified and grouped the following points as key elements contributing to the development of the relationship between the pharmacist and the patient in order to structure this part of the review. The first group I selected linked to interpersonal sensitivity (which included establishing initial rapport, demonstrating respect and interest, and using appropriate non-verbal behaviour); the second group linked to the patient's viewpoint (which included exploring the patient's problems as well understanding and acknowledging the patient's perspective of illness, their ideas, beliefs, concerns, expectations, effects on life and feelings, by being non-judgmental, empathic and supportive); and the third group linked to partnership building (which involved the patient in shared understanding and mutual decision making).

Interpersonal Sensitivity

This aspect of relationship building encompassed a number of qualities which contributed to a person being described as a "people-person". In the most successful relationships these were present on both sides. The qualities mentioned by Street (2003) that were considered to be supportive of effective healthcare relationships were empathy, respect, trust, honesty, sincerity, genuineness and warmth. These qualities became apparent through both verbal and non-verbal behaviours.

Many authors emphasised the importance of rapport for strengthening the provider-patient relationship for pharmacists (Rantucci 1990, Sigband 1995); for doctors (Clark & Gong 2000, Street 2003, MCNZ 2006); and for nurses (Sheldon 2005). They maintained that some degree of rapport was established during the initial interaction by providing a sense of privacy, a friendly atmosphere, an organised approach and a positive attitude, as well as showing respect and genuine interest, and this continued to develop over time through an ongoing process. While these instructions appeared idealistic and theoretical I suggest that identifying them aided the process of determining whether these were elements that might be learned, whether they were innate qualities or possibly simply attitudes that might be adopted if desired.

The literature indicated that the development of trust was a key factor for developing a successful relationship and was linked to the expression of respect or the unconditional acceptance of another person's beliefs (Sheldon 2005, Brown et al 2006). Trust was also linked to being genuine, honest and sincere (Tindall et al 1984). People respected sincerity much more than superiority and displays of knowledge (Quintrell 1994). It took time to develop credibility and trust and one failure could destroy all that had already been achieved. An underlying motivation of attending, alertness and a desire to understand (Welch 2003) was also important to develop mutual respect and build long term success into the relationship.

The Patient's Viewpoint

Before patient-centred care, questioning and listening was focused on finding out about patients' illnesses and symptoms as efficiently as possible, in order to decide whether to recommend treatment or to refer patients to their doctor (Quintrell 1994). With the advent of patient-centred care, the questions being recommended focused on developing empathic understanding, with active and reflective listening techniques. A key factor was that the concerns of the patient were valued, and that the patient felt that he or she had been heard. This was an aspect of the relationship that depended upon open two-way communication between the pharmacist and the patient. There was full focus on the words and meanings at all levels and both intellectual and emotional aspects were included. The person had no fear of being judged or criticised as incompetent. Empathic understanding was widely described in the literature for pharmacists (Tindall et al 1984), doctors (Maguire & Pitceathly 2002), psychotherapists (Welch 2003) and nurses (Riley 2004, Sheldon 2005). Relationship growth was nurtured by this empathic understanding, which could be achieved using a series of verbal techniques (e.g. open questions, reflective listening) that could be learned if applied with an open attitude and diligent practice.

From the perspective of evidence-based medicine, as mentioned in Chapter 1, research was published supporting patient-centred care. The literature for pharmacy, nursing and medicine studied patient-centred communication, where the patient felt heard and valued, and this lead to greater patient satisfaction and health outcomes (Clark et al 1998, Stewart et al 2000, Lewin et al 2001, Thomas & Pollio 2002, Street 2003, Worley-Louis 2003).

Partnership Building

A key feature of partnerships was working together to reach agreement, or concordance, to use current medical terminology (Chewning & Wiederholt 2003). The beliefs and wishes of the patient were integrated with the advantages, disadvantages and possible implications of healthcare information in order to provide choices for shared decision making. This was a feature of the Calgary-Cambridge model being taught to pharmacists for the Medicines Use Review service. The pharmacist was expected to involve the patient in shared understanding and decision making.

Discussion of partnerships was not complete without considering power and responsibility present on each side. As healthcare providers, pharmacists were considered to hold power by virtue of their specialized knowledge and legal status as professionals. However, this power was balanced by responsibility (Nessa 2001). In 1996 the Health and Disability Services Consumer Rights were created stating that all health professionals have a responsibility to provide information about health to the patient (HDC 2004).

However, the patient also had power in terms of self-efficacy, especially with the new concept of patient-centred care. The patient was now being recognised as pivotal in the decisions involved in taking each and every dose of medicine. The role of the healthcare provider was now to empower the patient to manage treatment effectively, by negotiating options, making compromises and discussing what might work best for the patient (Rusk 1993). This involved more than simply providing information, and the partnership model was ideal to create a sense of responsibility in the patient, so that they might gain some control of their health. This link between patient activation within the consultation and improved health status was shown in research (Bertakis et al 1998).

Taking the purely consumerist model to extremes, the customer could become so demanding that potential benefits provided by the professional viewpoint were not utilised (Roter & McNeilis 2003). On the other hand, the patient-centred, partnership model had yet to spread throughout all of society and many were more comfortable with the traditional, hierarchical, paternalistic style of interaction where the doctors and pharmacists issue instructions to patients. The patients might simply have wished to be informed about what they should do and might not wish to be assertive or express their

ideas, concerns and expectations. Research with pharmacists and patients in the US revealed that pharmacists were taking up the new concept of patient-centred care, but that the patients did not have the same understanding of their role in terms of being 'responsible' and 'active' or of the pharmacist's role in 'creating a patient-centred relationship' (Worley et al 2007).

The Effect Of Personality

The literature suggested that personality affected styles of communication, which in turn affected the formation of relationships. Personality was described as a unique and enduring bundle of motivations and needs, attitudes and behavioural tendencies that made each of us who we were (Hoffman 2002). The work on temperaments provided another way of viewing people's differences, where people had certain preferred characteristics and ways of functioning (Keirsey 1984). Temperaments were seen to be linked to personalities, although not synonymous. To elaborate on the four temperaments identified, a person might be inclined to exhibit impulsive, joyful actions, or be duty-bound in outlook; they might seek knowledge and power or they might be focused on the essence of being human. There were various other authors studying types of personalities, however, the other well known work initiated by Jung in the 1920s and developed further by Myers-Briggs proposed various 'psychological types' that formed part of personality. Types were the mental processes and attitudes through which people preferred to experience their lives (Lawrence 1996). They related to one's orientation of energy (extroverted/introverted), orientation to outer world (planned or flexible) and one's processing of information (taking data in as concrete facts or intuiting deeper meaning and also making decisions using logic or feelings). The types also represented different patterns of motivations, interests, learning styles and aptitudes.

The way in which personality was created, sustained or changed was hotly debated and there were many unanswered questions. The psychological types were considered to emerge in young people with possible influences from environmental factors. With maturity it was considered that balance could be achieved by developing processes that were not naturally preferred (Lawrence 1996). However, it was considered unlikely to achieve a complete transformation, particularly along the dimension of introversion - extroversion, and also that this became harder as people aged (Hoffman 2002). It had been proposed that it was only realistic to achieve a minor modification to the inner core

of the personality, such as learning to develop new behaviours to cope with certain situations. This suggested that it was possible to adjust the style of speech used in order to match the preferred style of the person being addressed and thereby improve communication. A greater knowledge of preferred styles and temperaments could assist the process of recognising how best to approach each person and what adjustments could be needed (Keirsey 1984, Lawrence 1996).

For example, someone whose preference was to plan in detail (judger) might have needed to speak to someone whose preference was for flexibility (perceiver). The judger might have been seen as unwilling to take time to explore creative options and the perceiver might have been seen as straying from the set agenda. Awareness of both styles might have allowed appropriate compromise or acceptance, so that communication could be meaningful and effective in both directions. As a second example, the pharmacist might have preferred to think using reason and logic, whereas the patient might have preferred to use values and subjective judgment. If the patient was fearful of a certain medication, he or she might need to have those feelings acknowledged before the pharmacist could proceed to explain why those fears might have been unfounded. Negating those feelings might have created a barrier and the expert technical advice from the pharmacist might have remained unheard.

In the health literature, styles of communication were mentioned briefly. One study on doctors' consultations concluded that ordinary chat (rather than businesslike speech) where there was emotional agreement and social interaction was important in providing a sense of being helped, even when there was little therapeutic knowledge to be offered (Brown et al 2006). They recommended the use of ordinary, enjoyable conversation to enhance the quality of communication and develop the relationship. The nursing literature referred to two styles - rapport (harmonious) contrasted with report (factual) (Schuster 2000). While rapport might be associated with female and report with male tendencies, she proposed that both styles of speech might be used to good therapeutic effect for both genders. I agree that this gender association was over-generalising, and that every individual should be addressed in a manner that suits their own style. In direct contrast to this work, earlier writing by pharmacist Warden-Flood (1987) suggested that the pharmacist should listen carefully to the patient, judge the importance of his or her remarks and know when to interrupt idle or unproductive chatter. Given that Warden-

Flood was writing in the 1980s, he was possibly reflecting that time, but things have now moved on as indicated by Brown et al (2006) above, in keeping with this changing context. The "idle or unproductive chatter" that was not valued by Warden-Flood in the 1980s was selectively blocked whereas in the 2000s it was seen by Brown et al to be a valuable element contributing to a successful therapeutic relationship and satisfaction for both patient and professional.

Cultural Sensitivities

The contribution of culture to interpersonal communication and relationships could not be ignored. The underlying beliefs, values and assumptions needed to be considered when interacting with other people. It was essential to make a full commitment to incorporating cultural awareness into caring (Brown et al 2006). They viewed cultural competence as a continuous process of striving towards adequate service, rather than assuming that an adequate recognition of diversity could ever be achieved. Cultural diversity was complicated because of the variation both between groups and within groups. Respect was considered to be a bedrock assumption of multicultural and diversity competence and some people might experience a wrenching sensation when they first learned that others viewed the world differently and that the others' claim to understanding carried as great an argument for truth as their own (Welch 2003).

Participatory communication occurred more readily between two people when they had the same cultural backgrounds, such as ethnicity, gender or age (Cooper-Patrick et al 1999, Nussbaum et al 2003, Welch 2003). Many resources were available to help reduce assumptions, avoid stereotyping and communication errors (Metge 2001, Moss 2004).

Cultures might be either individualistic with autonomous decision making or collectivistic where decisions were made with the consensus of the group and pharmacists needed to be aware of this (Sheldon 2005). Communication followed the rules of the group and attention was paid to authority. Relationships could need to be built not only with the patient, but with their family and possibly their extended family as well.

Blocking Behaviours

Numerous factors were identified as blocking good communication and hindering relationship building in consultations with patients. This applied to pharmacists (Tindall et al 1984, Rantucci 1990, Quintrell 1994, Welch 2003), to nurses (Booth et al 1999, Riley 2004) and to doctors (Clark & Gong 2000, Maguire & Pitceathly 2002, Brown et al 2003, Greene & Burleson 2003, Street 2003, Thompson et al 2003).

Being unfriendly and domineering were among the basic attitudes identified as blocking behaviours. Others related to time pressures, such as spending too little time explaining things. The issues that created most dissatisfaction were interrupting frequently and giving premature advice or reassurance before identifying the main problems. Patient behaviours considered to block relationships related to being poorly informed and passive. It might also have been that a patient was in denial of their illness and attempting to regain some control by being uncooperative (Welch 2003).

Learning To Build Relationships

The Learning Process

No one has ever mastered communication skills (Sheldon 2005). Our skills evolve with time and experience and our personality shapes how we talk with patients. Time was also mentioned as a necessary factor for building successful relationships with patients (Suikkala & Leino-Kilpi 2001).

The concept of knowledge 'that' and knowledge 'how' was described in order to differentiate between information and techniques. Knowledge 'how' is used routinely to achieve well-practised effects for individual clients (Evans 1991). Bloom's taxonomy for learning, was reviewed and updated and the dimensions of knowledge and of cognitive processes were identified (Anderson et al 2001). Types of knowledge listed were factual, conceptual, procedural and metacognitive (strategic). Types of processes listed were remembering, understanding, applying, analysing, evaluating and creating.

Considering whether or not good performance of communication was an innate ability, Street (2003) doubted that greater awareness of how we communicated would enable improvements. He suggested that the communicator had goals and perceptions of a

situation, which produced a specific stream of behaviour. When a situation was familiar, things would progress very rapidly, unless a new piece of information triggered a perception of a different situation and then a different stream of behaviour would result. Learning a new way of behaviour would have to create change in automatic responses, therefore continued practice in real situations would be essential, together with motivation to adopt this new pattern (Evans 1991).

Watching colleagues in the workplace was proposed as a useful way to enhance communication skills as it took advantage of the social context for learning social skills (Brown et al 2006). They believed that there was value in this style of informal learning, although learners would need to be self-directing and autonomous.

Pharmacist-patient relationships were viewed from a different angle, where they were already built up with patients and their families over the years. These strong relationships would enable pharmacists to be influential, especially for promoting health (Anderson 2000). This perception would indicate that the building of relationships was an intuitive skill that developed with experience over time. However, Anderson failed to comment on whether this skill might be improved even further with instruction or awareness of 'best practice' techniques.

Self-Directed Learning

If pharmacists wished to develop their own skills for building relationships with patients, there were a number of books and articles available. The older books available for pharmacists focused on communicating with patients (Tindall et al 1984, Warden-Flood 1987, Rantucci 1990, Meldrum 1994, Quintrell 1994, Sigband 1995). More recent authors included content about relationship building, although the texts were still identified as communication skills handbooks. While originally written with doctors in mind, they were also useful for pharmacists moving into consultative roles (Kurtz et al 2005, Silverman et al 2005) and some included sophisticated techniques such as exercises, cartoons and CDs to help with motivation and efficacy in self-directed learning (Hosley & Molle 2006).

All of these texts tended to echo the same concepts of empathic conversation, open questions, active listening and reducing barriers, all of which were fundamental to

building effective relationships with people. Given that people had preferred approaches to learning and that some might have been most comfortable learning from books in a self-directed fashion, there was ample choice for them to access suitable materials. The internet was another way that pharmacists could search for relevant information to learn from, if that were their preferred approach to learning.

In addition to these communication skills manuals, there were patient narrative books that were useful for the self-directed learner as they presented a totally patient oriented view on health provision. They would help a pharmacist to gain insight into the patient viewpoint, and therefore the empathic understanding that is fundamental to relationship building. It was suggested that illness should be considered as a social construction and that the reality of a disease state would have a different meaning for different individuals i.e. the patient, the health professional, other members of society, and members of other cultures (Sharf & Vanderford 2003). Labeling of the illness could create a different meaning for people in terms of risks and it highlighted the centrality of communication to health care delivery. For example, a smile was valued by Fiu (2006), and having her feelings validated was important for Torpie (2005). These narratives were not held up as being 'the truth', but rather how things seemed or what they meant to one individual. These insights could be blended with biomedical knowledge, in order to produce a health professional with empathy and a broadminded, reflective approach to life, rather than the detached attitude encouraged in the past (Brown et al 2006).

Attendance at conferences was another way to gain knowledge about patient experience with relationships between pharmacists and patients. Elva, a mental health patient with a diagnosis of bipolar disease, spoke of her experiences (Edwards 2007). She referred to her difficulties with clinicians who did not validate her feelings about medicines she considered were giving her side effects. When she was able to work with a clinician who enabled her to be involved in a collaborative care situation, she was able to be more proactive in her treatment choices and her illness was brought under control because she was now motivated to adhere to her regimen. She also commented that she had an excellent relationship with her mental health unit pharmacist and that district health boards should support improvements to pharmacist-patient relationships.

Debating The Case For Training

A need for improvements in relationship building was often identified. If some of the communication processes involved were considered to be skills, then they might be done well or poorly (Greene & Burleson 2003). Several opinions expressed in the literature recommended additional training when skills were found to be unsatisfactory in pharmacists (Sleath 1996), nurses (Wilkinson et al 1999) and doctors (Clark & Gong 2000, Maguire & Pitceathly 2002, Silverman et al 2005). Reading about concepts in communication could help to raise awareness, even though patient counselling could not be learned from a book (Rantucci 1990). The pharmacist must be committed to a gradual process of learning and self-development involving self evaluation of performance and finding ways to improve. The pharmacy literature did not provide comments about the reluctance of pharmacists to undertake training.

However, the medical literature often referred to the need for remedial education and the reluctance to undertake such study. There might be skills that experienced doctors had either forgotten or never been taught, and there might be entrenched habits that needed to be overcome and unlearned before new and more desirable skills might be incorporated into practice (Kurtz et al 2005). Barriers to attending training courses included difficulties with lack of available courses and time. Early training in the detached biomedical model made adjustments difficult. British doctors did not value, and were reluctant to undertake, communication skills training despite the known association of difficult communication situations and emotional burn-out in doctors (Feinmann 2002). In the USA, a medical course director was quoted as saying that doctors believed that they only needed to learn the science and they would be able to communicate adequately (Feinmann 2002). In the UK, the chair of the surgeons' college pointed out that the technical aspects that attracted doctors actually made up only 25% of their work and the rest was about communicating with patients (Feinmann 2002).

Self-esteem was important for effective communication as a health professional or nurse (Schuster 2005). High self-esteem allowed direct, clear and honest communication, with appropriate, effective, responsible actions and realistic expectations of outcomes. Someone with high self-esteem could learn from their mistakes, because they respected and valued themselves and their abilities. People with low self-esteem found it difficult to cope with failure.

The compulsory status of communication topics in today's undergraduate curriculums should have worked against these difficulties, although the challenge that it represented has been pointed out (Kurtz et al 2005). Effective teaching of communication skills needed dedicated time, especially when the curriculum was burdened with copious clinical information. In Europe, some medical training attempted to include more communication but failed because of practitioner perception that it was more important to be efficient and cost-effective, and because interviewing was considered to be an activity that took time and had no direct and measurable return on investment (Feinmann 2002).

Brown et al (2006) proposed that motivational and cultural change was needed to convince doctors that communication skills training would benefit patients. Health care teams, which included pharmacists, had to feel that communication with patients was a good idea and be committed to it.

Training Courses

British pharmacists in training as supplementary prescribers, another type of consultative role not yet possible in NZ, held positive views of communication skills teaching and learning (Addison 2005, Cleland et al 2007). Topics raised as particularly useful were how to structure the consultation, eliciting a patient-centred history, including the patient's perspective on their situation and/or illness, working in partnership with the patient and appreciation of the Calgary-Cambridge model. The results emphasised the importance of providing communication skills training for extended roles, especially in the skills not usually required in traditional pharmacy consultations. Some pharmacists explained that learning about the skills required them to explore the patient's health beliefs and the broader social, psychological and occupational impact of illness, which was not seen as something they did in traditional practice. They viewed as new, the exploratory, collaborative skills for seeking the patient's perspective on their situation, illness and treatment plan and for aiding the pharmacist-patient partnership.

The medical and nursing literature included some studies showing that both short workshop training sessions and longer courses did enable lasting improvements in communication with patients (Clark et al 1998, Wilkinson et al 1998, Booth et al 1999, Wilkinson et al 1999, Bowles et al 2001, Suikkala & Leino-Kilpi 2001, Chan et al 2003,

Arranz et al 2005). Various types of learning methods were involved, such as interactive seminars, integrated workshops, audio-recordings, video-taping with self-critique and reflection, role play with observation and feedback, as well as small group discussion for self-reflection and support. One study found that explicit training was a better teacher of such skills than years of experience even for older doctors. These results provided evidence that the ability to communicate was not only an innate quality, but also a skill that could be learned effectively (Chan et al 2003). On the other hand, it was interesting to note that one study showed benefit for nurses from long courses of integrated workshops with audio-taping and reflection, while short workshops did not (Wilkinson et al 1998).

Learning Methods

For those accessing tuition, the aim should be to use training tasks as close to actual practice as possible (Brown et al 2006). A skills-based approach to the learning of communication was important (Kurtz et al 2005, Silverman et al 2005) as the practical techniques were what learners often had difficulty with, when learning relationship building within the Calgary-Cambridge model. Elements identified as hard to learn were:

- Demonstrating appropriate non-verbal behaviour
- Picking up and responding to the patient's non-verbal cues
- Demonstrating empathy
- Involving the patient (in a partnership)

This reinforced the notion that people needed to learn 'how' to improve their communication and would need appropriate experiential learning methods rather than written descriptions.

This focus on learning by practical application of ideas presented was a recurring theme. Opportunities for recording consultations as the basis for further feedback and reflection were valued by participants in the university based pharmacist training in Britain evaluated by Cleland et al (2007). They felt additional formal communication skills training would be useful as well as reflective learning in the context of a supportive network of pharmacist colleagues. This training involved 50 hours of distance learning plus two half-day taught sessions. The distance learning included a checklist for planning and reviewing a consultation, and reflective exercises. The residential teaching was based on applying the Calgary-Cambridge model in practice, including 'building

relationships' as one of the six stages in a consultation. It was assumed that the success of this training programme reflected the effectiveness of the experiential methods employed.

