“I haven’t even phoned my doctor yet.” The advice giving role of the pharmacist during consultations for medication review with patients aged 80 or more: qualitative discourse analysis

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Objective To explore the advice giving role of pharmacists during consultation for medication review with patients aged 80 or more.

Design Discourse analysis.

Setting Participants’ homes.

Participants Subsample of consultations within a large randomised trial of home medication review among patients aged 80 or more who had been admitted to hospital.

Main outcome measures Extent to which advice given by pharmacists was accepted and acknowledged by patients.

Results Pharmacists found many opportunities to offer advice, information, and instruction. These advice giving modes were rarely initiated by the patients and were given despite a no problem response and deliberate displays of competence and knowledge by patients. Advice was often resisted or rejected and created interactional difficulties and awkward moments during the consultations.

Conclusions The advice giving role of pharmacists during consultations with patients aged 80 or more has the potential to undermine and threaten the patients’ assumed competence, integrity, and self governance. Caution is needed in assuming that commonsense interventions necessarily lead to health gain.

INTRODUCTION

The UK government white paper “Choosing health” proposes an approach to healthier lifestyles that involves people making healthy choices through the provision of increased access to information and low intensity interventions and support services. The new community pharmacy contract offers a raft of wide ranging activities. Medication review is one such enhanced service. Medication review is described as a cornerstone for the management of modern medicines and is recommended by the national service framework for older people and by the National Health Service plan.

In practice the changing role of the community pharmacist in the United Kingdom is uncertain and under researched. Despite the pharmacy being the most often visited healthcare outlet and viewed as ideally placed between lay and professional networks, pharmacists are still ultimately viewed as shopkeepers and dispensers of medicines. Furthermore, the role of the community pharmacist as advice giver or drug counselor is ill defined and diverse. Little training exists for these new roles and even less in-depth research has been done into the implications of this new philosophical approach to the work of community pharmacists and its effect on relationships between healthcare professionals and patients.

The literature on doctor-patient communication has a strong evidence base to suggest that good communication skills in the consultation have a significant positive effect on patient satisfaction and healthcare outcomes such as adherence. A growing body of knowledge also shows that these skills can be taught. Research shows that patients’ reception of advice is influenced by the conversational environment in which the advice is delivered. Premature advice that is given without any previous questioning of the client about the topic or without any attempt to elicit the patient’s perspective is often not picked up or acknowledged by the patient and is often rejected.

We previously evaluated whether domiciliary medication review affects hospital admission rates and quality of life among people aged 80 or more. The trial produced the counterintuitive finding that the intervention was associated with increased hospital admission and home visits by general practitioners and did not significantly improve quality of life or reduce the numbers of deaths. We report on a
qualitative element of the trial that focuses on the medication review consultation. This element was built into the original trial proposal from its inception. Using in-depth interviews and discourse analysis techniques we explored the ways in which pharmacists and older patients engage in the medication review consultation.

PARTICIPANTS AND METHODS

We invited patients recruited to the HOMER (home based medication review by pharmacists) trial between October and December 2002 to take part in the additional study. Twenty nine of 758 eligible participants with an abbreviated mental test score of eight or more (88.7% of the trial sample) were recruited.

Eleven of the 22 review pharmacists recruited to the parent trial expressed an interest in taking part in the substudy. Seven took part in the 29 observed and taped consultations and four were excluded for reasons of distance, availability, or matters concerning their patients. Six of the pharmacists were women. The pharmacists did not know the patients before visiting them as they were not necessarily from the same locality. They were all working as community pharmacists and were paid on an ad hoc basis to provide the medication review service. They had a minimum of 15 years’ experience (range 15-40) and at least one postgraduate qualification each (table 1). All pharmacists participated in a two day training course, including lectures on adverse drug reactions, prescribing in elderly people (aged 80 or more), improving concordance, and communication skills.

Sample selection was essentially pragmatic and dependent on the availability of review pharmacists, the researcher (CS), and the agreement of patients, during the fieldwork period (97% of those approached agreed to participate in this substudy). Participants were representative of the parent trial (table 2). Sample saturation was judged to have been reached when no new styles of consultation were witnessed and when each of the seven review pharmacists had each done a minimum of three consultations. Patients gave informed written consent.