Preferences for modeling using video demonstration and practice using role play, followed by reflection and feedback from self-critique and peer evaluation in a supportive environment were reported also by several medical and nursing authors (Heaven & Maguire 1996, Suikkala & Leino-Kilpi 2001, Feinmann 2002, Maguire & Pitceathly 2002, Chan et al 2003, Greene & Burleson 2003, Thompson et al 2003, Addison 2005, Kurtz et al 2005). This was despite the potential discomfort for students while becoming conscious of their own interaction behaviour. This focus on simulated practice appeared to support the notion that a skills-based approach was ideal, especially when preceded by modeling using demonstration, and followed up with in depth evaluation.

Using an analytical approach to understand the significance of these successful methods, Greene & Burleson (2003) outlined three arenas of learning: experiential, reflection and analytical-conceptual, each with different tools and teaching methods.

1. Experiential used simulations, negotiation exercises and virtual tutorials, videotaping. Useful when tutor suggested more effective alternatives to observed scripts.
2. Reflection followed simulation and provided opportunity to analyze and generalize from experiential learning. Methods to promote reflection included debriefing of simulations, diagnostic feedback, assessment tools, analytical journals, videotape critiques and formal written analyses.
3. Analytical-Conceptual learning employed readings, cases and film to examine negotiation behaviour in context, to observe nonverbal behaviours and to understand the complexities of the process. Comparing two cases enabled deeper consideration of the underlying processes, because of the need to move further than observing the similarities.

Other methods mentioned in the literature were electronic media and reflective practice. A web-based, multimedia format was found to stimulate doctors' thinking about attitudes and biases influencing communication in sensitive situations (Feinmann 2002). Journal keeping was reported to assist nursing students to explore and change their attitudes towards patients, although not necessarily their interpersonal style (Suikkala & Leino-Kilpi 2001).

The context of skill practice was considered to be influential for doctors practising communication techniques (Maguire & Pitceathly 2002, Kurtz et al 2005). They recommended discussing the new knowledge with an experienced coach so that it could be related to what the learner was actually doing. Practising with simulated patients was valuable for relinquishing blocking behaviours. However, more effective skill acquisition would result from giving feedback on real consultations, rather than simulated ones. Working with experienced doctors, Rollnick et al (2002) set up a series of simulated encounters with a paid actor visiting the doctors' own clinics and working through a scenario with them. Learning was discussed in seminars before and after each visit, but the practice was in 'real context'. The doctors valued this method of learning because it placed everyday experience in the foreground and communication skills in the background. It rejected the assumption that they were deficient in terms of performance and needed teaching by 'experts on communication skills'. This method was considered to be particularly suited to improving the performance of experienced doctors who opposed de-contextualised workshop attendance. The results did not clarify whether this method was more effective, but it was certainly more acceptable to the participants. The use of video rather than audio-recordings was suggested as an alternative in order to study non-verbal behaviours as well as verbal.

At the same time as using contextual skill based communication training, an integrated approach was advocated by Kurtz et al (2005) with knowledge, communication skills, problem solving and physical examination all blended together as much as possible into the curriculum. They continued with the importance of assessment to legitimise the value of communication skills. While stressing the benefits of both formative and summative assessments, they pointed out the need to consider whether it was intended to measure knowledge, competence, performance or outcomes of the new skills. Good facilitator skills and small class size were also essential components of effective communication skills training (Kurtz et al 2005).

Conclusion

The literature indicated that relationships between pharmacists and patients were valued and that effective relationships could empower patients to improve their health as well as increase job satisfaction for pharmacists. While providing information to the patients was the main aim for pharmacists, developing good relationships was seen as a way of improving the acceptance of that information by patients. The use of empathic understanding and the development of trust appeared to be key issues in the formation of a beneficial relationship and knowledge of the most suitable style of communication could enhance interactions with patients. Acknowledgement of the patient's viewpoint was seen as fundamental to keep the lines of communication open for the relationship to develop. Partnership building for shared decision making was identified as beneficial for health, by empowering the patient to take responsibility for certain aspects of the management of their own illness.

A number of health professionals, including doctors, nurses and pharmacists appeared to need to improve their relationship building abilities, but seemed resistant to this idea. Training courses that had been evaluated reported that improvements could be achieved. Pharmacists undertaking new roles valued training in new skills required to manage patient consultations.

The best methods for teaching and learning how to improve relationship building involved experiential situations such as watching others, simulations, role-plays, videos, and demonstrations, especially when associated with reflection and analysis. Written resources that assisted self-directed learning were widely available and often used. Probably the most important outcome of this literature review was that many useful techniques could be taught and learned that could contribute to improved pharmacist-patient relationships.

The next two chapters outline the methodology underpinning the research study and the data from the research. The following chapter then links this literature review with the data from the research and discusses the outcomes.

CHAPTER 3: METHODOLOGY

Context

This research focused on the interactions between pharmacists and patients in community pharmacy settings where there were repeat visits and opportunities for relationships to develop. The additional scope for building relationships that was inherent in the structure of Medicines Use Reviews carried out by community pharmacists (as explained in Chapter 1) was also of interest to this study. The elements in these interactions were the pharmacists, their patients and the relationships. As I was interested in professional behaviour and training, it was appropriate to study these relationships from the point of view of the pharmacists, rather than the patients. I wanted to ask the pharmacists about their experiences.

Pharmacists work in a number of capacities, such as in hospitals, academic, administrative or community environments. In this study it was the community pharmacists who were the focus of the research question. Therefore, this study involved the pharmacists who worked in community pharmacies and who provided pharmacy health services to independent individuals on an everyday basis, and were in a position to build relationships with the patients who were regular customers or patients with chronic conditions who needed individual ongoing health care. This population of pharmacists would vary in gender, years of experience and ethnicity, and would have different histories in terms of learning experiences in relationship building and communication skills.

Methodology

There are two major competing traditions that influence research frameworks, namely the quantitative and qualitative approaches. The way that these approaches were understood was affected by the way that different people thought about them. The beliefs, values and assumptions underpinning their thinking influenced what they did in the practice of research. The assumptions underlying these two approaches were fundamentally different and in opposition to each other, and as a result of this many

researchers considered that these quantitative and qualitative research methods could not be mixed. There were many that did not agree that quantitative frameworks could also include interpretation. Other researchers believed that it was possible to bring these two opposing approaches together, as there were advantages and disadvantages to both (Creswell and Plano Clark 2007). For example a quantitative survey could be carried out first and then be followed by qualitative interviews to gain more understanding. Alternatively some interviews could be done first to determine which questions would be most useful in a numerical survey.

A research framework was needed to access the experiences and knowledge of these pharmacists about relationship building with patients. The first consideration was that a numerical approach would not elicit the kind of information to find out how relationships were built and how pharmacists went about learning to build them. A purely numerical approach was therefore seen to be inadequate for the intent of the research (Munhall 1994, de Vaus 1996). On the other hand, individual interviews or case studies might have provided deep and rich data about the meaning of building relationships with patients using a phenomenological approach, however there was insufficient time for this to be attempted. Another consideration was that it might be narrow and limited, rather than a wide and diverse range of responses. Alternatively, focus groups might have elicited a wider range of ideas and concerns from the pharmacists involved, but might be time consuming to schedule and gather the pharmacists into group meetings.

I considered it would be helpful in answering the research question to use a qualitative approach so that participants could say more about their experiences and thereby provide richer data for the thesis. However, I had a significant time shortage due to extenuating circumstances and did not consider there to be sufficient time to carry out interviews or focus groups. As a compromise measure, a questionnaire approach was selected in order to acquire as much data as possible in the reduced time frame available. My research question was about understanding how pharmacists build relationships with patients, which was an interpretive concept. I therefore used some open questions to obtain qualitative comments as well as some supporting quantitative questions. I was not trying to predict and control as is usually the case with quantitative survey methods but actually trying to understand and describe meaningful social action.

The survey research method selected for this research project is generally considered to be a quantitative method that fits with the positivist philosophical viewpoint. However, in my view, this particular research question did have some interpretation involved in the data analysis process, as a result of the open questions which probed for more understanding and which elicited written responses. The respondents were recording their perceptions of the questions asked and, as the researcher, I was interpreting their responses. So, in spite of the quantitative framework, interpretation was still part of the way that participants understood their situations and the way that I understood what they had written. In my view, I used a quantitative method to achieve a qualitative outcome.

To delve further into this apparent contradiction, the research question was examined in terms of the five key areas of difference itemised in Davidson & Tolich (1999). The first issue considered the traditional positivist approach of the quantitative paradigm, which was based on the reductionist assumption that the individual parts of a phenomenon behaved in the same way whether they were isolated or whole. This opposed the interpretive paradigm, which was based on the relationships between the elements as more important than the individual elements alone. I argue that the reductionist approach was inappropriate to the analysis of the findings in this study because of the interlinked nature of the elements involved in relationship building such as contextually bound factors including real life experience, personality and time.

The second issue was that of values, and the quantitative approach embracing positivism regarded research as value free. Contrasted to this, the qualitative approach was concerned with the meaning that people attribute to their experiences. This study also searched for the meanings and values that participants place on their experiences of building relationships and of learning how to build them. I maintain that examination of their perceptions was inherently value laden.

The third concern was the prominence given to reliability of data in the positivist framework, while prominence was assigned to validity in the case of the interpretivist framework. In this study, the perceptions of the participants revealed a range of concepts which were elicited by the research question and were therefore valid responses. The concept of reliability would search for a single truth that was consistent across all of the respondents. However, this idea did not fit with this study, as the

findings elicited were a range of viewpoints from individuals with different experiences of pharmacist-patient relationships. Also, because of the fact that I was already aware of some differences between pharmacists' perceptions of the usefulness of courses, I did not expect that they would all respond in the same way.

The fourth issue related to the fluid and changeable nature of society, which implied that findings gathered in another place and time in society were inevitably different, and the continually changing context within pharmacy supported this idea. The intent of this study was to gather appropriate and useful insights in keeping with an interpretivist approach rather than findings fitting the positivist paradigm where there was only the one and 'right' view. This contributed further to the notion of a qualitative process in the analysis of the findings in this study.

The fifth issue to examine was what constitutes 'good evidence' in terms of the representativeness of the sample selected for the study. As dictated by the quantitative framework, the sample in this study was randomly selected. The benefit of this method was that a range of respondents was likely to be involved. On the other hand, an interpretive approach would favour deliberate selection of theoretically important units, which shared the activity that the research was examining. The low response rate hindered a quantitative outcome where generalisations might be made about the results. However, the variety of results received has provided exploratory and descriptive data of use to a qualitative outcome, even though there was not sufficient depth to explain the nature of the processes studied. Another factor to consider here was the potential self-selection bias, which would result in people who were interested in this topic being the most likely ones to provide responses to the questionnaire. This could actually contribute to the theoretical sampling that would effectively support qualitative outcomes, that is, people who focused on building relationships in practice would provide most of the data.

To summarise, I have brought these five factors together in support of the qualitative nature of the analytical process used in this study. Rather than using a reductionist approach, this study values the integrated nature of the relationship building process as supported by interpretivism; it recognises the respondents' values rather than denying them; it gives prominence to validity rather than reliability; it recognises the changeable nature of society and accepts that there is more than one 'truth'; and it accepts

representativeness as being connected to the activity being studied, rather than related to the full width of the population. Therefore, I consider the outcome to be qualitative in nature, even though it is placed within a quantitative framework by virtue of the written questionnaire survey tool.

Method

The survey method was chosen as the most suitable method on this occasion, because there was insufficient time available to pursue more qualitative methods such as interviews or focus groups. This time constraint resulted from an unanticipated and lengthy delay working on the abandoned project, before changing topics and gaining ethical approval for this research project. The survey included an explanatory information sheet and a structured, written questionnaire with eleven key questions (see Appendix Two). The information sheet explained the background and purpose of the project and invited pharmacists to participate. The questionnaire involved a combination of closed and open questions with boxes to tick for the closed answers and clear space for written answers to the open questions. This was sent out by post to enable the collection of as much information as possible within the existing time constraints.

The closed questions were intended to gather some demographic information and details about training experience and teaching methods in order to provide a measure of the relative frequency of various findings. The open questions elicited descriptive responses to explore the participants' ideas about building relationships and communicating with patients as well as their perceptions about how they learned to perform these actions. The questions also asked about any training they had undertaken, and how useful this had been. Pharmacists were requested to add any other comments in as much detail as they could.

Sample

There are about 900 pharmacies in New Zealand, and the available funding support enabled posting to 300 of these. A systematic sample was calculated to be one third of the pharmacies. Support was also forthcoming in the form of a pre-printed set of sheets of labels for all of the pharmacies listed in the phone book. Administrative support was offered if whole sheets were used. In order to randomly select a third of these sheets of

labels, the random start concept was used to select a number between 1 and 3 from a random number table. The result was 1. Therefore selection started with the first sheet of labels, followed by every third sheet through the total bundle. This provided a random selection of one third of the pharmacies across the whole of New Zealand. Two sets of the documents were enclosed in each envelope to each pharmacy selected. Reply paid, addressed envelopes were included for participating pharmacists to return their responses.

Response Rate

Six hundred questionnaires were sent at the end of June 2007 to 300 pharmacies randomly selected from the 900 (approximately) in New Zealand. A response rate of about 30% was anticipated, which would have provided 200 answers from the 600 questionnaires sent to the 300 pharmacies. Forty-seven completed questionnaires were received back between July 9th and August 14th 2007, which was disappointingly low. It represented 15.6% of the 300 pharmacies or 8% of the 600 questionnaires sent. However, the shortness of available time and the expense involved in mailing for a second time both counted against sending out a reminder. If timing and funding had not been an issue, it would have been beneficial to follow up with a reminder to encourage more pharmacists to send in their responses. Additional responses would have provided more robust findings.

As a result, the sample of responses was quite small. However, it was not intended to apply quantitative analysis to the results or to generalise from the numerical results in a way that could control or predict future outcomes. Nevertheless, the findings were examined in detail, and the written responses were evaluated using an interpretive approach, while acknowledging that the importance of the results was reduced by the small number of respondents and the potential bias towards people interested in this study and training courses. The questionnaires received could only be considered as contributing to exploratory and descriptive data that could inform the research and possibly identify areas for further research in the future.

Analysis Of Data

The responses received from the participating pharmacists were typed into the computer, using the Microsoft Word application. Each participant was allocated a number as the questionnaire was received. Responses were entered into tables when the data were quantitative or typed into numbered lists for each qualitative question. A number of illustrative graphs were created using Microsoft Excel to facilitate visualization of the collated responses. A series of comparisons were made using the quantitative results to determine whether there were any apparent trends. For example, the numbers of pharmacists with various years of experience who had attended training courses were compared to the numbers who had not. Some of the data associated with gender and ethnicity were also illustrated with graphs. The written data were sorted according to each question number and then sorted into themes using a highlight and drag computer mouse technique. Many of the themed comments were included in Chapter 4: Analysis of Data. The main themes were summarised into a coherent story representing the perceptions of all of the responding pharmacists and given in Chapter 5: Discussion. These were then evaluated and linked back to the findings in Chapter 2: Literature Review.

The quantitative data were inspected to discover if there were any relationships between variables, and whether these could be used to predict or control events. This process was not expected to provide robust data owing to the low numbers of respondents. However, it would provide a description of the population responding to this project. Demographic characteristics included ethnicity, gender and number of years of experience as a practising pharmacist. This measure of experience was considered to be more important than age, as it focused on the time spent in a professional setting where pharmacist patient relationships could be built, rather than time spent in society as a whole. However, in most cases it would reflect years of life experience as well, given that many people become pharmacists in their 20s and 30s. Other questions that provided some numerical data related to how pharmacists believed they learned to build relationships, what topics they studied in courses attended and which methods they favoured for that learning.

The results were collated, analysed and discussed for presentation to a wide audience beyond the existing pharmacy readership. The contextual setting for the research question was explained in detail to enable more general understanding of the implications of this study. At the same time, this study might be instructive for community pharmacists who were required to learn to build pharmacist-patient relationships. It might also provide insight to those who developed training courses for pharmacists on the subjects of relationship building and communication.

There was a statement in the information sheet sent to participants, which explained that the results of the study would be made available for those interested. It would also be beneficial if the findings were published in a suitable journal for wider dissemination to the pharmacy profession.

Limitations Of The Research

The problem of bias was considered to be inherent in the self-selection process of responding to the questionnaire. If a pharmacist did not value this research topic, they were considered to be unlikely to respond and this would result in a set of responses that was biased in favour of relationship building and communication skills training. While some negative responses were received, it was not possible to determine to what extent this source of bias had affected the respondents' replies. However, a range of responses was obtained, even though the real weighting of the perceptions expressed was not known.

The numerical questions had the potential strength of ascertaining the magnitude of the group of pharmacists who were in favour of communication skills training compared to those against. The potential weakness was that generalisations could only be made if a large percentage of returns were received, and this was not forthcoming in this instance. The poor response rate was a limitation in its own right. The 47 results (8%) received could only provide an indication of how some community pharmacists go about building relationships and which methods of learning were used by some respondents. Conclusive results about the most popular or effective methods used to teach these topics were not able to be determined. Graphs were used as descriptive tools to aid

visualization of the data, although the small size of the sample responding to the questionnaire together with the potential bias reduced the usefulness of the results.

The study questionnaire asked for the years of experience of the participating pharmacists, as this was seen as a useful measure of practical professional experience where opportunities for developing relationship building could occur. After the postal survey was completed, the Pharmacy Council of New Zealand produced a report from a national pharmacy workforce survey. This workforce survey data included details of the ages of practising pharmacists, which was very useful information about the population of pharmacists from which the participants in this relationship building study were drawn. However, the mismatch of years of experience versus age meant that valid comparisons were not possible. If the workforce survey data had been available when the questionnaire was planned, it would have been more useful to change the questionnaire to ask for the age of the responding pharmacists rather than their years of experience, so that direct comparisons could have been made.

The strength of the themed qualitative findings lay in their ability to offer insight into the related questions with numerical results. The themed findings provided open ended information in the participants' own words, which provided meaning shaped by the participants' personal histories. It also represented a diversity of views and thereby complemented the numerical results. The weakness of the descriptive data was that it was unable to provide a clear measure of how widely a particular view was held within the respondent group or by pharmacists as a whole. However, the integration of the descriptive and numerical data provided a practical way of focusing on what was happening in practice.

One shortcoming with this methodology was that it was based entirely on pharmacists' perceptions of how well they built relationships with patients and assumed they performed adequately when communicating. Further research asking other questions would be needed in order to gather objective measures on how well the pharmacists succeeded in building relationships or communicating effectively. This would also need to identify which outcomes should be selected to be valid measures of effectiveness.

Ethical Considerations

The purpose of ethics is to ensure protection for the participants in this research. This supports the basic human rights of respect, autonomy, privacy and justice. Minimisation of harm of a physical or psychological nature is important. Informed consent, social and cultural sensitivity, and avoidance of unnecessary deception and conflict of interest are key factors to be addressed.

The considerations based on the Massey University screening questionnaire were that there was no risk of harm greater than that normally encountered in daily life. There was no need for informed consent as this was assumed when the anonymous replies were sent back. There were no privacy or deception issues because it was an anonymous questionnaire. Power issues such as employee or student situation were minimal, as the questionnaire was anonymous, and College courses were not compulsory. The section determining the requirement for the Health and Disability Ethics Committee involvement listed health providers. Therefore I proceeded to establish whether this research proposal required approval from the Health and Disability Ethics Committee (HDEC) (Ministry of Health), as it concerned health professionals, namely practising pharmacists. The response was that it was not considered necessary to submit my proposal to HDEC as its primary purpose was not seen as adding "to generalisable knowledge about a health or disability issue" (Refer paragraph 2.3 of Ethical Guidelines for Observational Studies). It was explained that it was the nature of the research rather than with whom it was being undertaken that determined this outcome. I was advised that the institutional ethics committee should review the proposal.

Consequently, to satisfy the needs of the HDEC, a full ethics approval application was submitted to Massey University Human Ethics Committee. Some comments were raised and resolved prior to final approval of the project. One issue related to ethnicity data collection, which they wished to have included in the data collected, as they believed that pharmacists were likely to reflect the demographic profile of New Zealand. I had not included an ethnicity question initially as I did not believe I would receive sufficient responses for any ethnicity related findings to be numerically significant. Given that Maori represent about 12% of the population at large, and there were only about 2-3% of pharmacists identifying as Maori or of Maori ancestry, Maori were under-represented

within the pharmacy profession. This means that there was even less likelihood of meaningful data being obtained. However, despite this reservation the ethnicity question was included in the final questionnaire.

A second query related to the potential difficulty of cross-cultural communication barriers between my questionnaire and pharmacists of other ethnicities. I explained that other pharmacists would be able to relate to the questionnaire by virtue of the common ground and professional socialisation inherent in "pharmacy culture", even if there were also cultural differences between myself as author and pharmacists of other ethnicities. I am Australian with Maori ancestry and consider myself to be European in cultural viewpoint. I have lived in New Zealand for 8 years, Britain for 21 years and Australia for 28 years.

The questionnaire was made anonymous to eliminate any possible consequences from the act of answering the questionnaire, and this should have enabled participants to be much more open when explaining their points of view. This supports the ethical principle of doing no harm or non-maleficence. If pharmacists did respond to the questionnaire they would be providing useful knowledge and experience that may contribute to our professional knowledge and possibly assist in the improvement of the health of the nation. In this way, this research project may support the ethical principle of doing good or beneficence. Anonymity would also support the ethical principle of autonomy, as pharmacists would be able to follow their professional judgment in responding in whichever way they believed they should without any possible repercussions.