One researcher (CS), a social scientist, observed, taped, and transcribed the 29 medication review consultations. She noted down any non-verbal cues, facial expressions, and body language. Participants were revisited by CS within a month of the original consultation to collect data on their perceptions of the encounter. In-depth interviews were carried out with the pharmacists before and after the medication review consultation. In addition, formal feedback meetings with the pharmacists followed by focus group discussion, enhanced validation of the analysis and findings. Meetings once every two months with an advisory panel ensured constant discussion of the credibility of the research process and its findings. One to one monthly supervision between CS and KH ensured the analysis stage involved iterative and rigorous procedures. This three pronged approach to data collection increased the trustworthiness of the data and subsequent analysis.20

ANALYSIS

CS transcribed and examined the transcriptions and field notes by hand. The transcription conventions adopted were those of Jefferson (box 1).21

Discourse analysis is a methodological approach that can be used in the study of communication in healthcare consultations. Activity type analysis permits the identification of characteristic forms of talk such as advice giving.22 Fine grained analysis of the conversational properties of the consultation enabled recognisable patterns of awkward or critical moments to be identified. We highlighted instances where the

Table 1 | Baseline characteristics of pharmacists in primary trial and qualitative study. Values are numbers (percentages) unless stated otherwise

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Primary trial (n=22)</th>
<th>Qualitative study (n=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>13 (59)</td>
<td>6 (86)</td>
</tr>
<tr>
<td>Mean (SD) age (years)</td>
<td>41.8 (7.4)</td>
<td>43.4 (5.2)</td>
</tr>
<tr>
<td>Mean (SD) years since first registration</td>
<td>17.4 (8.2)</td>
<td>22.5 (5.8)</td>
</tr>
<tr>
<td>Higher qualification after registration:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma, masters degree, or PhD</td>
<td>7 (32)</td>
<td>4 (57)</td>
</tr>
<tr>
<td>Postgraduate certificate only</td>
<td>10 (46)</td>
<td>2 (29)</td>
</tr>
<tr>
<td>Main employment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community pharmacist</td>
<td>12 (32)</td>
<td>5 (71)</td>
</tr>
<tr>
<td>Locum community work</td>
<td>3 (14)</td>
<td>2 (29)</td>
</tr>
<tr>
<td>Hospital pharmacist</td>
<td>5 (23)</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>2 (9)</td>
<td>1 (14)</td>
</tr>
<tr>
<td>Previous experience:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication review</td>
<td>13 (77)*</td>
<td>4 (57)</td>
</tr>
<tr>
<td>Home visit†</td>
<td>5 (29)</td>
<td>2 (29)</td>
</tr>
</tbody>
</table>

*Data on 17 pharmacists.
†Not including delivery of drugs or supply of oxygen.

Table 2 | Baseline characteristics of participants in primary trial and qualitative study. Values are numbers (percentages) unless stated otherwise

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Primary trial (n=855)</th>
<th>Qualitative study (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>534 (62.4)</td>
<td>18 (65)</td>
</tr>
<tr>
<td>Mean (SD) age (years)</td>
<td>85.5 (4.0)</td>
<td>83.3 (3.1)</td>
</tr>
<tr>
<td>Living alone</td>
<td>531 (61.1)</td>
<td>21 (65.5)</td>
</tr>
<tr>
<td>Mean (SD) abbreviated mental test</td>
<td>8.9 (1.5)</td>
<td>9.2 (0.7)</td>
</tr>
<tr>
<td>Mean (SD) total No of drugs</td>
<td>6.3 (2.6)</td>
<td>6.7 (2.6)</td>
</tr>
<tr>
<td>Monitored dose system</td>
<td>152* (18.6)</td>
<td>9 (31)</td>
</tr>
<tr>
<td>Social class†</td>
<td>333‡ (42)</td>
<td>11 (37.9)</td>
</tr>
<tr>
<td>Baseline diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>278 (32.5)</td>
<td>10 (34.5)</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>126 (14.7)</td>
<td>8 (27.6)</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>101 (11.8)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>97 (11.3)</td>
<td>4 (13.7)</td>
</tr>
<tr>
<td>Neurological</td>
<td>65 (7.6)</td>
<td>2 (6.8)</td>
</tr>
<tr>
<td>Other</td>
<td>188 (22.0)</td>
<td>5 (17.4)</td>
</tr>
</tbody>
</table>

*Data on 817 patients.
†I, II, or IIIInm.
‡Employment details available for 793 patients.
Box 2 | Conversational attempts to resist advice