Because of the anonymous nature of the questionnaire it was not considered to be necessary to gain informed consent for this study. If a pharmacist chose to respond they were considered to be self-selected and therefore consenting to the research. The information sheet prefacing the questions in the questionnaire provided details of the study and also the answers to any anticipated queries from the participants. If someone did not agree to participate, they could simply have discarded their copy of the questionnaire and being unidentified they could not be disadvantaged in any way.

An important ethical consideration was that of conflict of interest. My position in the NZ College of Pharmacists was clearly stated on the project information sheet so that respondents were aware of who I was. This could have had an influence on the

responses from the pharmacists. While it was an anonymous response, they might have simply written what they believed I wanted to hear as a course organiser. Alternatively they might have considered that the whole concept of teaching relationship building was pointless, as they might perceive relationship building to be an innate ability that could not be learned or taught in any structured way. It might also be that my own belief in the benefits of training influenced my interpretation of the respondents' comments. It might also be that my position as course provider at the College of Pharmacists influenced the research, as I might be expected to favour the benefits of formal training, which would benefit the College business. However, the College is not operated to make a profit, although it is expected to cover its overheads.

Stress levels of respondents were considered to be an ethical concern. If the open questions were found to be too onerous it might create work pressure to the detriment of busy pharmacists. The questions were designed to draw out the participants' perceptions, but needed to minimise the burden of work while maximising meaningful data for the research. Pharmacists may be well-intentioned but still have barriers to responding. Possible reasons for pharmacists not answering could include lack of motivation, aversion to written work, excessive stress levels inhibiting free thought, busy workload absorbing available time, irritation at being asked for something beyond their own needs and interests, or even misplacing of forms. They might feel that communication skills training was not worthwhile and simply tick that answer and write nothing more.

I felt the anonymity was a practical way of enabling stressed pharmacists to choose to ignore the questionnaire without revealing their identity and feeling embarrassed about not replying. However, some may feel an element of guilt that they were unable to find time to complete a task that they would have liked to support if they had the energy left after work. On the other hand, some may be genuinely interested or have felt that they had a professional and ethical duty to support my research and made time to complete it thoroughly.

Overview

This chapter has outlined the preference for qualitative methodology for this research question in terms of understanding the meaning of building relationships with patients and how this is learned. While the time constraints have resulted in the selection of a quantitative method, namely the postal survey questionnaire, the use of some open questions was employed to bring some interpretative data into the research and meet the needs of the qualitative style of research question. It was argued that this constitutes interpretative or qualitative processes within the analysis of research using an otherwise quantitative methodology.

The next section, Chapter 4: Analysis of Data, presents the data from the research and begins the process of analysis. The following section, Chapter 5, discusses these findings and links them back to the literature review in Chapter 2.

CHAPTER 4: ANALYSIS OF DATA

Introduction

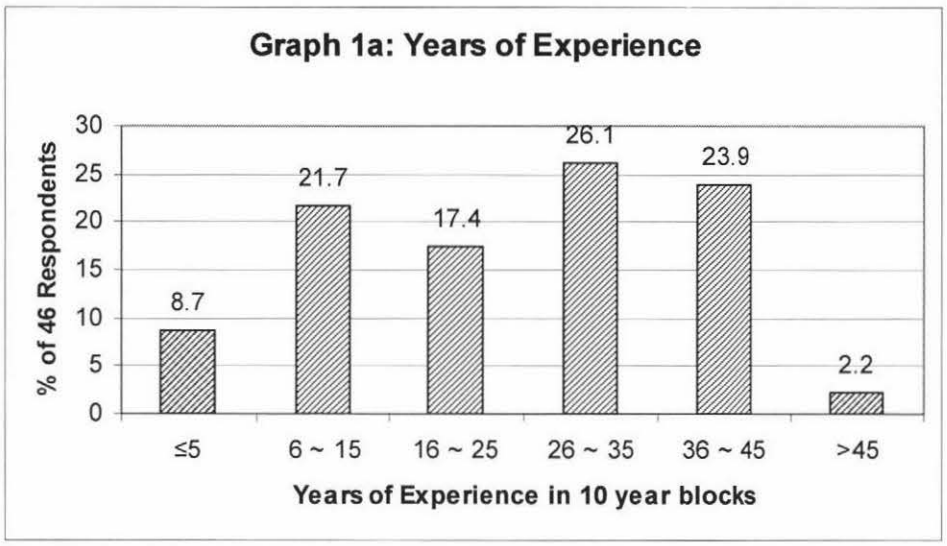
In this chapter, the responses from the participating pharmacists are examined and analysed. Comments are made to highlight the importance of the various findings. With the quantitative data, graphs are created where appropriate to illustrate the trends observed and to compare specific parameters between groups. For the descriptive answers to the open questions, a thematic analysis is undertaken to provide structure and improve understanding. Key quotations from the respondents are selected and included here to enrich the presentation of the study findings.

The structure of this chapter follows the order of the questions in the study questionnaire beginning with the demographic details of the sample responding. This is compared to the nation-wide demographics for pharmacists, recently released by the Pharmacy Council of New Zealand. The next section examines how pharmacists gained their relationship building skills followed by the way they went about building relationships. The next section focuses on training courses, their content and duration, their perceived benefits and the learning methods preferred. The final section explores other general comments that relate to the study. While the qualitative quotes and comments are illustrative and useful description for exploring this topic of relationship building and learning, it is important to remember that the sample size was small and conclusions based on this study were of limited application.

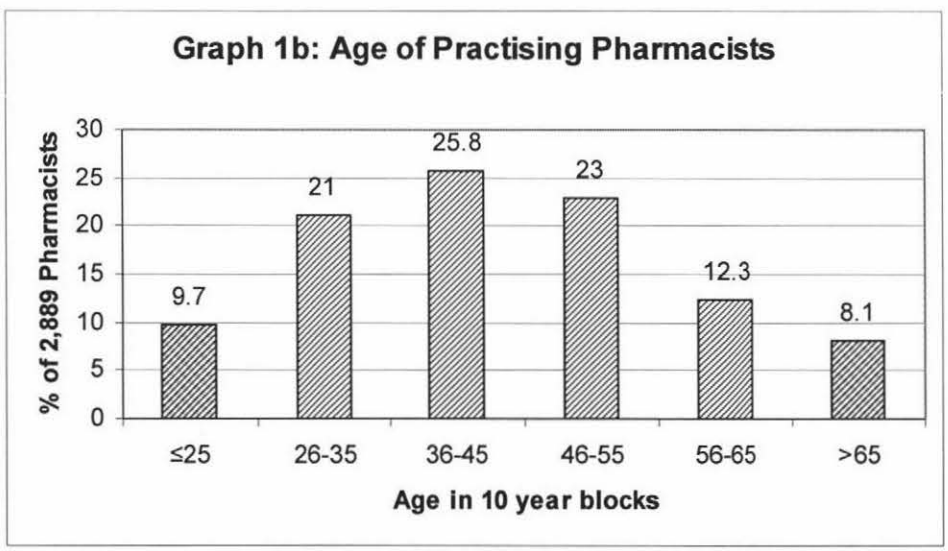
Demographics: Years Of Experience (Question 1)

"Question 1: How many years have you been practising as a pharmacist?"
The number of years that participants had been practising as pharmacists was considered to be able to provide a measure of their level of experience in building relationships with patients. This assumed that they had been working in a community setting during those years and that they had the opportunity to interact with customers and patients so that relationship building would be possible. One male respondent did

not provide this answer and therefore only 46 results were included in graphs relating to years of experience. The results ranged from 1 to 54. See Graph 1a.



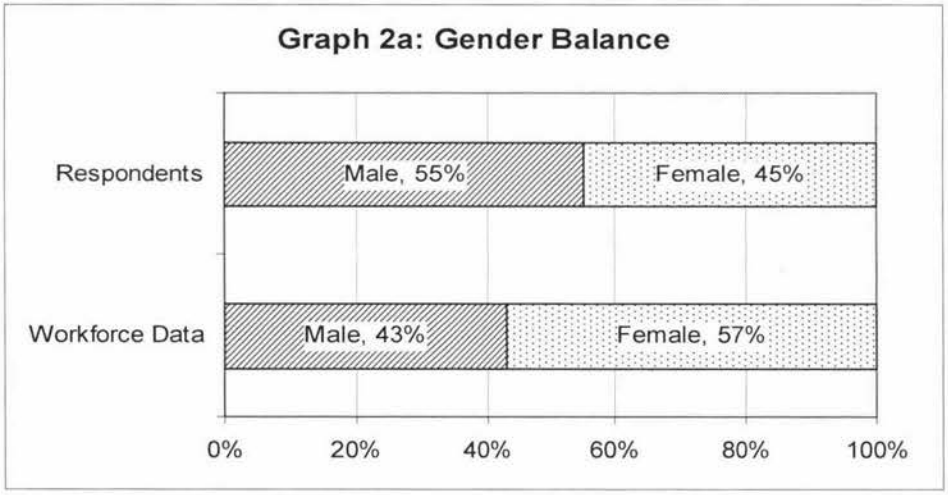
In order to see how well the range of responses from the sample of participating pharmacists compared to the total population of pharmacists in New Zealand, data from the workforce survey of the Pharmacy Council of New Zealand was obtained. This showed that the total number of practising pharmacists in New Zealand (as at 30 June 2007) was 2,889, of whom 2,261 (74%) worked in community pharmacies (PCNZ 2007). The ages of the 2,889 pharmacists were provided in the workforce survey (see Graph 1b).



Demographics: Gender (Question 2)

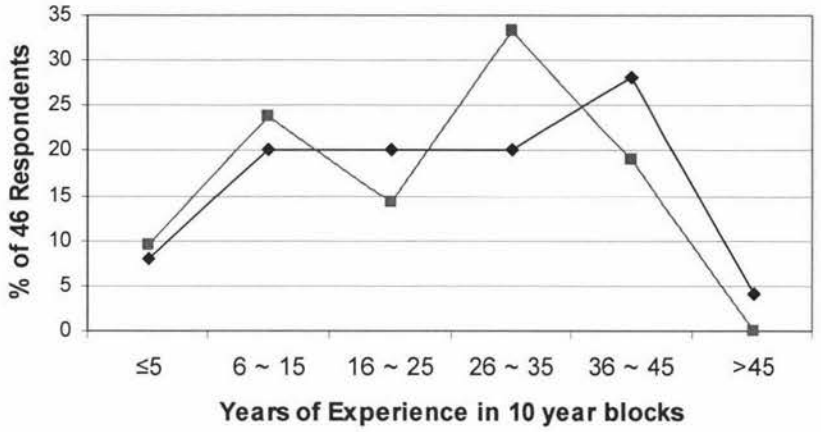
"Question 2: What is your gender?"

This question explored the possibility that the gender of the participating pharmacists might be linked to other parameters. The questionnaire respondents included 26 (55%) men and 21 (45%) women. The data from the Pharmacy Council workforce survey showed that of those 2,889 practising pharmacists, 1,247 (43%) were men and 1,642 (57%) were women (PCNZ 2007). The gender balance of the respondents in this study was compared with the data from the workforce survey (see Graph 2a). A greater percentage of men responded to the study questionnaire than was expected, based on the data in the workforce survey.

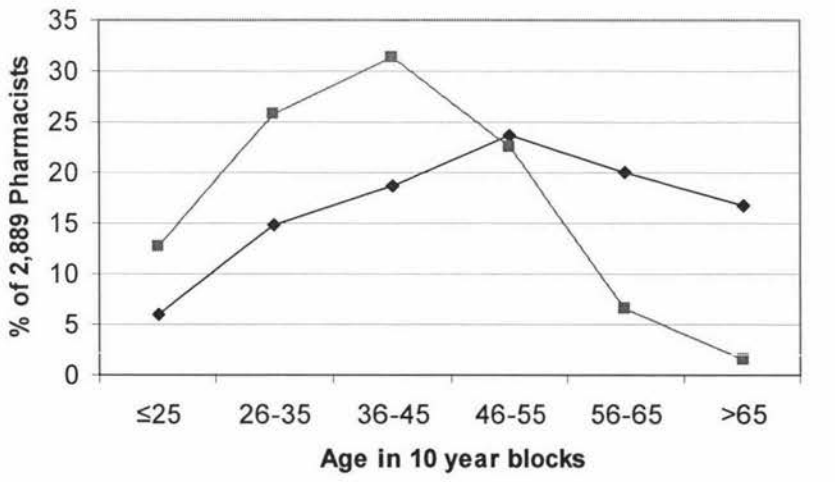


While it was not valid to compare the data for 'years of experience' for each gender in this study and the data for 'age' for each gender in the workforce survey, it was considered informative to create graphical presentations of these two sets of data.
While my direct observational experience with a number of groups of pharmacy interns led me to believe that most pharmacists would become registered in their 20s, the workforce survey data showed numbers increasing up until about age 40. This would indicate that age of registration occurred significantly in both the 20s and the 30s age groups.

Graph 2b: Study Results
Years of Experience and Gender of Respondents



Graph 2c: Workforce Survey
Age and Gender of Practising Pharmacists



A similarity in the two graphs was that the pharmacists from the oldest two groups were more likely to be men. The workforce survey graph showed that younger pharmacists were more likely to be women. The profiles of the two graphs could suggest that the respondents included fewer women than expected in the 16-25 years experience group

(which may be about age 40) than in the PCNZ survey data. However, the numbers were too small for this to be significant, and could relate to the age of registration of the sample group. Therefore I did not believe any conclusions could be drawn from this data.

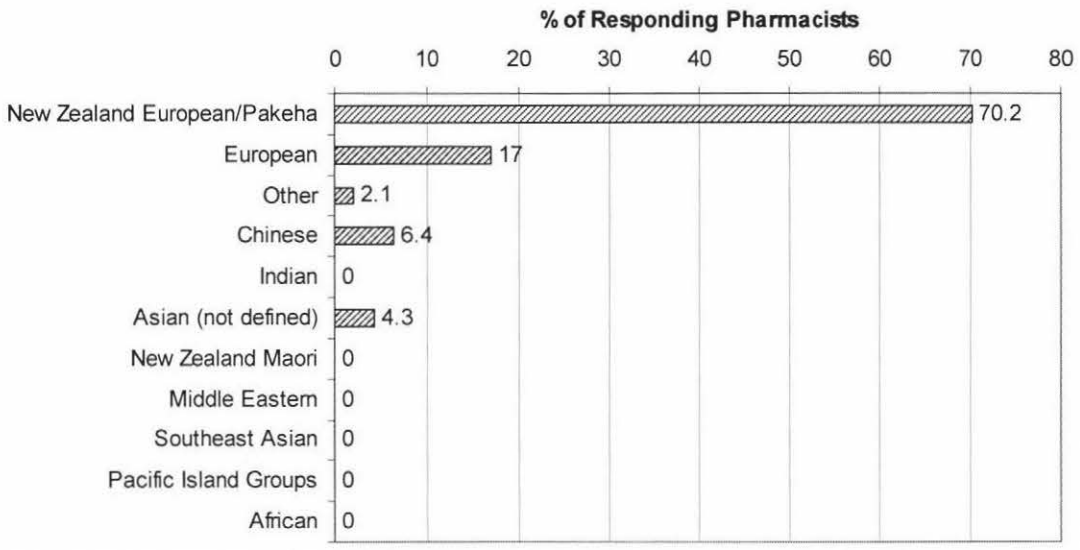
Ethnicity (Question 3)

"Question 3: What is your ethnicity?"

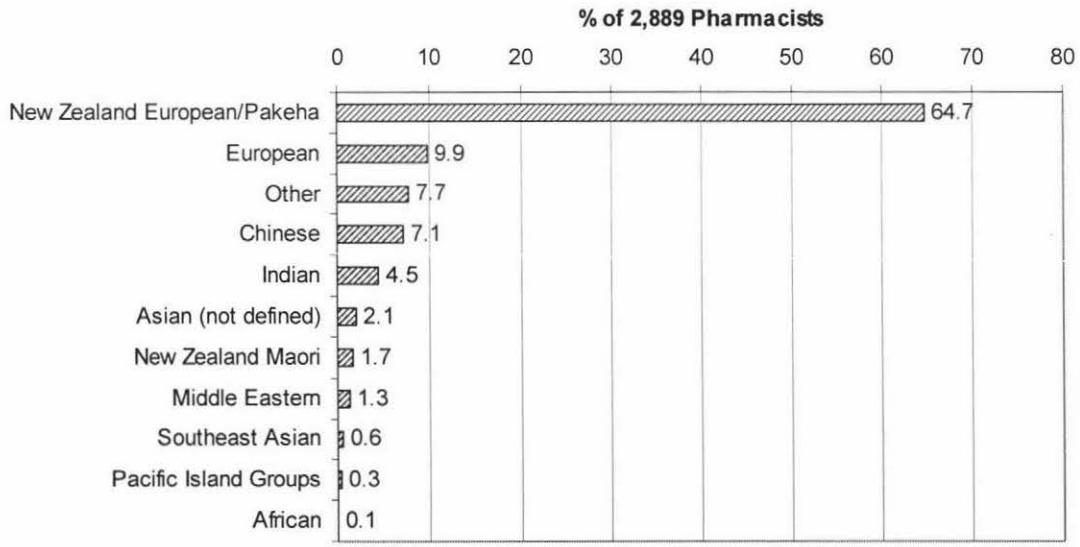
The ethnicity data requested in Question 3 showed that 5 (4 men and 1 woman) of the 47 pharmacists were Asian (2 Chinese, 1 Chinese NZ, 1 Sri Lankan, 1 Asian). The remaining 42 (22 men and 20 women) were of European extraction, and of these 33 were New Zealander European/Pakeha, 8 were European and 1 was Canadian (counted as Other). There were no respondents who were Maori. There were no other ethnic groups represented in this research. See Graph 3a. The years of experience of these respondents were spread over the age ranges and the correlation was not considered to warrant any further analysis.

The PCNZ workforce survey ethnicity data is shown in Graph 3b for comparison. The two groups show some similarities, despite the different group sizes. The main similarity was the preponderance of New Zealand European pharmacists in both sets of data. The group of Europeans was similar in terms of being the next largest group, but differed between the 17% and 9.9% values. The Asian respondents demonstrated similar numbers to the whole group, but could not be closely compared because of the distortions created by a small sample size. The percentage of Maori pharmacists in the whole pharmacy workforce is low at 1.7%, compared to the national population at 1 in 7 (14.3%) as recorded in the 2001 Census (Statistics NZ 2007). The study sample provided no Maori respondents, which is not unexpected after considering probabilities and small sample size.