1. Ph 05. Have you had any changes since you’ve been into hospital
2. Pt 04. What medication
3. Ph 05. Hhm
4. Pt 04. No still the same things as I said to you the only thing they give
5. Pt 04. me is hhm=
6. Ph 05. =Paracetamol
7. Pt 04. Because I do take co-codamol=
8. Ph 05. =You do
9. Pt 04. Yes from the doctors
10. Ph 05. Do you know that you can’t take the two together
11. Pt 04. Oh I don’t take the co-codamol at the moment
12. Ph 05. You don’t=
13. Pt 04. =No= 14. Ph. =Do you take these (paracetamol)=
15. Pt 04. =Yes not while I’ve got those=
16. Ph 05. =So you know that its either one thing or the other=
17. Pt 04 =Yes they did tell me at the hospital
18. Ph 05. How many would be a maximum of these
19. Pt 04. Well I was having four a day when I first went in with the pain
20. Pt 04. in fact I kept on having an injection as well but as its eased off I
21. Pt 04. take two in the morning and then two at night before I go to bed
22. Ph 05. Well the maximum is eight in twenty four hours
23. Pt. 04 Yes I know I do know yes I wouldn’t do any more than that=
24. Ph 05. =You have to be careful with paracetamol as you already realise
25. Ph 05. because co-codamol contains paracetamol and=
26. Pt 04. =Yes I have read all the leaflets because you know=

The patients adopted a variety of conversational strategies, including direct or indirect challenges to the pharmacists’ authority and knowledge boundaries.

Patients’ knowledge and experience as a challenge to the pharmacists’ advice giving role

Conversational attempts by the patients to resist advice included assertions of knowledge and experience. The extract in box 2 illustrates an interrogative sequence of the type that was common during the consultations. A key concern of the pharmacists was over use of analgesics. The sequence begins with the pharmacist asking if the patient has had any changes to her medication. On discovering that the patient has been prescribed both paracetamol and co-codamol the pharmacist asks whether the patient knows she cannot take both together (line 10). The patient says “oh I don’t take the co-codamol at the moment” (line 11), thereby effectively brushing the pharmacist’s question aside. The pharmacist, however, continues cross examining as well as inserting advisory caveats, thus creating a familiar blend of question and instruction (lines 14, 16, and 18). Despite at least four attempts by the patient to reassure the pharmacist that she was not taking both drugs and to assert her competence (lines 11, 15, 17, and 19-21), the pharmacist still advises the patient “well the maximum is eight in twenty four hours” (line 22). At line 24 the pharmacist manages to impart her advice yet again saying “you have to be careful with paracetamol as you already realise because co-codamol contains paracetamol.” The patient interrupts the pharmacist’s repeated advice giving string by saying that, yes, she knows because she has “read all the leaflets” (line 26). This kind of repetitive advice giving was a familiar feature of the consultations.

Patients could also be categorical in their rejection of offers of advice. In the second example (box 3) the pharmacist asks if the patient would like to know what his medicines are for (line 7). The patient’s response is negative and categorical. It represents a rebuttal that embarrasses the pharmacist and causes interactional uncertainty (line 10).

Box 3 | Categorical rejection of pharmacist’s offer of advice

1. Ph 07. The digoxin tablets (0.3) the other tablets (0.2) the where are
2. Ph 07. they hhm (0.4) that’s it can you tell me what all of those are those
3. Ph 07. we know can you tell me what the other two are for
4. Pt 01. What those for
5. Ph 07. Yeah
6. Pt 01. Not the slightest idea
7. Ph 07. Right (0.2) would you like (0.3) me to help you out there (2.0)
8. Pt 01. Well (0.2) I I don’t want to know what they’re for so long as I’ve
9. Pt 01. got to take them that’s all that matters=
10. Ph 07. =Right okay (embarrassed laugh) (mumbles to self checking list) (0.8)
11. Ph 07. fine okay one of the things I needed to check as well is you’ve been
12. Ph 07. taking these tablets (0.2) hhm (0.4) how have you got on with them have
13. Ph 07. you had any problems with them at all
14. Pt 01. No my dear

RESULTS

The medication review consultations lasted an average of 45 minutes each. The results showed a uniform shape to the consultations. A strong mode of talking or discourse of advice giving was identified. It was during many of these identified episodes of advice giving that disruptions or critical moments occurred.

The style of advice giving was essentially didactic. The pharmacists provided advice, information, or instruction on a constant basis throughout the consultation. During the 29 taped consultations almost no patient initiated requests for advice or information. On only one occasion did a patient specifically announce that he wanted to ask a question. Advice given was often unsolicited and invariably in the absence of a patient initiated problem or request for advice. It was often resisted or rejected by the patients.

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Patients’ knowledge and experience as a challenge to the pharmacists’ authority and knowledge boundaries.

Communicative competences of the participants were put under pressure. The transcripts have been selected for their representative nature and simplified for presentation and ease of reading. (Further transcripts are available from the corresponding author).
Advice was often given after an interruption by the pharmacist. This meant that the patient’s perspective was unheard and has implications for the reception and take-up of advice. In the sequence in box 4 the pharmacist offers the patient a new medicine tray. The pharmacist interrupts in several instances. The patient, despite the interruption, explains how he manages (lines 2–4). When the pharmacist makes an offer of a new tray (line 18) she receives a rebuttal, with the patient giving an emphatic “no I ain’t that far gone yet.”