Graph 3a: Ethnicity Data of Respondents



Graph 3b: Ethnicity Data of Practising Pharmacists



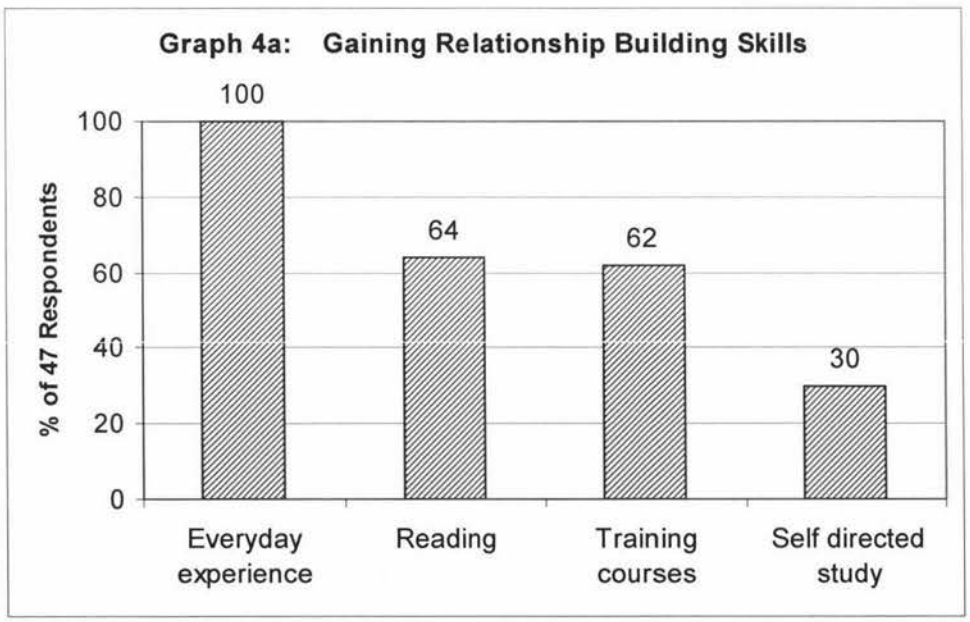
Gaining Relationship Building Skills - Methods (Question 4)

"Question 4: Have you gained your relationship building skills from (please tick as many as apply to you):

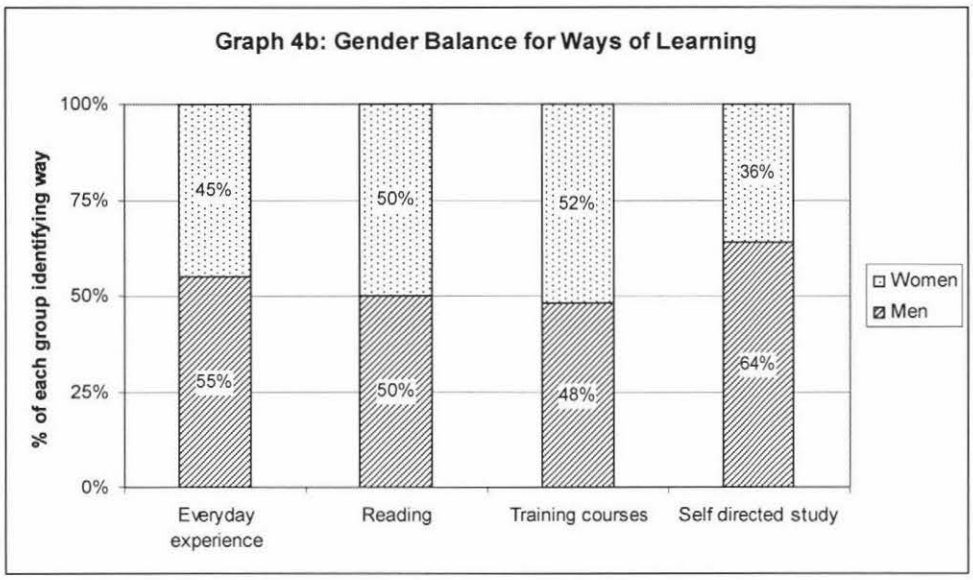
a. Training course ☐
b. Everyday experience ☐
c. Self directed study ☐
d. Reading ☐
e. Some other way ☐

(Please specify what the other ways were)"

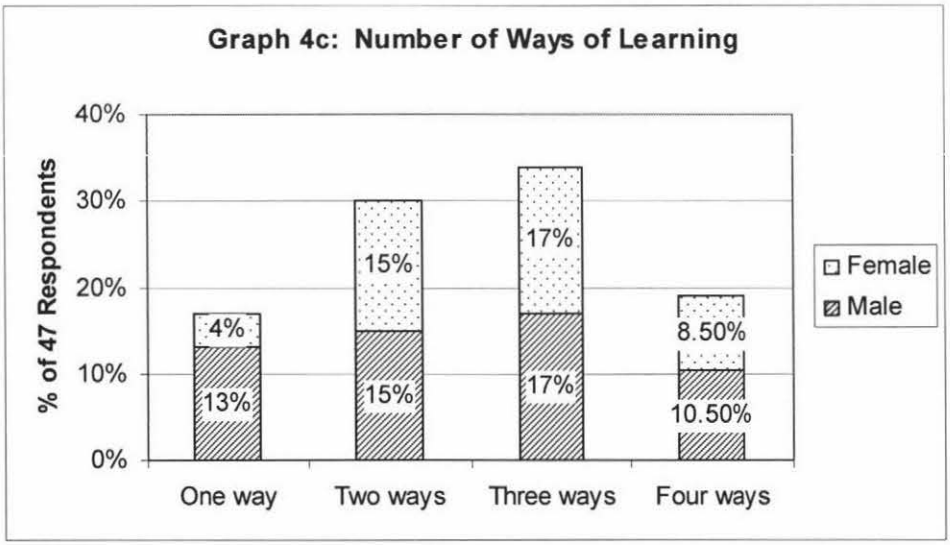
Question 4 asked how participants gained their relationship building skills and provided one very clear outcome, that all forty-seven participants selected everyday experience as one of the ways, whether they ticked one or more other options or not. Reading and training courses were then next two most frequent ways to gain relationship building skills. Self-directed study was the least frequently used way. See Graph 4a.



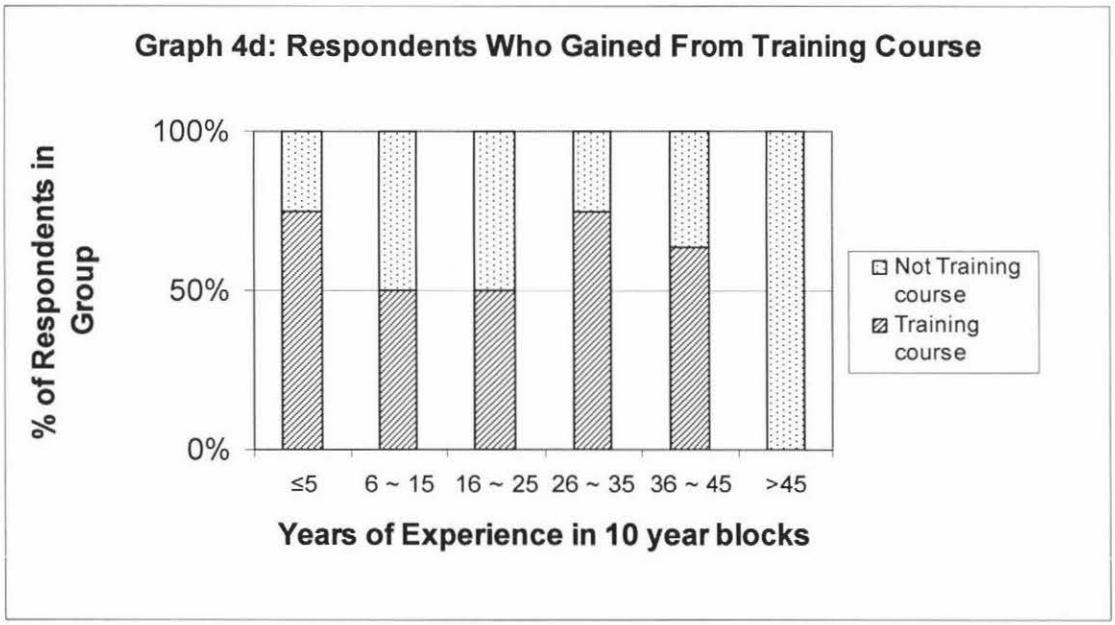
The data in Graph 4a was linked to gender to see if this revealed any correlations. There was a slight tendency for women to be less likely to use the self directed study method, but this is unlikely to be significant because of the small numbers involved.



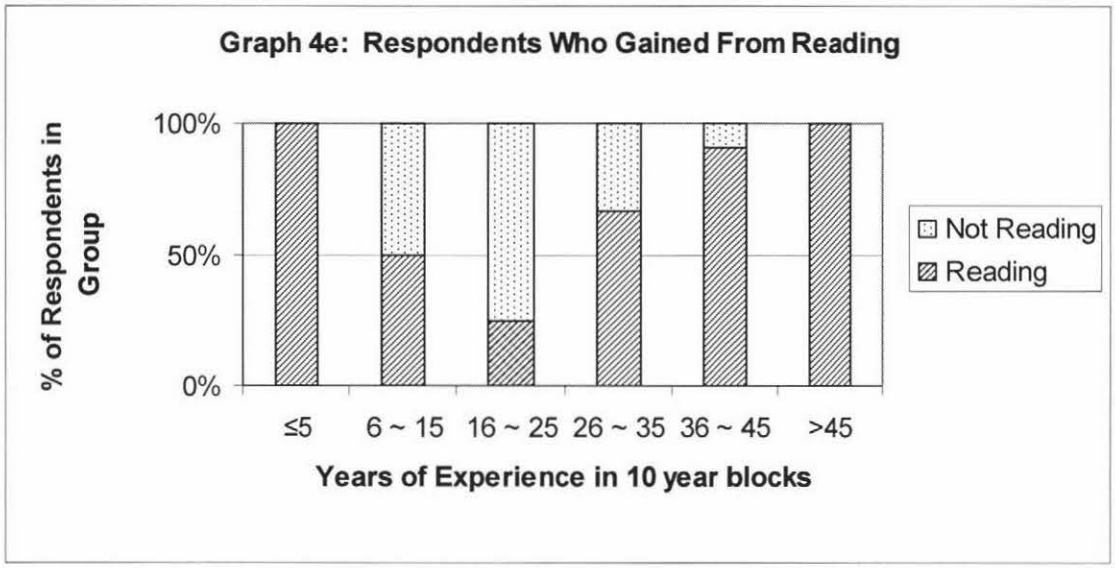
The data was inspected to ascertain how many methods each respondent had used and the average was 2.5 different ways. See Graph 4c. Eight of the 47 (17%) selected only everyday experience. The following graph showed that most respondents (83%) had gained their relationship building skills in more than one way. Each column in this graph was also split into a gender balance. It was interesting to note that few women (4%) only used one way, compared to men (13%).



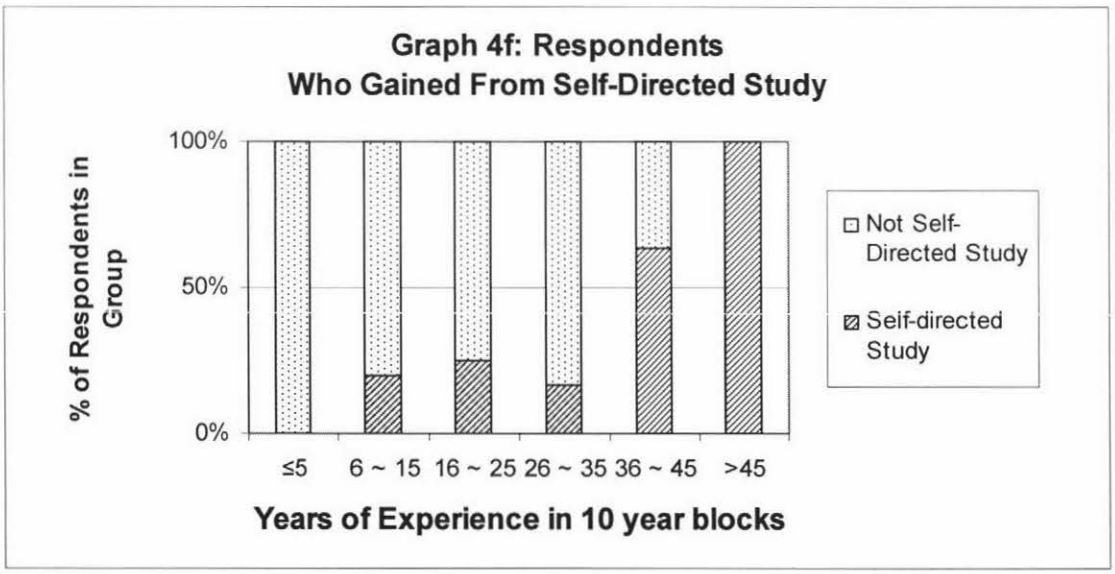
Training courses were also selected by 29 out of 47 (62%) of the pharmacists. Examining the gender balance, of these 29 pharmacists 14 were men (48%) and 15 were women (52%). Of the 18 (38%) who had not attended training courses 12 were men (67%) and 6 were women (33%). While the numbers were too small to be conclusive, it may be that men have a greater tendency to avoid training courses than women. Examining the link between the number of years of experience of respondents and whether or not they had gained their relationship building skills from training courses, Graph 4d shows that participants in this sample with less than 5 years or with 26 to 45 years experience were more likely to have gained from training. (Note: one pharmacist did not answer years of experience; therefore, the total sample in Graphs 4d, 4e and 4f was only 46).



The number of the respondents who identified reading as a way of gaining relationship building skills was 30 out of 47 (64%). Women (50%) were as likely to read as men (50%). Pharmacists of less that 5 years experience as well as the more experienced were more likely to have gained their skills from reading. See Graph 4e.



Relationship building skills were gained from self directed study by 30% of respondents (14 out of 47), and there were fewer women (11% or 5) than men (19% or 9). The more experienced pharmacists responding were more likely to have undertaken self directed study. See Graph 4f.



The overall indication based on these responses was that relationship building skills were gained primarily from everyday experience, but also added to by other methods, mainly courses and reading, but also self-directed study. Other ways of gaining

relationship building skills that were reported by participants included conferences, seminars, lectures, short courses, listening courses, cassette tapes, staff discussions, peer discussions, observing mentors and other people, and one woman specified "having 5 children".

Gaining Relationship Building Skills - Comments (Question 5)

"Question 5: Please tell me about your experiences with these types of learning in as much detail as possible: (except for training course, as there is a further question asking for precise details for that)
(Why and how this learning was initiated, how it occurred, what resources were used, and what the outcomes were)"

Question 5 asked for general comments about the learning experiences mentioned in Question 4, (other than the courses) and the responses were grouped into the following themes, based on the frequency of occurrence: everyday experiences, learning from real life, observing others, motivating factors, time, personality, interpersonal sensitivity and reading.

Everyday experiences

Everyday experiences were seen as a major source of learning, including skills such as listening, asking the right questions, giving printed resources and the effect of body language, in order to establish empathy with the patient. The workplace was the focus for some comments, while others related to family and friends. Learning from real life showed advantages that were contrasted to learning from simulations in courses. One found training was boring because it was difficult to apply to real life. The following quotations illustrated these key points:

Learning in the workplace:

> *"By putting learned skills into practice on a daily basis in the workplace I feel my skills continually improved".*
>
> *"Everyday experience requires keen observational skills and a willingness to listen to what the patient needs"*
>
> *"Building relationships with customers came without conscious effort"*

Learning with family and friends:

"Learned from everyday experiences, from school, personal experiences and at home"

"Everyday learning with friends and family - a more relaxed way to communicate but useful none the less"

Learning from real life:

"Real life experiences [are] always more accurate learning experiences and give 'truer' reality checks on how you think you portray yourself"

Observing Others

Observing others was a valued learning method, which included observing other pharmacists, patients and people in general. Respondents found benefit from trying various things to see what happened and learning from their mistakes. The following quotations illustrate these key points:

Observing colleagues:

"Watching how they interact with patients and how they ask questions and explain things to them"

"Awareness of what other people do that doesn't work"

Learning from mistakes:

"On a day to day basis I am able to consider how the last 'encounter' went and how I could improve it next time."

"Learning from our mistakes, being receptive to customer requests and being more knowledgeable but not over 'confident' and intimidating"

Motivating Factors

Maintaining motivation was important in learning to build relationships, especially self-generated attitudes and a desire to continuous improvement. Alternatively, pharmacists need to be motivated in some way. Comments for self-motivation included:

"Mostly self-motivated and self taught"

"Praise and criticism are powerful motivators too... I do feel we have to initiate freedom and self motivation in pharmacists ... by challenge and stimulating them to do something to help themselves".

Time

Some participants considered that relationships grow over a long time, and that "going the extra distance for our patients" helps this process. Time is a factor in building relationships as well as learning to build them. The influence of time was commented on:

> *"Obviously over time you gain a wide experience of different situations when dealing with the public and you apply your knowledge based on previous experience"*

Personality

Issues about personality were mentioned, and that it was a benefit to be a "people person". It was seen as a disadvantage not to have those aptitudes that enable effective communication with all types of people. Personal traits, character and attitudes were valued more than focused learning. Kind and caring attitudes to all, including social outcasts, were seen as important.

> *"A kindly word and nice action really do help!"*
>
> *"Without those aptitudes you will always be second rate if you don't have the personality qualities to effectively communicate with all types of people.*
>
> *Interpersonal skills involve more than "training" or focused learning. Personal traits, character and attitudes to the cosmopolitan world we live in are as important"*

One comment was negative

> *"If you can't communicate don't get a job in a retail pharmacy. Now you think I have to be taught this??"*

Interpersonal Sensitivity

Prejudices and hidden racism were warned against, while sensitivity to language comprehension and cultural differences needed to be increased.

> *"Treat people like you would expect to be treated"*
>
> *"Awareness of possible barriers e.g. cultural/physical"*

Reading

Reading about communication and relationship building skills was valued by some participants because it reinforced learning. It was important to work at applying the principles in the books to the practice situation. Comments included:

"Reading about some skills is a good aid in making you reassess [and] refamiliarise yourself with skills you may think you have and often just flicks the light switch on to make you appreciate situations differently"

"Reading articles in pharmacy magazines reinforces skills eg how to listen, body language, customer rights. Getting these things right builds good relationships."

On the other hand one pharmacist did not find it very helpful.

"I have read some self-help books on developing relationships and communication skills but haven't really learnt anything new."

Building Professional Relationships: Own Culture (Question 6)

"Question 6: How do you usually go about building professional relationships with patients from your own culture? (Specific examples would be very helpful)"

The responses for Question 6 were collated into five general themes, although some of the comments spanned more than one of the themes:

"Treat as a friend (try to remember their names) and a person – politely, positively, patiently, honestly (not give false answers or claims)"

"Get to know your patients, engage them in conversation, be friendly, respect them and give them honest sound advice. Treating everyone the same, this is very important."

In order of reducing frequency, the themes were: (i) being friendly, interested and helpful; (ii) showing respect and concern; (iii) being honest and trustworthy; (iv) talking, listening and language; and (v) time and availability.

Being Friendly, Interested And Helpful

This was the first and most important theme emerging from the respondents' comments. Pharmacists tried to be friendly and helpful, and showed an interest in their patients, their families and their health. Being friendly included being polite and relaxed. Being helpful involved medical problems and advice of a high quality.

"We try to greet customers warmly and try to remember their names"

"Show an interest in them, their family and their medical problems"

"By giving my patients help with medical problems"

They also tried to establish any common interests.

"Talk about similar interests or concerns.

Showing Respect And Concern

Genuine respect and concern embody the several comments in the second theme, which led into showing that they cared and wished to help. They liked to invite the patients back to talk about progress and took their health concerns seriously. They listened to their opinions with genuine interest, in a one-on-one comfortable setting, taking cues from body language and maintaining appropriate eye contact. Comments included:

"Respect their opinions/concerns"

"Show genuine concern for their well being"

Being Honest And Trustworthy

A few comments made up this third theme, where pharmacists strived to be ethical and professional in their practice. They wanted to be reliable and accurate with all they said and did for their patients. They wished to be honest with their answers and admit if they do not know something.

"Being honest about how one can help the patient"

"Be reliable and accurate in all you do for them and when speaking. If you do not know admit it"

Talking, Listening And Language

Numerous communication factors were gathered into the fourth theme. Pharmacists strived to talk clearly to people in both casual and formal styles. They employed good listening techniques such as reflective listening and tried to understand the person's needs:

"Talk to them about their family"

"Empathy, active listening skills, paraphrasing, avoid use of jargon"

They recognised the two-way nature of the relationship, seeking feedback when possible:

"Relationships are two-way"

"If I recommend a product OTC to a patient always ask the patient to give me feedback on the product (doesn't always work though)"

They were aware that it was important to use everyday language rather than medical terms they took for granted:

"Ensure that you are speaking in terms that they understand"

Time

There were a few comments about time, the fifth theme. Pharmacists spent time talking to their customers and patients and strived to be available when they were needed. When consulting with a patient they did not rush and this made the patient feel important. They put as much effort, persistence or patience as they could into fulfilling the needs of the patient. The time taken to build a good relationship with a customer was recognised as a key factor.

"A relationship ... takes time"

"Impatience is our worst enemy."

Building Professional Relationships: Other Cultures (Question 7)

"Question 7: How do you usually go about building professional relationships with patients from other cultures? (Specific examples would be very helpful)"

The cross cultural aspect of the relationship building process introduced in Question 7 prompted a number of respondents to answer "as above", referring to the range of answers outlined above in Question 6. They did not see the need to behave differently when building relationships with people from other cultures, other than learning something about their language and culture. The additional responses about cultural issues in Question 7 were then sorted into the following themes: (i) being treated with equal respect; (ii) being friendly and helpful; (iii) understanding; (iv) language; (v) cultural sensitivity; and (vi) patience and time.

Respect

Being treated with equal respect came through in many comments. The respect should be shown for the patient, their opinions and concerns as well as their culture. Treating everyone as important to you was a fundamental idea. Comments about respect included:

"Respect the patient first and foremost";

"Respect and listen and patience"

Comments about treatment included:

"Treat people like you would expect to be treated"

"I treat all patients with respect and care. I don't think there is any reason to treat people of other cultures differently (and I have never had a problem!)"

Cultural difference was not seen as needing different treatment:

"Colour of skin/ethnicity does not make any difference"

Being Friendly And Helpful

This theme was mentioned again by several pharmacists. Some pharmacists identified the need to greet all patients with a happy smile and a welcome; to talk to them and be interested. Comments included:

"Generally we are open friendly non-judgmental and sympathetic"

"Be non-threatening, try to be helpful"

"We try to take a real interest in them as people and help with their needs"

Understanding

This theme included many comments about talking, listening and checking for understanding, as mentioned above in Question 6. Listening seemed to focus in more comments than talking, although understanding was the key underlying issue. The listening comments included:

"Approach people in an open manner and listen to their requests"

"By being a good listener and listening to their concerns and in the process learning from them"

Ensuring you understood their needs and they understood what you were saying were both important, which necessitated the patient repeating back what they understood:

"More effort to ensure understanding is 100% - asking patient to repeat what is told them."

"Get the very basic information across, and get them to repeat it to ensure that they understand."

"Always try to be on patient's level. Never articulate at a level the patient does not understand and monitor level of patients understanding as you proceed"

Language

The several responses to this theme focused on ways to promote understanding as well as learning some of their words. There may be difficulties with English being the second language, and it was important to speak clearly and carefully in appropriate language, without using technical or medical jargon. Some comments involved staying in English:

"Don't shout at them but speak to them in very simple language and if they don't understand then try again".

"Saying things clearly and in different ways, in English is important."

If English was not an effective way to communicate they tried other options:

"Write things down, draw diagrams. Look for interpreter if appropriate."

"I try to learn some of their language and customs"

Cultural Sensitivity

Knowledge of other cultures was valued by a number of pharmacists so that inappropriate comments or behaviour could be avoided. Respecting their cultural values was important, as well as knowing about possible communication barriers:

"Asking someone how to say their name and trying to remember it."

"Learning about how other cultures talk about things eg Maori women very reticent about using names for intimate body parts and functions – need to find appropriate and acceptable words"

Differences in body language between cultures were mentioned:

"Learning about differences in body language"

"Pacific Islanders do not make eye contact when they are talking (as a sign of respect)"

One comment described difficulties in relationship building across the cultural divide:

"With some cultures you can't build a professional relationship due to their arrogance and their chauvinistic attitude to the female staff. You try your best but whether you build up loyalty is another matter."

Time

This theme included a few comments about spending time and being available, and particularly being patient:

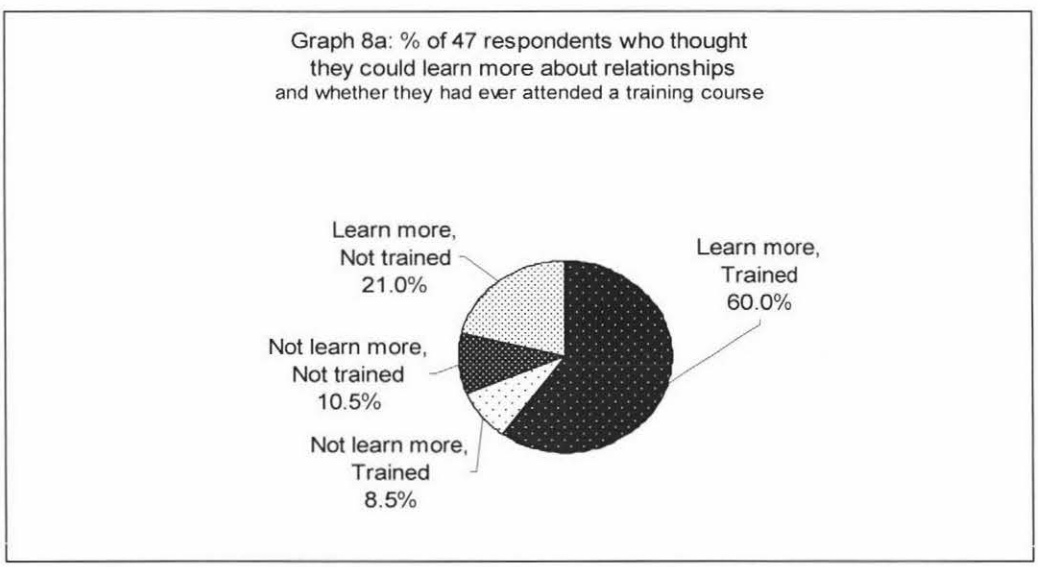
"By being available at all times to consult with anyone who seeks advice"

"Pacific Islanders respond to clarity and patience."

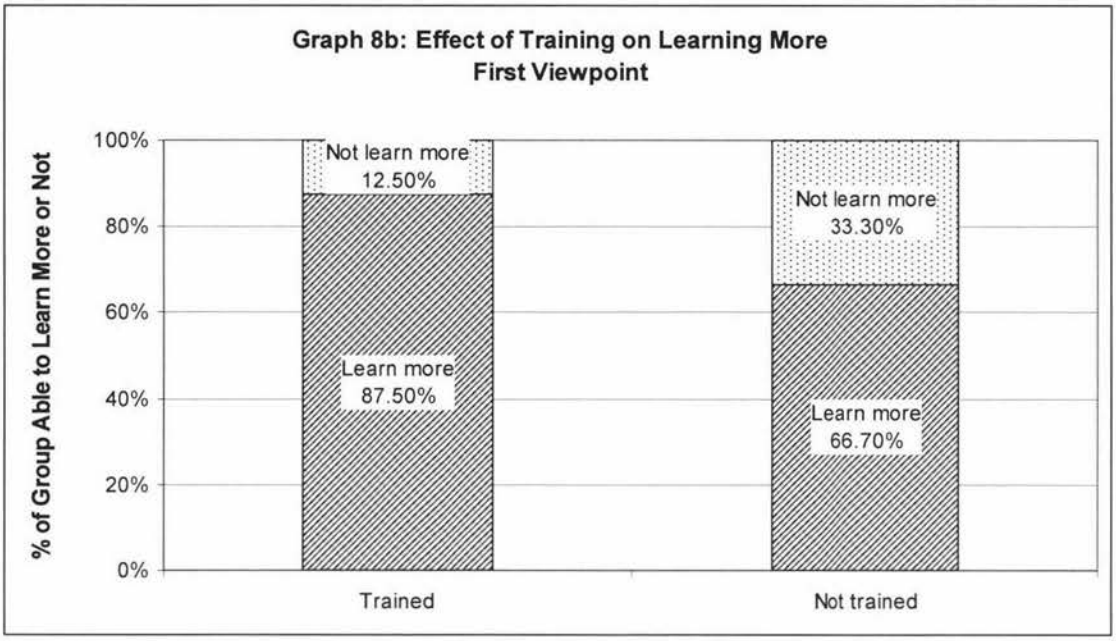
Learning More (Question 8)

"Question 8: Do you think you could learn more about building professional relationships with patients? Yes □ No □"

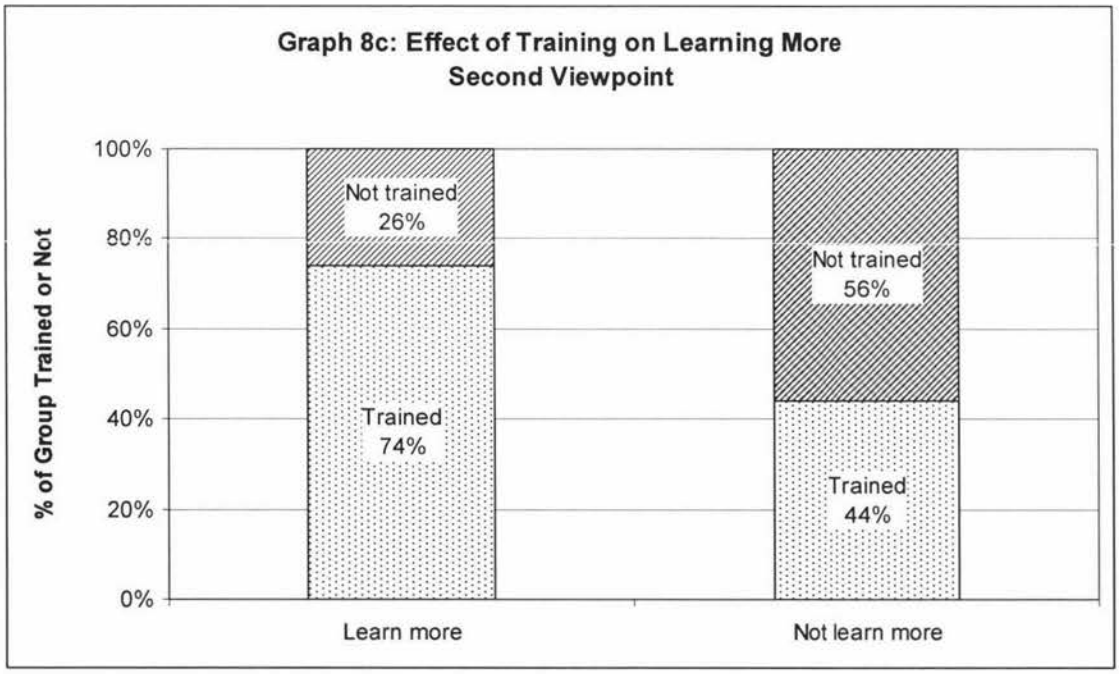
Question 8 asked pharmacists if they thought they could learn more about building professional relationships with patients. Of the 47 participants responding to the questionnaire, 38 (81%) thought that they could learn more. Question 9 asked for details of training courses attended. Of the 47 participants, 32 (68%) had attended training courses. This course attendance was combined with the results from Question 8 and a pie chart was constructed illustrating the proportions of pharmacists who had or had not attended courses and whether or not they thought they could learn more. See Graph 8.



While the numbers were too small to provide conclusive results, and there might also be self-selection bias operating, the data was examined for trends. It indicated that, for the study participants, those who had already attended training courses were more likely to think that they could learn more compared to those who had not already attended a training course. Graph 8b presents this data in a different format for clarification. Of the 32 who had attended training, 87.5% thought that they could learn more, compared to the 15 who had not attended training, only 66.7% thought that they could learn more.



Another way of viewing this data comparison showed those who thought that they could learn more (38) were more likely to have attended a training course. Those who did not think that they could learn more (9) were less likely to have attended a training course. See Graph 8c.



The data for gender and age were compared to whether or not participants felt they could learn more about building relationships or had attended courses. The spread seemed to be evenly distributed and there did not appear to be any correlation between gender and age and Question 8 or 9.

Training Courses Undertaken (Question 9)

"Question 9: If you have undertaken a training course in relationship building or communication skills please tell me about this training:

Hours Of Study

"Question 9a: How many hours of study were involved?"

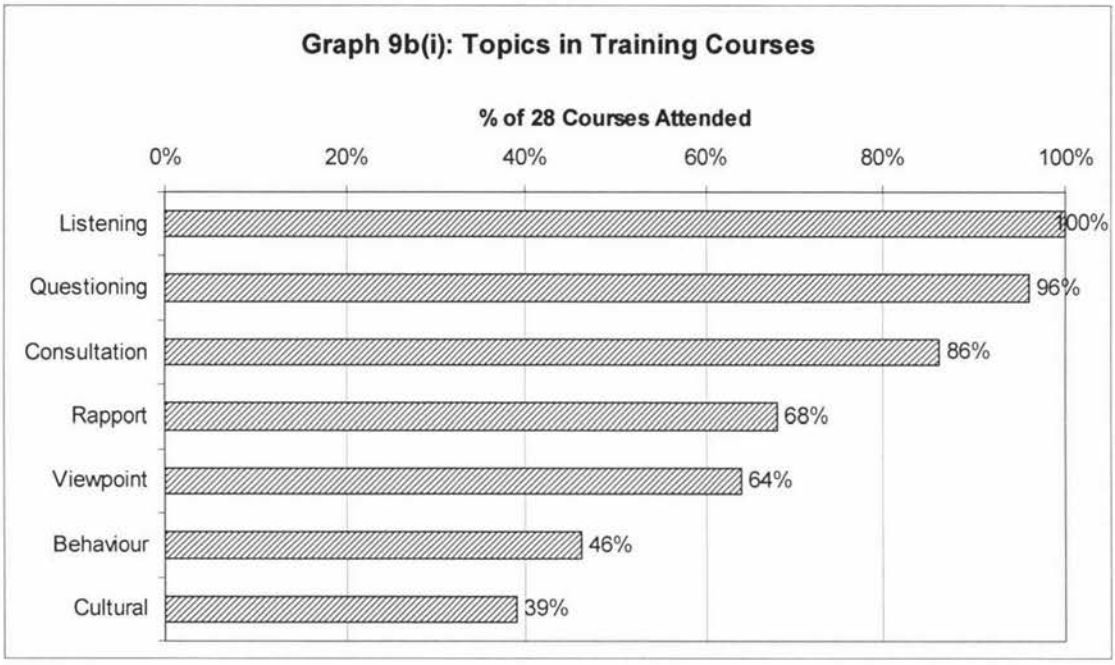
For those who had attended a training course, as indicated in Question 4a, this question focused on the duration of the training involved in the course attended. Participants reported course durations that varied widely from hours, to days, to months. There were no trends observed. Some reported a small number of hours that could indicate an evening course or part of a larger composite course. Some respondents mentioned hours or days that would indicate events taking 1, 2, 3 or 4 days. Others referred to prolonged courses that lasted for a number of months, although this could be assumed to be either part time study or part of a larger full time programme. Some respondents could not remember the exact duration of the courses they had undertaken over their lifetime.

Course Topics

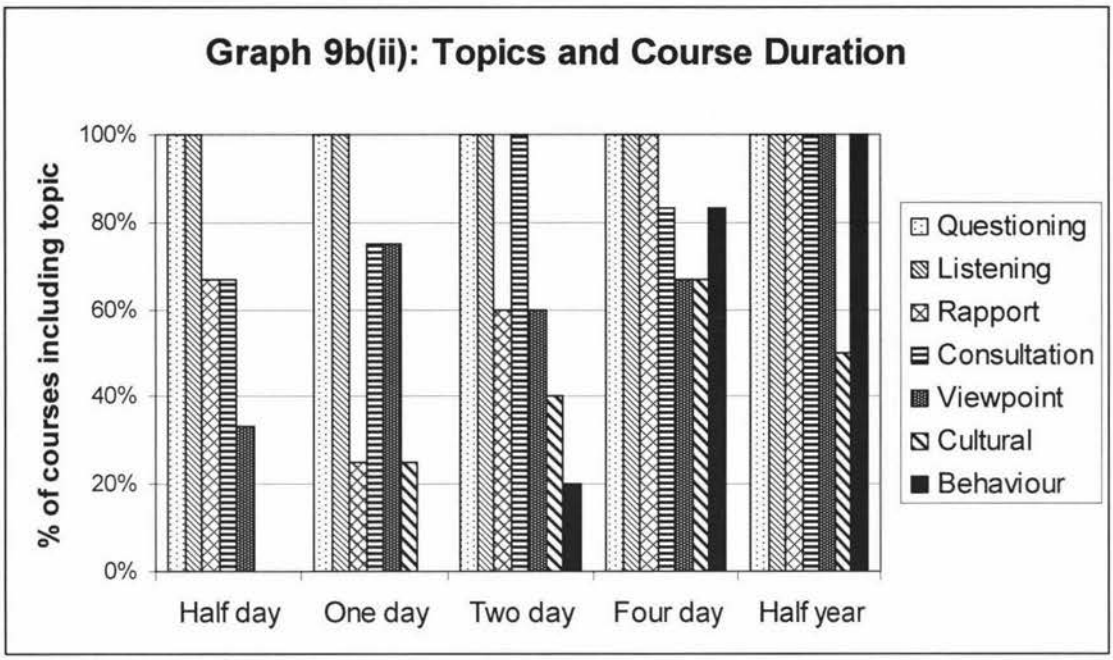
"Question 9b: What topics were included?"

i. Questioning techniques □
ii. Listening techniques □
iii. Building rapport □
iv. Consultation skills □
v. Behaviour change □
vi. Patient viewpoint □
vii. Cross cultural communication □
viii. Other (please specify)_____

Graph 9b(i) compares the frequencies reported for the topics included in the courses that participants had attended. Twenty-eight participants reported answers for this question. All courses attended included listening (100%) and all but one included questioning (96%). Consultation skills (86%) were included in most courses. Two topics closely linked to relationship building, namely building rapport (68%) and patient viewpoint (64%), were only included in some of the courses undertaken. Behavioural change (46%) and cross cultural communication (39%) were the topics included least often.



Combining the data in Questions 9a and 9b, it was possible to explore the correlation of course topics with the duration of the course. Twenty responses provided sufficient information to make comparisons. The results were illustrated using Graph 9b(ii). This analysis showed that the shorter courses were less likely to include as many of the topics listed as were the long courses. All courses included questioning and listening. Building rapport, consultation skills and patient viewpoint were more likely in the longer courses. Cross cultural communication was not included in half day courses. Behavioural change was not included in half or one day courses.



Other topics that were mentioned in addition to those listed above included managing difficult situations, communications aids (visual), psychology, neurolinguistic programming principles, negotiation skills training, personal presentation and checking for understanding.

Beneficial Topics

"Question 9c: Which topics were most beneficial to your practice and why?"

Responses ranged from the completely positive "All helpful" to the completely negative viewpoint "None". Other comments ranged between these two extremes:

"All of the course beneficial and interlinked"

"All of the above especially listening and questioning"

"Most"

"Don't think the college course had a major impact on me"

"I did not find them helpful"

"Probably have done some of these over the years, but generally they were useless and a waste of time"

The most frequent responses favoured listening and questioning techniques:

"Good questions get good answers!"

"If you don't get the right info from the customer you don't give the right response and the customer doesn't get the service they need and your relationship has evaporated."

Other responses focused mainly on listening:

"Listening removes the need for some of the questioning"

"Listening techniques (eg minimal encouragement) are beneficial in everyday life as well as at work."

Some responses mentioned rapport and patient viewpoint also:

"Questioning and how to build rapport and show empathy"

"Listening techniques and patient viewpoint. Without effective listening and an active demonstration that you have heard the patient then you can't bring about any change"

Other beneficial course topics were cross-cultural communication, solution-thinking, body language and consultation skills. Two participants commented on informal learning that covered these topics:

"No specific courses but have been involved in all these topics"

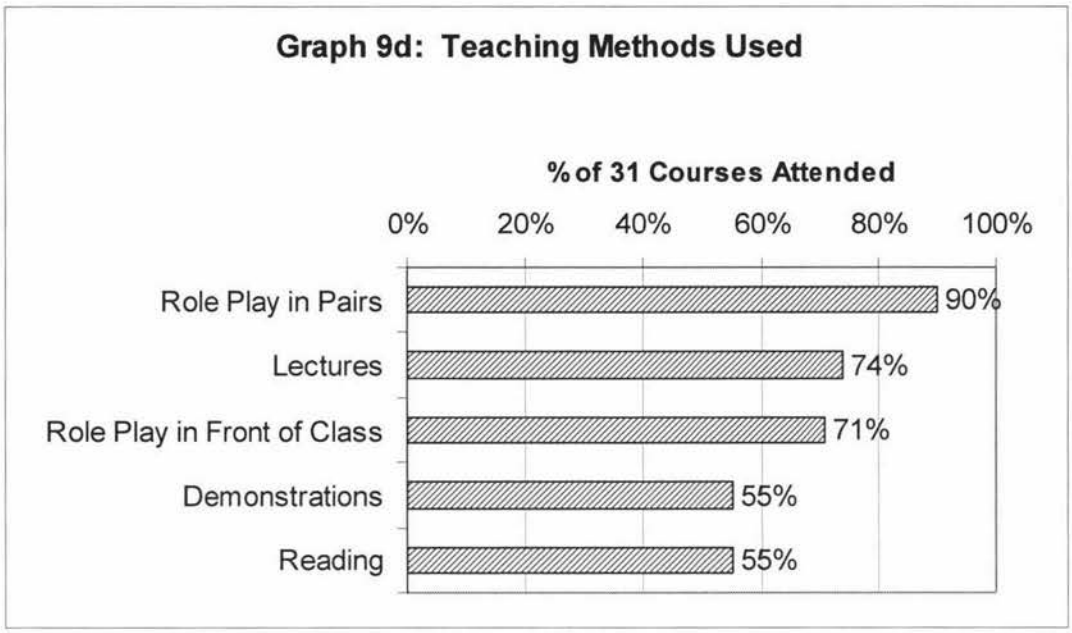
Teaching Methods

"Question 9d: What teaching methods were used? (Please tick as many as apply to you):

i. Lectures □
ii. Reading □
iii. Demonstrations □
iv. Role play in pairs □
v. Role play in front of class □
vi. Other (please specify) _____"

Graph 9d explored teaching methods and the 31 responses to this question showed a high frequency for role play in pairs (28/31), followed by lectures (23/31) and role play in front of class (22/31). Only about half of respondents reported use of demonstrations

(17/31) and reading (17/31). See Graph 12. Other methods used included discussion, video assessment and making short films, and fellow pharmacist's advice.



Effective Methods

"Question 9e: How effective was this method for your learning?"

Some responses for this question referred to all of the methods in a general way. The views expressed in the 29 responses to 9e that were filled out on the questionnaires ranged from positive:

"very effective"; "all methods were useful"; "I learnt a lot"

to negative:

"not very"; "not particularly good"; "useless"

Some respondents commented on specific methods and praised the effectiveness of role play, demonstrations and films:

"Its one thing to read about it and it helps emphasise your learning with role play and demonstrations";

"Many lessons stick in my mind from the short films";

"Very effective once I got over my initial reluctance to role play!"

However, two views on role plays were unfavourable as seen in these comments:

"I hate role plays"; "embarrassing".

One comment referred to the benefit of years of experience in developing skills for dealing with patients and building rapport:

"Very satisfying especially when you were role playing with the principals from the university. Being a 'mature' pharmacist I had to do more research on drug management which the newer graduates were more competent at but the dealing with patients and building a rapport was much easier and I was complimented on this and dealing with the 'GP'."

A few comments related to learning from real life:

"Nothing compares to on the job training"

"gave a basic overview, but essential part is putting all the theory into practice on a day to day basis"

Two of the negative comments differentiated their own experiences from other course participants:

"Not very for me";

"I think it helped people who were not very good at communicating but I didn't find it helpful".

One comment referred to an aspect of the teaching context in the particular course:

"Reasonably effective since the student to teacher ratio was about 8:1".

Improvements To Pharmacy Practice (Question 10)

"Question 10: How has this learning improved your pharmacy practice and/or the quality of the relationships you build with patients?"