Calling on the higher authority of the doctor
One of the strongest rebuttals to the pharmacists’ attempts to counsel and give advice was patients’ use of the higher authority of the doctor. Many examples existed. In one consultation the pharmacist asked the patient if he was still taking his cod liver oil. The patient announced that he would restart but only as “soon as the doctor says I can.” In the sequence in box 5 the patient consistently resists the pharmacist’s intervention and line of questioning with a dismissive “I don’t know” (lines 7, 11, and 15). The patient is a retired nurse and of a nervous disposition because of her physical frailty. Her son manages her medicines for her. Later in the consultation she reveals a wealth of knowledge and experience of medicine taking. However, in common with other patients in the study she did not want information or advice from the pharmacist. Her resistance in this extract culminates in her saying “I haven’t even phoned my doctor yet.”

Patients’ relationships with their doctors are foremost in the management of medicines. The pharmacist was often thwarted in her advice giving role by mention of the doctor. In the sequence in box 6 the pharmacist attempts to counsel the patient with advice about her swollen ankles but is met with resistance and a defensive tone. The patient blocks the pharmacist’s warning by saying that her “own doctor” will “sort out these little problems when he comes” (lines 2–4).

In box 7 the extract takes up after a sequence of advice giving about eye drops. The pharmacist had told the patient that she really ought to be using her eye drops everyday. The patient said she had not done so for a long time and saw no reason as her eyes seemed absolutely fine and that as they did not use eye drops in hospital she had concluded that they could not have been important. The pharmacist is reading through some scripts when the patient begins with praise for her doctors (line 7), particularly her general practitioner. She and her husband both state vehemently that they do not want to be seen as “rocking the boat” or seem to be complaining (lines 15–18). This provides a further illustration of how pharmacists’ intervention can have a potentially unsettling effect on patients and their assumptions about their existing healthcare network and medicines regimen.

DISCUSSION
Review pharmacists take every opportunity to offer advice and information. This advice was often resisted or rejected by the older patients in this study. Advice was often given in the absence of any stated problem by the patient and often provided even after displays of knowledge and competence by the patient. Active resistance was shown through displays of knowledge and authority as well as calling on a higher authority such as the hospital or general practitioner. Furthermore, the pharmacists’ advice giving role during the medication review consultations seemed to have the potential to undermine and threaten the patients’ relationships with their doctors (italics indicate overlapping speech).
assumed competence, integrity, and self governance. These findings complement what is already known about the difficult nature of advice giving in healthcare communication generally, specifically for pharmacists.11 12 23

Limitations and strengths of the study
The effect of the researcher as an observer is unknown. It could have an effect on the consultation and may inhibit either party. A further limitation of this study is that we only included patients aged 80 or more and it is possible that other patients may accept advice from a pharmacist. This study, however, supports the findings of the only other reported sociolinguistic study of consultations between pharmacists and patients.11 This was a hospital outpatient based study concerned with young patients with cancer and their carers, where pharmacists often give out advice and information unilaterally and patients and carers rarely ask any questions or initiate any topic changes.

The strength of this study is that observation and follow-up interviews increase the credibility and trustworthiness of the findings: pharmacists confirm the awkward nature of their advice giving task and patients regularly confirm that they have learnt little from the consultation. In addition, the same speech patterns reported in the results were manifest in interactions involving the sole male pharmacist.

This study raises several key issues for policy and practice: it shows that interventions for medication review need to develop further to ensure their relevance and usefulness; it questions assumptions about the appropriate advice giving role of the pharmacist; it shows the pharmacy professions’ need and desire for further training in communication skills; and it establishes that context and competence are important for advice giving.23

Perhaps even more important are the policy conclusions that can be drawn when the findings of this study are considered in the light of the counterintuitive findings from the parent trial: that medication review consultations raise hospital admission rates, increase the number of home visits by general practitioners, and do not significantly increase quality of life. A possible conclusion that supports other research concerned with advice giving17 24 is that misaligned advice can sow doubt in patients’ minds. This may lead to uncertainty and ultimately to a loss of confidence in a patient’s individual healthcare regimen. This study suggests that caution should be exercised in assuming that common sense interventions necessarily lead to health gain.

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**Competing interests:** None declared.

**Ethical approval:** The protocol for this study was approved by Norwich District, King’s Lynn, and Great Yarmouth & Waveney local district ethics committees.

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