Positive and negative comments were received in response to this question. Those finding general benefit indicated that it was part of an ongoing process:

"was a good starting point"; "built on already existing skills and native nous";

"probably needs the occasional reinforcement"

Some answers did not report improvements to practice as a result of training.

"Unsure"; "no"; "It probably hasn't";

Some comments reported improved communication:

"Made us more aware of communication";

"Made it...easier to understand patients"

"It allowed me to have the skills to communicate effectively and efficiently"

A few others reported changes resulting in improved relationships:

"Trying to use open questions all the time has helped with this relationship building."

"I feel more confident to build a good relationship with customers/patients from all cultural backgrounds."

Improvements to their pharmacy practice were identified by a few respondents:

"Important in reducing non-compliance"

"Important in how customers value our knowledge"

"By introducing better practice techniques, I have received positive patient feedback – not that I had any negative comments"

One comment related to the different personality profiles:

"Understanding that all people have different personality profiles and you need to adjust accordingly. Some people want short sharp conversations, others don't."

Learning To Build Relationships (Question 11a)

"Question 11a: Please add any other comments that you may have about learning to build relationships with patients

A number of respondents referred to the learning process as essential and ongoing with comments such as:

"essential to keep working on it – you cannot simply learn it from a training course"; "it is an ever-evolving process";

Other comments linked to context for learning on the job and developing the business:

"on the job experience is the best way to learn from mistakes as well as successes";

"If you don't [learn to build relationships] you won't have a business";

Most other respondents repeated the themes outlined in question 6 above (how they go about building relationships) referring more to content to be learned (how to build relationships), rather than on the learning process itself (how to learn to build relationships). Comments were again grouped into themes:

Listening

Listening effectively to the other person's viewpoint emerged as an important skill to be learned. Some of the many comments were:

"Being patient and listening are the two most important features of communication – then explaining yourself clearly."

"You must listen to the other person's viewpoint. If they are wrong or haven't quite grasped the facts, this should be pointed out to them as tactfully as possible."

Talking

Talking to your customers with clear, concise, simple explanations and sound, well informed and knowledgeable advice were also valued by a number of respondents. Comments included:

"Good advice = good experience = good relationship";

"Explanations to patients about issues e.g. funding for medicine can gain patient acceptance".

Attitudes

A number of attitudes, such as being positive, enthusiastic, open, interested, empathic, patient, calm and caring were recommended by several respondents such as:

"Caring about the patient's life and interests in general is a good start. But we must be genuine."

"Understanding where the patient is at, i.e. stressed (not well, delayed at doctors, in pain)"

Time

The idea that 'time' and 'being available' were fundamental elements of relationship building was a recurring theme throughout the various questions. Comments included:

> *"If you don't have the time it is hard to build a relationship."*
>
> *"Building relationships with patients takes time, it doesn't happen overnight. There is also a big trust element involved. If patients don't trust you your relationships will never be as effective as they could be."*

It was also mentioned that wisdom to build relationships comes with time:

> *"Being human helps – some esp[ecially] younger pharmacists seem too clever by half and not aware of others situations (highlights wisdom that comes with experience and age as reg[istered] for 35 years)"*

Personality

The role of personality was discussed further. Some comments suggested that innate characteristics were needed to start with:

> *"Comes down to your personality – an outgoing positive person can build relationships with anyone"*
>
> *"You have to be a "people" person and have an empathetic personality to be able to build a relationship in the first place. All the training in the world cannot help some people fulfill others needs sometimes. Enjoying your job helps immensely."*

One comment suggested that there was some useful information that could be learned:

> *"Understanding different personalities would be useful"*

Common Ground And Difference

Two comments referred to finding common ground and recognising difference:

> *"Shared interests (even rugby games)";*
>
> *"Everyone is different – jokes with one will not be liked by others!!"*

Cultural Backgrounds

Some comments referred to the importance of having an understanding of diverse cultural backgrounds:

> *"Learning about cultural beliefs and how people relate to people of higher training and to females. Some cultures would not be able to cope with direct technically challenging questions from a female in authority."*

Communication Skills Training (Question 11b)

"Question 11b: Please add any other comments that you may have about undertaking communication skills training"

A few general comments about undertaking communication skills training supported the beneficial viewpoint:

"Essential for everyone in pharmacy related workplaces"

"Always learn something"

"A lot of misunderstandings are all a result of poor communication."

Teaching Methods

Comments linked to teaching methods were varied. One respondent suggested exams and metal badges as rewards. General overview comments were:

"It needs to be fun and informative"

"Keep any course basic and quick to complete"

Some comments were recommendations for effective training methods, especially using practical exercises or workshop style:

"It should have direct practical application for the pupil and have a very tight focus"

"Workshop training is more efficient than reading or internet training

Some comments referred to the usefulness of reading and attending lectures, another comment advised participants about commitment when attending training courses:

"Be prepared to join in"

Role plays featured again in some comments:

"Role plays are never real/serious. You have to think on your feet!"

"Even though you were role playing you had to understand where the patients were coming from"

Cultural Aspects

A cultural theme emerged with some comments, where it was suggested that the only real way to practice cross-cultural communication was with actual people from other cultures:

"Role playing with another European will not be adequate"

"Involving people from other cultures, so that they can tell us directly some of their challenges and concerns"

Other comments referred to the impossibility of providing training for the full range of different pharmacists and patients involved:

"Everybody is different so any training will always be incomplete and can only be regarded as part of required training. Learning from others on the job is the best way."

"How comprehensive and all encompassing can communication skills training be? The pharmacy that employs me has a relatively large Indian customer base, seasonal workers (Chinese, Brazilians, those from Europe) and tourists passing through in the season. Courtesy and patience is required as well as good listening skills."

Difficulties

The last theme covered difficulties with communication skills training, particularly managing to implement what had been learned in the course into the practice situation:

"Implementing this training may not be so easy and practical"

"It's hard for older people to change their behaviour"

"Very hard to change inbuilt behaviour patterns"

"Leopards never change their spots"

Another barrier was time and cost:

"Costs and time are barriers to some"

"Keep it inexpensive to enroll. Charge something though";.

There were also a couple of comments opposing training courses:

"I didn't really like or enjoy it"

"Actual experience is best!"

Issues And Benefits (Question 11c)

"Question 11c: Please add any other comments that you may have about issues and benefits of building relationships with patients."

The responses to this question were arranged with issues being the first main section. The responses about benefits were further sorted into the following themes: trust and respect, aptitude versus learning, and benefits to (i) pharmacy practice i.e. improved patient health outcomes, (ii) benefits to pharmacists i.e. job satisfaction, and (iii) benefits to business.

Issues

The comments about issues were based mainly on time and funding. Some comments indicated that both pharmacists and patients were subject to time pressures. This may impact adversely on the relationship or the safety for patients:

> *"Time – may not have time to build relationship in a busy pharmacy"*
>
> *"Misunderstanding may occur if interaction is rushed"*

The relationship involves both pharmacist and patient, so both need time:

> *"A lot of people are in a hurry these days or are very stressed when they get to a pharmacist and so it is important to learn skills to engage them briefly and effectively so that you can get the message across."*

Funding issues relating to the current context of pharmacy in New Zealand can have a significant effect, if they reduce the time available, both duration and frequency of visits:

> *"Current remuneration is forcing a much more impersonal service which is to the detriment of job satisfaction and healthcare."*
>
> *"The stat (3/12) [3 monthly] dispensing regime has reduced patient contact just as we are encouraged to have more patient contact – but that's bureaucrats for you."*

To explain, 'stat dispensing' was a government initiative introduced in 2003 for most prescription items and it specified that repeat prescriptions should be provided as a three month supply. Previously patients visited the pharmacy every month enabling frequent pharmacist-patient interactions and strong relationships. Current pharmacy contractual

issues relate to perceived low remuneration rates for dispensing which results in high pressure workloads for pharmacists. This reduces the time available for pharmacists to communicate with their patients, which also impacts significantly on their opportunities to build relationships.

General Benefits

Several comments related to trust and respect and their fundamental position within relationships. They were mutually interdependent:

> *"Traditional pharmacy has gained huge respect and trust from the public by building relationships";*
>
> *"Building respect, empathy and understanding is all part of relationship development."*

A recurring theme was the idea that an aptitude for relationship building was something that could not be learned:

> *"You either have people skills or you don't"*
>
> *"Remember salesmen are born, not made"*
>
> *"No amount of 'skills training' will help those who have not learnt to love and care for others genuinely. People can spot the difference."*

Benefits To Pharmacy Practice

There were many comments supporting the benefits of building relationships with patients to the practice of pharmacy and patient health. Many were practically oriented relating to understanding and assistance with treatments:

> *"It is very important that patients understand how to take their medicines correctly and if you can build up a relationship before you have to spend time explaining something complex, then you have a better chance of ensuring that they understand everything that you want them to."*
>
> *"Pharmacy is a person business whether it is dispensing drugs, giving advice on prescriptions or OTC products or as often happens giving 'free advice' the client, patient, customer has got to have confidence in the information and advice given."*

A small number of comments related to pharmacists being more approachable when

there was a strong relationship in place. Patients were comfortable telling pharmacists about their health concerns:

> *"Trusting relationships [provide] better interaction with patients, respecting patient confidentiality, able to seek advice re sensitive/embarrassing issue, feel at ease when asking questions/seek advice"*
>
> *"Patients will tell you of small variations in their health, whether they are compliant and you can help to improve this."*

A couple of responses spoke of the challenges of dealing with patients:

> *"Pharmacy is stressful. Some customers remain a pain – no matter how we try"*
>
> *"We must also learn how to tolerate the 2% who rile us most and treat them professionally and well."*

Benefits To Pharmacists

A number of comments supported the benefits to pharmacists, mainly in terms of job satisfaction, but on a personal level as well:

> *"It can be hugely rewarding on a personal level, but most importantly, if you have a good personal relationship with a patient then you will find correcting any errors much easier and can ascertain any potential problems far more readily."*
>
> *"The more you build relationships, the more good experiences and good fortune you will get by return."*

A couple of responses provided warnings about poor communication or attitudes:

> *"Without communication skills that are effective, you will always be an inferior performer."*
>
> *"Important of course, but…the superior attitudes of some spoil any so called learnt skills."*

Benefits To Pharmacy Business

A number of responses commented on the benefits of good relationships with patients to building pharmacy businesses. These focused on attracting customer loyalty and building the size of the customer base, which linked back into financial success:

> *"Highly important for business relationships build loyalty"*
>
> *"Happy patients and customers >> increased business"*

One comment recommended changes to university courses:

> *"I think this is one of the most important factors in determining the success or failure of a community pharmacy business. The pharmacy schools should incorporate a training course in the curriculum. (30 years registered)"*

One final comment stressed the essential nature of building good relationships:

> *"You'll go broke if you don't."*

Conclusion

Demographics

The data collected by way of this research questionnaire was collated and examined, and a number of key findings emerged. The demographic background data indicated that respondents represented a diverse range of years of experience, and also a balance of gender, although slightly different from the profile of the whole of the pharmacy profession. The range and frequency of ethnicities represented was also similar to that of the pharmacy profession in New Zealand. While the number responding was low at 47, the results were seen to be useful in providing some exploratory and descriptive data.

Gaining Skills

All pharmacist respondents were found to have gained their relationship building skills from everyday experience, in both the workplace and life in general, from family and from friends. Reading and training courses were both popular methods of adding to this learning and for some self directed study was also useful. Some respondents learned by observing others and learning from mistakes. Self motivation and adequate time were considered important, while interpersonal sensitivity and being a people person were valued more than focused learning.

Building Relationships

When questioned about how pharmacists build relationships with patients the following themes emerged. Being friendly, interested and helpful, and finding common interests; showing respect and concern; being honest and trustworthy; talking and listening with two-way feedback; using appropriate language that could be understood; and lastly

concepts of time, availability and patience. When commenting on cultural difference, most respondents felt that the same factors were involved, especially respect and treating equally, as well as friendliness and helpfulness. They stressed the importance of checking understanding on both sides especially if there were language barriers. Cultural sensitivity was valued and the theme of time and patience arose again.

Learning More

Most respondents thought that they could learn more about building professional relationships with patients, even though most of these had already attended training courses previously. The small numbers of responses and potential bias needed to be borne in mind. Duration of courses attended varied widely. Topics most often included were listening and questioning, followed by gradually less often, consultation skills, rapport building, patient viewpoint, behaviour change and cross cultural communication. Longer courses were more likely to include more topics. Most people found the most beneficial topics to be questioning and listening, although most found all of them helpful.

The methods used to teach these topics in the courses were most often role play in pairs, but also lectures and role play in front of class. Demonstrations and reading were mentioned less often. Comments on the effectiveness of these methods varied from good to useless, with some praising role play, demonstrations and films. Some preferred learning from real life and others thought that while some people learned from courses they could not. When asking about the benefit of this training to their practice of pharmacy, the responses varied widely. Some saw it as a useful starting point in a continuous process, while others were unsure of the benefit. Some appreciated the increased awareness provided by the training.

Concluding Comments

The concluding questions (11a, b and c) provided a variety of comments that highlighted the essential nature of learning to build relationships with patients. Training courses were seen as essential by some, especially with a practical focus and application to the workplace, although the difficulty in changing well established behaviour patterns was recognised. The barriers to building relationships were seen to be shortage of time which linked to funding issues, but the benefits of strong relationships were acknowledged by

most respondents. These benefits were linked to patient health, pharmacist satisfaction and business success.

In the next section, Chapter 5: Discussion, these comments were analysed further by focusing on four major themes. These were compared with the findings in Chapter 2: Literature Review. In Chapter 6: Conclusion the emerging ideas were drawn together with recommendations for future study and development.

CHAPTER 5: DISCUSSION

Introduction

The findings from this study were presented in Chapter 4 and four major themes have emerged. These have been used as the framework for this chapter. The data supporting each of these themes is presented initially, followed by the relevant points from the literature review. The discussion within each theme compares the viewpoints of the study participants with the authors and develops a final position on each theme.

The first major theme, interpersonal sensitivity, emerged from the exploration of how relationships were built and how pharmacists learned to build them. The second major theme, everyday experience, linked to the way in which relationship building was learned, but was also supported by other ways of learning. The third theme was time, which emerged as a continuing thread running throughout both of the above themes. A smaller but important final theme arising from the section on benefits of relationships to practice was that of the essential nature of good pharmacist patient relationships.

The following discussion focused on these four themes, namely interpersonal sensitivity, secondly on learning from everyday experience, thirdly on time and fourthly, that relationships matter.

Interpersonal Sensitivity

The first major theme, interpersonal sensitivity, was formed by grouping together certain qualities that the participants in the study identified repeatedly as fundamental aspects of relating to other people. They were friendliness, respect, trust, honesty, sincerity, genuine concern, warmth and empathy:

> *"Treat as a friend...and a person – politely, positively, patiently, honestly..."*
>
> *"Get to know your patients, engage them in conversation, be friendly, respect them and give them honest sound advice. Treating everyone the same, this is very important."*

While discussing interpersonal sensitivity, there were several responses concerning the part played by the personality of the pharmacist in the development of relationships:

"You need to be a "people person" firstly"

"Comes down to your personality – an outgoing positive person can build relationships with anyone"

This suggested that innate characteristics were potentially pre-requisites for being able to build relationships with patients and that without these personal qualities a pharmacist would not be able to succeed. One respondent went so far as to say that without any people skills, a person should find another type of job. These were qualities that could not be learned, but had to be present naturally, as inferred from the following comment:

"Interpersonal skills involve more than "training" or focused learning"

Another consideration was that both the pharmacist and the patient were involved in the conversation and therefore the relationship would depend upon the personality of both parties.

"Relationships are two-way"

Acknowledging that there were different types of personalities could lead to the conclusion that some were easier to work with than others. If it were possible to offset the difficulties that may arise, this would be of benefit in many instances when trying to build relationships. In fact, one participant considered that some aspects of this process could be learned:

"Understanding that all people have different personality profiles and you need to adjust accordingly. Some people want short sharp conversations, others don't."

Focusing on the benefits of training to their practice of pharmacy, most people identified listening and questioning as the two most useful topics. Many participants expressed the view that listening and questioning using the right words and techniques was extremely helpful for building relationships:

"Trying to use open questions all the time has helped with this relationship building"

"Empathy, active listening skills, paraphrasing, avoid use of jargon"

This links the use of well chosen words to the process of being empathic, where the pharmacist acknowledges the patient's feelings and concerns.

Comments from respondents about other cultures mainly reinforced the factors mentioned above, but two additional factors were emphasised. Many participants indicated that all patients should be treated the same, regardless of their ethnicity:

"Treating everyone the same, this is very important."

This also included ensuring full understanding on both sides of the relationship because of the possibility of language difficulties, and checking for this understanding. Without understanding, the responses could not be empathic:

"Ask questions to ensure they understand or whether they want any additional information"

The literature supported the viewpoint that being warm and friendly was important for building relationships (Rantucci 1990). Trust was another quality that was mentioned and was linked to being genuine, honest and sincere (Tindall et al 1984). The literature also referred to developing initial rapport using the personal qualities mentioned above, as crucial factors for successful relationship building (Tindall et al 1984, Rantucci 1990, Quintrell 1994, Sigband 1995, Street 2003). Patients needed to feel valued and respected as individuals and needed to trust the pharmacist in order to feel safe revealing their feelings. While it may not be possible to teach about trustworthiness, an awareness of its importance may prompt a pharmacist to reflect on their underlying attitudes with a view to reassessing their own motivations. Whether this awareness was sufficient to enable change was doubted by some authors (Street 2003). One suggestion was that the presence of an underlying motivation and desire to help and understand would assist in the relationship (Welch 2003).

Referring to personality, the literature agreed that it should be possible to adjust the style of communication used so that it matched that of the other person in the encounter. The effect of maturity was recognised as beneficial in enabling these adjustments to be made. This indicated that knowledge of personality characteristics might be useful to enable pharmacists to compensate when their own personality factors differed from those of their patients (Schuster 2005, Lawrence 1996, Keirsey 1984). Depending on the patient, being harmonious or chatty may be more appropriate than being factual and businesslike (Brown et al 2006, Schuster 2000).

The literature stressed the importance of empathic understanding with active and reflective listening techniques, as part of the consultation process (Tindall et al 1984, Maquire & Pitceathly 2002, Welch 2003, Riley 2004, Sheldon 2005) and by creating open two-way communication between the pharmacist and the patient (Silverman et al 2005). In addition to this verbal language there was the role of non-verbal or body language. This needed to match the words being used for the concerns expressed to be considered genuine. Questioning and listening were widely discussed in the literature as techniques that can be improved (Tindall et al 1984, Warden-Flood 1987, Quintrell 1994, Sigband 1995, Rantucci 1990, Schuster 2000, Harvard 2003, Brown et al 2006).

There were a number of blocking actions identified in the literature that would interfere with communication and relationship building. This applied to pharmacists (Quintrell 1994, Tindall et al 1984, Rantucci 1990, Welch 2003), to nurses (Booth et al 1999, Riley 2004) and to doctors (Maguire & Pitceathly 2002, Greene & Burleson 2003, Street 2003, Brown et al 2003, Thompson et al 2003, Clark & Gong 2000). Being unfriendly and domineering, interrupting frequently, and giving premature advice or reassurance before identifying the main problems were the main attitudes or behaviours identified as problems. Awareness of these issues might also facilitate behaviour change in pharmacists.

The literature suggested that people from other cultures should be given the same level of respect and attention. They need to be treated in the most appropriate way for each of them, and this might not always be the same (McGee & Fraser 2001). Cultural awareness was an important issue raised by a number of authors (Cooper-Patrick et al 1999, Nussbaum et al 2003, Welch 2003, Moss 2004, Metge 2001, Sheldon 2005).

The study participants and the literature agreed that there were a number of qualities that were fundamental to the development of good therapeutic relationships, namely being friendly, respectful, trustworthy, honest, sincere, genuine, patient and empathic. The question was whether these qualities could be improved in some way or whether they were innate characteristics that could not change. One viewpoint was that it was the attitudes and motivations underlying their behaviour such as genuine friendliness, caring attitude and a willingness to help patients that made the difference and enabled the rapport to develop into an enduring and trusting relationship on both sides.

I agree with the author who suggested that an underlying motivation and desire to help and understand would facilitate a sense of caring with a warm and friendly approach (Welch 2003). I believe that the presence of these qualities would result in the patient feeling valued, which is at the heart of patient-centred care. Potentially, the most important issue is whether the pharmacist cares about the patient's health or not. Whether caring for patients is something that a pharmacist does innately, or whether he or she can consciously decide to care, is perhaps a more pertinent question. Rather than simply suggesting improvements to practice, one author cast doubt on whether increased awareness of these qualities would make a difference (Street 2003), while one respondent implied that there were factors that could not be learned in courses. I suggest that the respondents who had personal aims of exceeding customers' expectations would be likely to achieve these goals, because of their underlying motivations and attitudes. This also emphasised the continuous nature of the process, which would require constant diligence to maintain consistent success. There would always be new and different patients to relate to.

There was also agreement that a friendly and an outgoing personality would help a pharmacist to build relationships with patients. This natural aptitude for communicating well with all types of people was considered to be an innate personality trait. As such it would provide the pharmacist with an asset of great benefit to relationship building with patients. While the participants and the literature proposed these qualities as the best qualities for pharmacists to have, the differentiation between innate characteristics that could not be learned and qualities that could be changed was not clear.

An awareness of the importance of different ways of conversing was mentioned in the references to personality types in the literature and in the study. This would enable pharmacists to adjust for different preferred styles of conversation and types of personalities. It would enable them to improve their relationships with patients, even if they needed to put more effort into it than others for whom it came easily.

The literature and the study both supported the view that empathic understanding could be improved by using particular methods of questioning and listening, such as reflecting back to the person the fact that you had heard what they had said, and acknowledging their feelings and concerns. The literature also contained many examples of the sort of

things to avoid as they would block empathic understanding. In my view, the choice of words is part of the demonstration of interpersonal sensitivity. Relationship building is enhanced by the appreciation of the patient viewpoint, which is shown by virtue of the words chosen while demonstrating empathic understanding to the patient. Knowledge of the best words to use is something that can be learned in training. I therefore consider that empathic understanding can be improved with focused training. While many people agree with this viewpoint, I acknowledge that there are some who do not believe that this learning can help. On the other hand, I do maintain that this still needs to be supported by appropriate caring qualities as mentioned above, because the communication process itself is a combination of both verbal and non-verbal language, and the non-verbal language needs to be in congruence with the words for the full impression of caring to be manifested.

The concept of partnerships for mutual agreement was only forthcoming in the literature review and did not feature significantly in the study findings, although the concept of relationships being two-way was mentioned. While mentioned in the literature review, issues of power did not arise in the study data, although it was considered crucial that the patient was respected. I suggest that this respectful treatment would provide a measure of autonomy for the patient and would therefore be empowering and supportive of the notion of mutual agreement for treatment management planning.

In my view, pharmacists need to be able to deal with the diversity inherent in both cultural and personality differences. While treating people with equal care and respect is important, this may be slightly different to treating them "the same", as mentioned by some of the study respondents. Pharmacists would benefit from knowing as much as possible about potential differences so that their patients may feel valued and cared for, and so that beneficial relationships may be formed.

Everyday Experience

The second major theme arising from this research related to how pharmacists learn to build relationships. The fact that all participants responded to Question 4 in the study questionnaire by stating that they had learned to build relationships from everyday experience was a clear indication of this being a widely held view. However, it is also

important to consider the implications of the other ways of learning and whether they impact on everyday experience.

Learning from real-life was reported by one respondent as the most effective way of learning to build relationships with patients:

> *"Real life experiences [are] always more accurate learning experiences and give 'truer' reality checks on how you think you portray yourself"*

A number of respondents identified both the workplace and home as places to learn these skills:

> *"By putting learned skills into practice on a daily basis in the workplace I feel my skills continually improved".*
>
> *"Everyday learning with friends and family"*

Learning by observation of more practised colleagues in real working contexts was seen as a useful way to learn to build relationships with patients. This would demonstrate the professional manner required and may be less fraught with pitfalls for the inexperienced:

> *"Watching how they interact with patients and how they ask questions and explain things to them"*

Respondents often referred to the willingness to observe and to reflect on what had happened. It was often easier to observe and critique what happened with others, rather than with oneself. Trying to focus on changing an existing style of working while actually carrying out the task could be very challenging. The learner would then follow the example set, and a process of trial and error should eventually lead to success.

A number of respondents referred to learning from their own mistakes:

> *"On a day to day basis I am able to consider how the last 'encounter' went and how I could improve it next time."*

Some respondents also reported that watching other colleagues when they were not successful was a useful way to learn:

> *"Awareness of what other people do that doesn't work"*

While many respondents had learned skills from training courses and reading, views were divided on their usefulness. Some of the comments indicated that other learning had raised their awareness about communication or that it had provided a good starting point for practice in everyday situations. This indicated that these additional methods

provided fresh input for the pharmacists to apply in practice when the next opportunity arose:

> *"Reading about some skills is a good aid in making you reassess [and] refamiliarise yourself with skills you may think you have and often just flicks the light switch on to make you appreciate situations differently"*

Other comments spoke against the benefits of other ways of learning:

> *"I have read some self-help books on developing relationships and communication skills but haven't really learnt anything new."*

Given that most people had learned by using two or more ways, the implication was that a combination of methods was effective and valued by many pharmacists. While a few study respondents had not learned by any methods other than everyday experience, it was not clear whether they had tried other methods and found them ineffective or had never tried anything else. There were a number of difficulties with training courses, especially relating to the transfer of the learning into actual practice in the workplace:

> *"Implementing this training may not be so easy and practical"*
>
> *"Actual experience is best!"*

One comment from a pharmacist who had been practising for 30 years hinted at another aspect of this problem:

> *"It's hard for older people to change their behaviour"*

Pharmacists were already able to build successful relationships with patients in everyday practice over a long time (Anderson 2000). Learning 'how' to do something new was seen as the crucial factor for changing practice (Evans 1991, Anderson et al 2001). Learning 'what' in a structured way appeared to be the starting point for applying this to practice, and by trial and error over time, the new method could be refined and incorporated into standard and automatic procedures on an everyday basis in the workplace. Watching experienced colleagues in the workplace took advantage of the real social context (Brown et al 2006).

The literature provided a number of studies where pharmacists benefited significantly from training (Addison 2005, Cleland et al 2007), as well as nurses and doctors (Clark et al 1998, Booth et al 1999, Wilkinson et al 1998, Wilkinson et al 1999, Suikkala & Leino-Kilpi 2001, Bowles et al 2001, Chan et al 2003, Arranz et al 2005). The literature about

training courses also supported the view that the most effective methods were based on experiential learning, such as demonstrations, videos and role plays. The benefits of practice in real situations after attending training courses that presented particular techniques to use, was also highlighted (Cleland et al 2007, Heaven & Maguire 1996, Suikkala & Leino-Kilpi 2001, Feinmann 2002, Maguire & Pitceathly 2002, Chan et al 2003, Greene & Burleson 2003, Thompson et al 2003, Kurtz et al 2005, Addison 2005). The closer the learning activities were to real life, the more acceptable they might be for experienced people (Rollnick et al 2002).

On the other hand some of the literature reported adverse attitudes towards training for relationship building skills for doctors (Feinmann 2002). Their comments indicated that communication was something that you could either do or not do, and no amount of training or study could change this.

The fact that there were so many books available suggested that there was a viable commercial market for these texts (Tindall et al 1984, Warden-Flood 1987, Rantucci 1990, Meldrum 1994, Quintrell 1994, Sigband 1995), and in this way the literature review supports the conclusion that pharmacists did undertake reading or self directed learning using these resources. The popular press was also a source of interesting patient narratives that were entertaining as well as informative and insightful (Fiu 2006, Torpie 2005).

Relationship building was part of everyday social activities, and people learned this with family and friends as well as in the workplace when they are adults. Learning from real life in this way was the predominant factor involved with the study data. One key element with learning from everyday experience was the inherent trial and error nature of the learning process. If a mistake was made, reflection on the reality of the situation and the serious repercussions on health and business outcomes was a strong motivator for improvement. Watching other people was valued by study respondents and this appeared to be a way of learning that avoided some of the pitfalls inherent in learning by trial and error. It was seen as important to have keen observational skills to make the most of the real-life role model you were observing.

Consideration of the study findings and the literature suggested that the challenge with training courses and reading was to transfer theoretical knowledge into the applied setting. Development of this theme led to the conclusion that training courses or reading could only provide theory and that the real learning only happened in the actual practice or workplace setting. Reflecting this point, some respondents identified the benefits of training as a place to start, by raising awareness of the ways improvements could be introduced into practice. On the other hand, learning about the wrong way of proceeding, contrasted to what was considered right, was another useful learning technique, although simulations or demonstrations were probably a more appropriate method for learning this, rather than observing poor communication in another pharmacist in actual practice.

Using real people as the role models in real-life situations should be more effective for the learner compared to artificial simulations, because of the underlying factors inherent in the unnatural situation that may distract from the task being undertaken. The generally held belief that body language played a greater part in communication than verbal conversation was considered. If a person was pretending to be someone else for a demonstration, they would be unlikely to have accurate or true body language to support the words they were using. Without this congruence they would be likely to be sending out mixed messages which would confuse, mislead, and therefore hinder learning. Actual situations would therefore provide the best context for real learning. Gaining experience in how people actually respond to certain questioning styles could also only be observed in real life. A simulation could only provide a suggestion of this reality, unless the people acting were highly skilled, and this would be unlikely within low budget pharmacy training programmes. Another comment on using real people from different cultures to learn about cross cultural issues underlined the importance of learning from authentic situations.

The high frequency of respondents learning relationship building from everyday experience had the added factor that it was probably unavoidable if working in a pharmacy. Pharmacists would be learning to build relationships simply by trying to remain employed or by focusing on building their business. Improved patient health would be an additional benefit, as well as personal job satisfaction. A pharmacist would not need to focus on generating self motivation to practise, if real-life experience was

occurring without any conscious decision being taken to do so. Again, the issue of a desire to improve needs to be raised, otherwise the experience may not be reflected upon and no progress would be made.

While the study findings indicated that training courses and reading were considered useful by many people responding, it cannot be assumed that this represented a majority of the whole of the pharmacy profession. Pharmacists who valued communication courses or reading might have been more likely respond to the questionnaire, and thus created an inflated proportion with this opinion.

Time

The third major theme was time. Building quality relationships takes time. The time dimension cannot be underemphasised, because it was a recurring theme in the study participants' responses to a number of the questions. Time stretched to an overarching long term dimension for relationship building:

> *"In some instances trust is built over time, not minutes or hours, sometimes weeks and even months."*

The long term view also included learning to build relationships:

> *"It is an ever-evolving process"*
>
> *"Obviously over time you gain a wide experience of different situations when dealing with the public and you apply your knowledge based on previous experience"*

The short term view examined the amount of time available each time the two parties were interacting with each other. Both patient and pharmacist needed to have time for the interaction. Pharmacists would avoid rushing when consulting with a patient so that the patient would feel important.

> *"Impatience is our worst enemy."*
>
> *"Taking time to listen to patients and giving helpful advice"*

Pharmacists also strived to be available when they were needed:

> *"Always being accessible"*

There was also the recognition of time as a constraining factor working against relationship building, whether it was workload pressure because of funding, reduced frequency of pharmacy visits by the patient because of 'stat' dispensing and even the

time needed to attend a training course. Comments illustrating the risk to patient safety when there was insufficient time emphasis the important of taking time to communicate well:

"Misunderstanding may occur if interaction is rushed"

The importance of time for building relationships was referred to throughout the literature. The transformation over time of the initial rapport into a trusting relationship was mentioned by several authors (Rantucci 1990, Sigband 1995, Clark & Gong 2000, Suikkala & Leino-Kilpi 2001, Street 2003, MCNZ 2006, Sheldon 2005). Another way of viewing time came from Anderson (2000) who valued the strength of relationships that had already been built up over time, which indicated that pharmacists were succeeding in this activity within the traditional model of pharmacy practice that was essentially carried out 'over the counter'.

It was also reported that devoting time in the beginning of a consultation to find out all of a patient's concerns would result in a more satisfactory outcome (Maguire & Pitceathly 2002). One of the blocking behaviours listed in the literature review related to time pressures, such as spending too little time explaining things, and this was seen as a cause for complaint and dissatisfaction (Maguire & Pitceathly 2002, Tindall et al 1984).

Learning continued over time in an open-ended and evolutionary process (Sheldon 2005), as did the commitment to raising awareness of differences in culture (Brown et al 2006).

The study and literature findings suggested that sufficient time must be available or invested in the interactions with the patient so that the beneficial interpersonal qualities of the pharmacist may be observed by the patient. Repeated and consistently favourable interactions enabled patients to know that the pharmacist's interest in them was genuine and to gain confidence in being respected. A trusting relationship would eventually be developed if this situation was maintained during the series of interactions occurring over the long term.

Time also came into play in terms of the amount of time that the pharmacist was able to spend with the patient each time they visited the pharmacy. A long time spent with a

patient demonstrated that the patient mattered to the pharmacist, and this contributed to mutual regard and helped to build the relationship. In addition to time given to patients, the concept of being available for patients at any particular time they came in was mentioned. Pharmacists would need to invest in adequate staffing levels so that they could spend time with patients when they arrived. Alternatively they would need to manage their time by making an appointment if it was for a consultation or review service. Looking at timing even more closely within the flow of conversation, some respondents referred to being patient with their clients and giving them time to answer fully. Appropriate reflective listening techniques would assist with this practice, so that all of the patient's concerns could be heard before moving the consultation on to the problem resolution stage.

A further way in which time was involved in the whole process of relationships was that it took time and practice to learn how to build them in the first place and it was not something that would ever be complete. Considering everyday experience as the most widely employed method for learning relationship building, this fitted with the idea that it took a long time to learn to do it well, and that the process would continue as long as new and different people were entering the pharmacy. With time available in any course being limited, it would be impossible to learn it fully within these constraints. It was fortunate that it was possible to continue learning and refining abilities in the long term workplace situation of everyday practice. Another aspect of time in terms of training courses was that pharmacists were very busy and would have difficulty allocating time to attending a training course, especially a long term course of study. On the other hand it was important to recognise that essential skills for relationship building would be of value and worth spending time learning.

Relationships Matter

The fourth and final theme emerging from this study was that building pharmacist-patient relationships was essential for success.

> *"Traditional pharmacy has gained huge respect and trust from the public by building relationships"*

The benefits linked to patient healthcare, pharmacist satisfaction and pharmacy business survival. Patient safety, as well as improved health outcomes, were to be

gained by building effective therapeutic relationships so that patients would feel comfortable revealing personal information about their success or difficulties with their treatment regimen:

> *"Detects ADRs [adverse drug reactions] and unwanted side effects that patients may not want to bother the doctor with"*

Having a caring attitude towards patients would improve the quality of your service and patients would appreciate your efforts and diligence, resulting in personal satisfaction:

> *"Deliver great service > greater job satisfaction"*

As with any business, relationships with customers were an important part of effective management principles that would boost the customer base and increase profitability.

> *"Highly important, for business relationships build loyalty"*

Referring to the learning process, respondents emphasised the imperative nature of commitment to continually improving skills for building relationships:

> *"Essential to keep working on it – you cannot simply learn it from a training course"*

The literature review supported the concept that relationships mattered especially within the healthcare consultation, as detailed in the Calgary-Cambridge model. The relationship was called "the cement that binds the consultation together" (Silverman et al 2005, Kurtz et al 2005). Relationship building was as important as the structure of the interview and integrated throughout the whole consultation. The elements contributing to the relationship building process were placed into three groups, namely interpersonal sensitivity, patient's viewpoint and partnership building. These were seen as fundamental parts of the relationship. Many authors referred to elements within these three groups, as discussed above in this chapter in the section on interpersonal sensitivity (Tindall 1984, Rantucci 1990, Quintrell 1994, Sigband 1995, Street 2003).

The literature also reported on a number of studies that showed that patient health outcomes were improved when health providers used a patient-centred approach where the patient felt heard and valued (Worley-Louis 2003, Clark et al 1998, Stewart et al 2000, Lewin et al 2001, Thomas & Pollio 2002, Street 2003). The other benefits of good relationships that were mentioned in the literature were provider-oriented factors such as improved job satisfaction and self-esteem, less likelihood of being sued and reduced emotional burnout for doctors (Greene & Burleson 2003, Street 2003, Feinmann 2002).

The study data placed significant emphasis on the fact that relationships were essential to the practice of pharmacy in more ways than one. While improvements in patient health outcomes were considered to be the prime focus, good relationships would also benefit the pharmacists, the pharmacy businesses and the profession as a whole.

The inclusion of relationship building in the Medicines Use Review competence standards and the Calgary-Cambridge model used in the training course added further support to the importance of relationships for the pharmacy profession. Given that the relationship was such a fundamental part of the whole consultation, it was crucial that training in these skills was taken up by pharmacists wishing to carry out efficient and effective reviews with patients. They needed to learn how to be thorough with their consultation, and find out all of a patient's concerns and expectations in order for the relationship to be created in a sustainable manner. Because the Pharmacy Council had consulted widely when preparing the Medicines Use Review competence standards, this indicated that the pharmacy profession as a whole considered relationships to be essential to the consultation process involved in Medicines Use Reviews.

Given that relationships with patients play a crucial and fundamental part of the whole profession, it is also essential that pharmacists learn to develop them well and become motivated to seek improvements in the manner of life-long learning, where there is always further scope for refinements and additional practice.

Overview

Being a "people-person" was considered to be of great benefit in building relationships with patients, and this was seen as an innate ability. A number of qualities and attitudes comprising interpersonal sensitivity were identified as important for successful relationship building, although there was no conclusion about whether any of these could be improved with practice. I suggested that an underlying desire to help patients was an important factor in changing attitudes. It was considered beneficial to learn about different personality types in order to adjust your style of communication and improve relationships. Cross cultural sensitivity was seen to depend upon treating all people with equal respect and attention.

Pharmacists gained their skills for building relationships with patients during everyday experience in the workplace as well as with family and friends. On the job training in real life situations was the most effective way of learning, including observing others and learning by trial and error. The importance of listening was stressed as well as asking the right questions. Other beneficial learning opportunities included training courses, reading and, to a lesser extent, self-directed study. Learning methods of most value were ones with a practical orientation, such as role play simulations, although the application of this learning in practice was seen as a difficult and ongoing process. Most participants in the study thought that they could still learn more about building relationships, even though many of them had already attended training. The greatest benefit from courses was considered to be raising awareness although some of the respondents and authors raised doubt about whether this would be transferred to benefit in practice.

Another important theme to be discussed was that of time, as there were several ways that time was involved. Relationships took time to develop, in terms of duration of each visit and the frequency of visits. Learning to build the relationships also took time. The practical constraints against having time needed to be managed in order to provide the opportunity for relationship building.

The final theme emphasised that building pharmacist-patient relationships was essential for success in terms of patient healthcare, as well as pharmacist satisfaction, pharmacy business survival and the development of the pharmacy profession overall. Clearly, relationships mattered in pharmacy.

The next and final section, Chapter 6: Conclusion, draws together the study findings and develops proposals for further work in the future.

CHAPTER 6: CONCLUSION

Summary

Relationships with their patients mattered to pharmacists. They thought it was an essential part of the service they provided and had a number of benefits. They considered that it was important to genuinely care for their patients and to be motivated to meet every patient's expectations. Factors that supported the building of relationships with patients included personal qualities such as being friendly and showing respect, as well as using appropriate questioning and listening techniques to demonstrate the friendliness and respect intended. Having a naturally outgoing personality was seen as an added bonus. Recognition of diversity among their patients was an ongoing challenge to pharmacists. Relationships would be improved by having a warm and respectful approach to all individuals, and by a commitment to gain understanding no matter how difficult that may turn out to be.

> *"Pharmacy is all about building relationships with people and you must be enthusiastic and like dealing with people otherwise it's the wrong job for you. Its not always easy dealing with unwell people but if you show a genuine interest in people's welfare over time you build a great deal of goodwill which stands you in good stead and this is the backbone of your business."*

Learning to build relationships was seen as something that happened primarily in everyday real-life situations in the workplace and at home. Learning by watching others and by reflecting on each interaction undertaken were two learning strategies that they considered useful. Views were divided on the usefulness of training courses, reading and self-directed study. Some respondents found these to be useful starting points for learning in real-life. Others found it impossible to transfer these ideas from theory to practice. The emphasis on methods that were as close to real practice as possible was stressed and this explained the preference for role-plays, demonstrations and films as useful training methods.

The significant role of time in the whole process was a continuous thread running through all of these topics, and time was acknowledged as a precious commodity in a

busy community pharmacy. The benefits of good pharmacist-patient relationships were widely recognised and flowed between the patient, the pharmacist and the pharmacy business, in a mutually supportive cycle. If the patient was well cared for their health would improve, the pharmacist would experience job satisfaction and the financial aspects of the business would grow with an increased satisfied customer base.

Proposals For The Future

While the findings from this research project were presented here, further work has also been identified. This study has reported the importance of being friendly and polite when building relationships with patients in the pharmacy. Having a warm and outgoing personality was seen as being of great benefit to this process, making it far easier to build strong therapeutic relationships. Learning to relate to other people was seen to be something that was learned everyday at work and at home. However, a number of other questions arose that could possibly be explored in further research. Was being warm and friendly part of that learning, or an innate characteristic or quality? Was it linked to parental and social teaching as a child? Could it be learned later if it was not learned early in life? Alternatively, was this something that required a decision to behave in that way so that a simple shift of attitude or motivation would result in the desired effect?

This study revealed that asking the right questions of a patient and using reflective and empathic listening techniques was a constructive way to proceed in order to build therapeutic relationships with patients. I propose that the use of these questioning and listening techniques does create a respectful situation where the patient feels valued and that this is a significant part of being a 'people person'. I suggest that some of the aspects of being seen as friendly and polite are skills that can be learned by some people, providing there is a willingness to listen, self motivation and a desire to improve. Further research could explore this suggestion in more depth.

This study also asked the question about training courses and whether they help this process. Given that the views on this were divided, it would require further research to fully understand why these answers were given. One of the ideas hinted at by some respondents was that real life was the only way to really learn these skills. If this were accepted as the truth, it raises the question of what were the benefits of the

communication skills training courses that some people did find useful. Some people hinted at courses being a good way to highlight activities that would help build the relationship. The question then becomes why there are some people for whom this is not the case. Further research could interview pharmacists to compare the viewpoints of those who did or did not find courses useful in order to understand how they differed. Some respondents in this study indicated that they considered themselves to be different to others in that they did not find the training helpful, but they could see that it was helpful for others. Unfortunately, it was not obvious whether they thought that they already knew how to do these things or whether they thought that they would never be able to change what they already do.

There was good evidence in this study and in the literature that people preferred to learn aspects of communication using teaching methods that were closely aligned to actual practice situations. Given that the most difficult part of learning such skills was to transfer the theoretical learning to the practical situation, the idea of using learning tasks that were close to real life appeared reasonable. The study results and the literature supported this viewpoint by preferring demonstrations, simulations, films and audio-recordings with reflective self-critique and feedback. Learning exercises that were based on clinical situations that may be encountered in real practice would place the learning in context, and provide a sense of reality by requiring integration of the communication techniques with clinical management procedures. Further studies could add to the knowledge of effective teaching practices.

The literature on changing process behaviour patterns suggests that thinking routines need to be realigned to the new procedure and that this is a very challenging task. However, a willingness to learn should enable improvements of some magnitude, no matter what age the person is. The research with a group of doctors by Chan et al (2003) did show that this was possible. Alternatively, as new pharmacy graduates are trained with the new curriculum that includes the principles of patient-centred care, they will become adept at these relationship building skills at an early stage. They would not be trying to change well entrenched behaviours. Over time, a new generation of pharmacy professionals would make up the workforce, and additional post-graduate training would not be needed to make up for shortcomings in the undergraduate training that pharmacists had received. Assessment of competence in relationship building is a

difficult concept to bring into a practical situation. Further study could explore ways of achieving this and of ensuring that all pharmacists are practising at a competent level.

A profession-wide forum for spreading the word about the importance of relationship building would be a useful way to promote this message to the existing pharmacy profession. The Pharmacy Council of New Zealand and the Pharmaceutical Society of New Zealand publish regular newsletters that may provide a suitable vehicle to broadcast the message from this research. There are currently two New Zealand based pharmacy sector journals that could be approached to print items supporting this aim. Articles could also be submitted to the international pharmacy education and practice journals.

On a local level, I suggest that pharmacists should reflect on their learning needs with respect to building relationships with patients. Pharmacy owners could encourage their staff members to reflect on their abilities. Local peer support groups could discuss what type of learning about relationship building they have already undertaken and what they learned from that experience. In these ways, pharmacists may become aware that there are new ideas being proposed for the development of patient-centred pharmacy practice that could benefit their patients, themselves and their businesses. Pharmacists acting as preceptors who supervise the work of the new pharmacy interns undertaking their first year of practice with them in their pharmacies are becoming aware of some of the patient-centred care principles that apply to the intern assignments. Knowledge of the benefits of relationship building will gradually spread, as well as the types of useful communication and consultation skills that are an important part of the new Medicines Use Review training course.

If I were to consider this research question again, I would be interested to explore the process of learning to build relationships with a small number of pharmacists using an interviewing technique that would allow a deeper understanding of the process of learning to build the relationship itself, thus providing some explanatory findings. This could also help explain the differing views about the benefits of courses. The lack of time available in this present study meant that this was not possible in this project. It would also be useful to elicit patients' viewpoints about relationships with pharmacists, in order to explore the relationships from the other side of the encounter.

Possible questions for future research could be linked to analysis of real dialogues with patients. This technique could be used to determine whether pharmacists spend time specifically building rapport with patients, reflecting patient feelings, acknowledging viewpoints and beliefs. They could be studied to see if they express an acceptance of the patient's beliefs, thereby demonstrating empathic understanding. This could be assessed with new patients and also regular patients who are already known. It could be situated in over the counter interactions or within review consultations using a longer time frame. One issue that an audio method does not address, however, is that of the associated body language and the sense of warmth that is felt by the patient. Perhaps use of film would avoid this shortcoming, although evaluation of the study data from both verbal and non-verbal viewpoints would be very challenging. The effect of time might reveal improved skills as learning in practice proceeded or it might reveal the loss of learned skills and reversion to old habits. This would involve considerable time and effort to gather this style of detailed data, but might clarify the relationship between new knowledge of techniques and the actual implementation of these skills in practice.

Conclusion

New developments in pharmacy services take pharmacists into a direct patient care environment. The traditional style of communication that involved giving instructions and advice is no longer sufficient for these new consultation styles of practice. These new ways of working require pharmacists to upgrade their knowledge, skills and attitudes in order to provide services that meet the specified competence standards. Professional and ethical responsibilities need to be acknowledged and an effort made to reach these standards. How this is achieved will depend on the individual pharmacist's preferences, although in some cases accreditation processes will dictate attendance at particular courses.

Great emphasis is now placed on patient-centred care as the best practice model for pharmacy and healthcare in general. While I agree that this focus is an improvement on the traditional provider-centred situation, I believe further development of this idea will be beneficial. I suggest that the relationship is even more important, and this involves both the patient and the pharmacist at the same time. The contribution the pharmacist makes to the relationship building process is fundamental to the quality of the relationship

formed and this in turn provides the patient with the opening to participate fully in interactions with the pharmacist. This places the methods that the pharmacist uses to communicate as one element to be developed, but also recognises the importance of the attitudes and personal qualities that are an inherent part of the pharmacist's makeup. I believe useful methods and techniques for communication can be taught and learned. However, the effect of attitudes, motivations, personal qualities and styles is more complex. I suggest that awareness of the impact of these factors is crucial to the pharmacist deciding whether they wish to change how they relate to the world. If they are not motivated to change, then there would be no progress. This assumes that they are obliged to change, and I suggest that professional competence is related to honoring the responsibility that comes with the power of professional status. It is an ethical principle to strive towards patient benefit. I believe pharmacists should be motivated by genuine interest in their patients' welfare and hold a caring attitude to be considered professional.

Effective communication achieves things. So if we wish to achieve particular results we need to communicate effectively. I believe that effective communication is about sharing understanding with someone. The issue is then whether we can know if we are being understood and if we are grasping what is meant by the other person. If we have similar values and beliefs to the other person this will improve the chance of us understanding each other, because our conversation will be built on the same underlying assumptions. There will be a common history that links our thinking together. There are many different cultures involved in social groupings and these will provide a ready source of common ground that will facilitate communication and understanding. It may be living in a certain area that provides common interests and a sense of understanding, based on shared knowledge and social values.

Pharmacists are trained to assist patients to manage their health in the most effective way and therefore enjoy the best quality of life that is possible. If patients fully understand their treatment options they will be able to manage more effectively. If pharmacists build relationships with patients that empower them to manage their health more effectively, this vision may be achieved. I believe that relationships may be improved if pharmacists are aware of all the factors influencing the relationships. While some people may simply have a sheer natural talent for communicating and picking up

these skills, others may really have to work at building relationships. Also while some aspects may occur naturally, other aspects may be improved with increased awareness.

This study has revealed that relationships grow during everyday experience in response to a sincere attitude, genuine interest, and a warm personality. The process is improved when empathic understanding is a feature of the conversation, and when it is built on common ground and given ample time to develop. Training can give ideas about how to build initial rapport and increase understanding of personality types. The best methods are experiential, such as role-plays, simulations and demonstrations, but the learning still comes from continued practice over time in the real context of pharmacy practice. Attitudes and motivation based on a desire to improve seem to be essential for perseverance and eventual success.

This project has confirmed my perception that some pharmacists have found training in communication skills very useful while other pharmacists have not found any benefit at all from training sessions. This study has not clarified whether prior attendance at courses influences this opinion, only that some pharmacists seem open to learning from focused training and others not. It would need further research to understand why this was so.

Pharmacist-patient relationships are crucial to the delivery of health information and also to the empowerment of patients for taking responsibility in managing their health. Time for this relationship building needs to be funded as it is with Medicines Use Reviews, so that pharmacists can develop and utilise their skills in the workplace. Pharmacists need to be aware of beneficial interpersonal skills in order to optimise their relationships with patients and to understand the importance of maintaining self-motivation for improvement in an ever-evolving manner. Even though this will not be welcomed by some individuals, pharmacists also need to be encouraged to participate in training courses and reading, as a prelude to implementing new concepts and improving their practice:

"By introducing better practice techniques,
I have received positive patient feedback..."

CHAPTER 7: REFERENCES

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APPENDIX ONE:
PHARMACY COUNCIL COMPETENCE STANDARDS

These are selected standards that cover communication and relationships with patients.

Competence Standard 1: Practise Pharmacy in a Professional Manner

Element 1.6 Communicate effectively

1.6.1 Speaks clear English

Examples of Evidence:
Speaks English equivalent to at least overall band 7.5 on the Academic Category of the International English Language Testing System (IELTS), with no less than 7 in each band.

1.6.2 Writes clear English

Examples of Evidence:
Writes English of a standard expected of a professional practitioner, e.g. correct grammar & spelling
Structures & presents written information in appropriate way for situation & meets needs of the receiver, e.g, faxes, emails, prescription annotations, letters, memos, referrals & appraisals

1.6.3 Communicates effectively with others

Examples of Evidence:
Communicates effectively with others (pharmacy staff, colleagues, other health professionals, patients & other members of the public)
Listens actively
Asks questions that fit the situation
Provides advice, information & recommendations

Competence Standard 2: Contribute to the Quality Use of Medicines

Element 2.6 Communicate effectively

2.6.1 Communicates verbal and written information fit for the receiver

Examples of Evidence
Uses language fit for the receiver, e.g avoids unnecessary technical jargon
Uses questioning & listening skills effectively
Explains clinical & medicine information clearly

2.6.2 Communicates effectively with prescribers and other health professionals

Examples of Evidence:
Uses questioning & listening skills to elicit information
Communicates clearly with individual health professionals
Provides medicine information & recommendations in format fit for the situation: letters, faxes, emails & verbally by telephone or face-to-face

2.6.3 Communicates effectively with patients

Examples of Evidence
Uses questioning & listening skills to elicit patient history information
Explains clinical & medicine information clearly
If necessary uses aids to ensure patients understand information,
e.g language cards, videos, large print labels and Braille cards.

Competence Standard 3: Provide Primary Health Care

Element 3.8 Communicate effectively

3.8.1 Establishes rapport with the patient.

Examples of Evidence:
Uses body language to establish empathy & rapport
Uses open & approachable body stance, facial expression
Respects individual & cultural differences

3.8.2 Uses active listening techniques and asks questions relevant to the situation

Examples of Evidence:
Is attentive to patient and asks relevant questions in a logical sequence
Paraphrases to confirm & clarify information from patient

3.8.3 Tailors information to fit the patient and the situation

Examples of Evidence:
Adapts information for patient's level of comprehension & avoids technical jargon
Uses varied formats (e.g. verbal & written information, physical demonstration, diagrams/pictures, placebo devices) to best fit patients' needs

3.8.4 Checks patients' understanding

Examples of Evidence:
Listens, questions & interprets body language to ensure understanding
Gets patient to demonstrate or explain the treatment or advice
Asks patient to repeat back information if necessary

Competence Standard 5: Research and Provide Information

Element 5.5 Communicate effectively

5.5.1 Responds to queries and requests for medicines and health care information

Examples of Evidence:
Listens and interprets information from enquirer e.g. paraphrases to ensure request is understood
Asks questions to elicit all the information
Agrees on time frame for response

5.5.2 Communicates verbal and written information fit for the receiver

Examples of Evidence:
Avoids technical jargon when talking with patients
Provides information fit for situation: letters, faxes, emails & verbally by telephone & face-to-face

5.5.3 Communicates effectively with other health professionals and patients

Examples of Evidence:
Communicates clearly with individual health professionals to pass on information
Explains information clearly to patients & if necessary uses additional aids
e.g. language cards, videos, interpreters, large print labels & Braille cards

Competence Standard 6: Dispense Medicines

Element 6.10 Counsel patients about their medicines

6.10.1 Ensures patient receives the correct medicine

Examples of Evidence:
Check patient details, e.g. name & address.

6.10.2 Ascertains patients' understanding of their medicines

Examples of Evidence:
Talks with/questions patients to find out their understanding of medicines purpose & compliance

6.10.3 Informs and advises about medicines

Examples of Evidence:
Explains indications for use & benefits of medicines
Advises on dosage, storage, alterations in formulation/packaging, different brands supplied on genericrequest medicines
Advises about precautions & adverse effects without alarming patients
Advises on frequency; relationship to food & duration of therapy
Provides written information, e.g. pamphlets, self care cards

6.10.4 Demonstrates the correct method of administering medicines

Examples of Evidence:
Provides compliance aids if necessary, e.g. asthma spacers; tablet cutter
Provides verbal & written information & physical demonstrations to explain special techniques for using:
- inhalers, ear, nose & eye drops, nasal & oral sprays, suppositories & pessaries
- creams, lotions, patches & dressings
- cutting/dissolving tablets

6.10.5 Check patients' understanding of the advice and counselling

Examples of Evidence:
Listens attentively or questions patient to determine understanding
Gets patient to repeat information to ensure understanding

6.10.6 On request informs and advises patients about their conditions & diseases

Examples of Evidence:
Ascertains patients' understanding of their conditions/diseases
Provides verbal & written advice, e.g. pamphlets, self care cards

Element 6.11 Communicate effectively

6.11.1 Communicates effectively with prescribers

Examples of Evidence :
Uses questioning and listening skills to elicit information
Clearly communicates proposed prescription changes and recommendations

6.11.2 Uses language and non-verbal communication to suit the patient

Examples of Evidence:
Talks to patients in lay terms, avoiding technical jargon
Uses gestures, voice tone, stance, & facial expressions to suit situation & patient

6.11.3 Tailors information to suit the patient

Examples of Evidence:
Adapts information to suit patient's comprehension level
Uses varied formats to provide information in a way that suits patients' needs,
e.g. verbal, physical demonstration, written, pictorial, models & placebo devices

6.11.4 Asks relevant questions

Examples of Evidence Guide:
Uses questions to check patient understands advice & counselling
Listens attentively to response

Competence Standard 7: Prepare Pharmaceutical Products

Element 7.5 Communicate effectively

7.5.1 Writes in clear English

Examples of Evidence:
Produces all labels, records & instructions in clear legible English with no spelling or grammatical errors

7.5.2 Communicates effectively with prescribers, health professionals, care givers and patients

Examples of Evidence:
Uses questioning and listening skills to elicit information
Clearly communicates proposed formulation requirements and changes with prescriber
Communicates effectively with end user of product about the use of the product, e.g. TPN administration, eye drop use

Medicine Use Review Competence Standards

MUR 2 ESTABLISH AND MAINTAIN EFFECTIVE WORKING RELATIONSHIPS

2.2 Build a relationship with the patient

2.2.1 Acknowledges patient partnership and involvement of family/whanau/caregiver
2.2.2 Takes into account patient's individual circumstances and preferences including cultural and health beliefs
2.2.3 Maintains an effective relationship with the patient and family/whanau/caregiver

2.4 Communicate effectively with the patient

2.4.1 Understands and applies the concept of the concordance/adherence model
2.4.2 Agrees and sets goals with the patient
2.4.3 Communicates accurate and relevant information to the patient in a timely manner
2.4.4 Describes the principles of consultation skills including the structure of the consultation process
2.4.5 Describes the principles in motivating and facilitating behavioural change
2.4.6 Monitors and follows up on patients appropriately

APPENDIX TWO:

QUESTIONNAIRE DOCUMENTS

Building Pharmacist-Patient Relationships

Massey University

COLLEGE OF EDUCATION
Te Kupenga o Te Mātauranga

GRADUATE SCHOOL OF EDUCATION
Private Bag 11 222
Palmerston North
New Zealand

Title: Building Pharmacist-Patient Relationships

INFORMATION SHEET
I wish to invite you to participate in research on building pharmacist-patient relationships.

Researcher Introduction
My name is Diane Harries and I am a student with the College of Education, Massey University. I am undertaking a research thesis for the Master of Education (Adult Education). My supervisors are Dr Linda Leach and dr marg gilling of the School of Educational Studies, Palmerston North. I am employed as the Programme Manager with the NZ College of Pharmacists,

My research question is "How do pharmacists learn to build relationships with patients and how does communication skills training contribute to this?"

Project Aims
This project aims to explore the experiences of pharmacists who have learned about pharmacist-patient relationship building and discover how they learned to do this. It also aims to discover from those who have undertaken structured training courses, such as communication skills training, whether this has helped them to learn how to build professional relationships with patients, and whether and/or how this has been beneficial for their practice of pharmacy.

Potential Benefits
If pharmacists are inspired to improve their skills and to develop better pharmacist-patient relationships, they may become more competent to provide healthcare to patients. This project may also provide guidance for improvements in methods used by trainers and learners.

Methods
Please find enclosed a questionnaire which I would like you to complete and return to me in the return stamped addressed envelope.
Two copies are provided so that additional pharmacists can participate. Please photocopy the form if there are more than two pharmacists in your pharmacy who are willing to participate.

Participant Rights
You are under no obligation to accept this invitation. It is an anonymous questionnaire.
If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask any questions about the study at any time;
- be given access to a summary of the project when it is concluded.

Background to the Topic
Patient-centred care is now considered to be the model for best practice in health care delivery, as identified in the New Zealand Primary Health Care Strategy. As a health profession, pharmacy has focused on improving the skills of its members in line with this evolving development. Recently developed competence standards for pharmacists include a number of elements relating to facets of patient-centred care, such as building relationships and communication. Changes have been made to pharmacy training programmes for interns to include these topics and optional courses are available for practising pharmacists. While the desired outcome of this training is improved relationships with patients, the courses are generally known as communication skills training.

Recently graduated pharmacists have come to accept this as a normal part of their education as health professionals, however, more experienced pharmacists may have gained expertise in this area from everyday practice in the workplace, Given that most pharmacists in New Zealand today are under pressure to work long hours, and have little spare time for continuing professional development, reluctance to undertake unnecessary training is understandable. Some pharmacists may not feel that they need training in communication skills. However, I am aware that some pharmacists found training they had done to be very beneficial, despite initially thinking that they would not learn anything new. If structured training is perceived to be of benefit to pharmacy practice, this may alert other pharmacists to new possibilities for their own professional development.

Project Contacts
Researcher: Diane Harries: vanillablue@xtra.co.nz
Phone: work: 04 802 0036 home: 04 384 3262 (week) 04 905 1408 (weekend)

Supervisors: (Massey University, School of Educational Studies, Palmerston North)
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Dr marg gilling: m.gilling@massey.ac.nz Phone: 06 356 9099 Ext 8851

Committee Approval Statement
This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 07/13. If you have any concerns about the conduct of this research, please contact Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 8771, email humanethicsoutha@massey.ac.nz.

Yours sincerely

Diane Harries

Massey University
COLLEGE OF EDUCATION
Te Kupenga o Te Mātauranga

GRADUATE SCHOOL OF EDUCATION
Private Bag 11 222
Palmerston North
New Zealand

"Building Pharmacist-Patient Relationships" Questionnaire

1. How many years have you been practising as a pharmacist? _____
2. What is your gender? (Please circle one): Male Female
3. What is your ethnicity?
4. Have you gained your relationship building skills from (please tick as many as apply to you):

   a. Training course ☐

   b. Everyday experience ☐

   c. Self directed study ☐

   d. Reading ☐

   e. Some other way ☐

   (Please specify what the other ways were)

5. Please tell me about your experiences with these types of learning in as much detail as possible: (except for training course, as there is a further question asking for precise details for that)

   (Why and how this learning was initiated, how it occurred, what resources were used, and what the outcomes were)

6. How do you usually go about building professional relationships with patients from your own culture? (Specific examples would be very helpful)

7. How do you usually go about building professional relationships with patients from other cultures? (Specific examples would be very helpful)

8. Do you think you could learn more about building professional relationships with patients?

   Yes ☐ No ☐

9. If you have undertaken a training course in relationship building or communication skills please tell me about this training

   a. How many hours of study were involved? _____

   b. What topics were included?

      i. Questioning techniques ☐

      ii. Listening techniques ☐

      iii. Building rapport ☐

      iv. Consultation skills ☐

      v. Behaviour change ☐

      vi. Patient viewpoint ☐

      vii. Cross cultural communication ☐

      viii. Other (please specify)_____

c. Which topics were most beneficial to your practice and why?

d. What teaching methods were used? (Please tick as many as apply to you):

i. Lectures ☐

ii. Reading ☐

iii. Demonstrations ☐

iv. Role play in pairs ☐

v. Role play in front of class ☐

vi. Other (please specify)

e. How effective was this method for your learning?

10. How has this learning improved your pharmacy practice and/or the quality of the relationships you build with patients?

11. Please add any other comments that you may have

a. about learning to build relationships with patients

b. about undertaking communication skills training

c. about the issues and benefits of building relationships with patients.

Please attach more sheets of paper if the space provided is insufficient.

Many thanks for participating in my research and completing this questionnaire.

Please return the completed form in the stamped addressed envelope provided or send to Diane Harries, PO Box 11 640, Manners Street, Wellington 6142.