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RESEARCH

"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.[1] Community pharmacists have been seen as ideally placed to deliver many of these preventive healthcare initiatives. The new community pharmacy contract offers a raft of wide ranging activities.[2] 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 underresearched.[3-6] Despite the pharmacy being the most often visited healthcare outlet[7] and viewed as ideally placed between lay and professional networks,[8 9] pharmacists are still ultimately viewed as shopkeepers and dispensers of medicines.[10] Furthermore, the role of the community pharmacist as advice giver or drug counsellor is ill defined and diverse.[11] 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.[4 12]

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.[13 14] A growing body of knowledge also shows that these skills can be taught.[14] Research shows that patients' reception of advice is influenced by the conversational environment in which the advice is delivered.[15 16] 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.[17]

We previously evaluated whether domiciliary medication review affects hospital admission rates and quality of life among people aged 80 or more.[18] 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

Box 1 | Transcription conventions[21]

Underlining—word stressed or emphasised by speaker

Single parentheses—non-verbal, contextual, or interpretive information

Double parentheses—unintelligible or uncertain transcription

Units in parentheses—pauses and periods of silence, in tenths of a second

Equals sign—no interval between adjacent utterances

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

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

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

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.[19 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.[4] 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 2 | Baseline characteristics of participants in primary trial and qualitative study. Values are numbers (percentages) unless stated otherwise

Characteristics	Primary trial (n=855)	Qualitative study (n=29)
Women	534 (62.4)	18 (65)
Mean (SD) age (years)	85.5 (4.0)	83.3 (3.1)
Living alone	531 (61.1)	21 (65.5)
Mean (SD) abbreviated mental test	8.9 (1.5)	9.2 (0.7)
Mean (SD) total No of drugs	6.3 (2.6)	6.7 (2.6)
Monitored dose system	152* (18.6)	9 (31)
Social class†	333‡ (42)	11 (37.9)
Baseline diagnosis:		
Cardiovascular	278 (32.5)	10 (34.5)
Musculoskeletal	126 (14.7)	8 (27.6)
Gastrointestinal	101 (11.8)	0 (0.00)
Respiratory	97 (11.3)	4 (13.7)
Neurological	65 (7.6)	2 (6.8)
Other	188 (22.0)	5 (17.4)

*Data on 817 patients.
†I, II, or IIInm.
‡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 those
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=

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[4]).

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. 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 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

Box 4 | Advice given after interruption by pharmacist (italics indicate overlapping speech)

1. Ph 05. Yeah okay and you're happy with the box that you are using
2. Pt 09. Yeah I can manage them (0.2) they ain't all the same some of them have
3. Pt 09. got a slide but you have to watch you don't un uncover more than one
4. Pt 09. hole=
5. Ph 05. =Yes yeah I've actually brought some with me here
6. Pt 09. You see
7. Ph 05. I think the one you mean is (0.2) is it like that (0.3) is it like that so you
8. Ph 05. have to be careful when you pull the *slides out*
9. Pt 09. *That's right* yeah they're the ones
10. Ph 05. Yeah
11. Pt 09. Yeah (0.3) so that just pull one pull pull down to them morning
12. Ph 05. Pull down to the one you want
13. Pt 09. And then the next dinner time
14. Ph 05. Yeah and make sure you only go so far with them=
15. Pt 09. =That's right
16. Ph 05. Yeah
17. Pt 09. Otherwise you'll mix your pills up
18. Ph 05. But if you wanted to have one in particular that you felt was easier for
19. Ph 05. you
20. Pt 09. No (0.2) I ain't that far gone yet I mean I can=

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'

Box 5 | Invoking the higher authority of the doctor: 1

1. Pt 03. My son sorts it all out for me
2. Ph 05. So does he will he fill that up every week
3. Pt 03. He will do=
4. Ph 05. =He will do okay so that's your yeast tablets they're fine
5. Ph 05. they're a course of treatment and how often do you take
6. Ph 05. those
7. Pt 03. I don't know
8. Ph 05. Do you just do you go by what's on here
9. Pt 03. What's put in the box yes
10. Ph 05. So you don't (0.2) do you look at the labels at all
11. Pt 03. No I don't dear (0.2) he does
12. Ph 05. And how often do you take this for
13. Pt 03. I don't know it is all (written) down there
14. Ph 05. How long will you be taking warfarin
15. Pt 03. I don't know dear
16. Ph 05. 'Til you're told
17. Pt 03. Yes (0.2) I haven't even phoned my doctor yet

Box 6 | **Invoking the higher authority of the doctor: 2 (italics indicate overlapping speech)**

1. Ph 04. Because I noticed your swollen ankles
2. Pt 22. Yes well my own doctor said he would try and come and see me
3. Pt 22. yesterday but he didn't manage it but I should think he'll be in today
4. Pt 22. sometime and then we'll sort out these little problems when he comes
5. Ph 04. That's good because you need to show him your ankles and tell him your
6. Ph 04. diuretic has been stopped
7. Pt 22. He immediately will know that (irritated)=
8. Ph 04. =Because I'm mean I'm I'm thinking that the diur because the diuretic
9. Ph 04. has been stopped perhaps *your ankles* are swelling up again
10. Pt 22. *I think so* yes that's my private
11. Pt 22. opinion you see what's good for one thing isn't good for another
12. Ph 04. That's absolutely right (0.2) now you've got a few more tablets in here

assumed competence, integrity, and self governance. These findings complement what is already known about the difficult nature of advice giving in healthcare communication generally,[15 17] specifically for pharmacists.[3 11 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 giving[17 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.

Box 7 | **Unsettling effect on patients of pharmacists' intervention**

1. Ph 01. So (0.2) I think it is important that we do use the drops (0.2) regularly
2. Pt 06. Yeah
3. Ph 01. And (0.2) it is very important that I think I'll I'll have to let the doctor
4. Ph 01. know (0.2) so that (0.2) it might be necessary to have another pressure
5. Ph 01. test in between
6. Pt 06. Could I just say (0.2) that I feel that the way that my medicines have
7. Pt 06. been managed have been wonderful to keep me going so long in my
8. Pt 06. condition (0.2) that hh you know I'm so pleased really it's worked out
9. Pt 06. well=
10. Ph 01. =Good
11. Pt 06. Yes marvellous I mean when you think how long I've gone on in fair
12. Pt 06. health for me (0.2) I think (0.2) you no I don't feel like rocking the boat
13. Pt 06. if you know what I mean
14. Husband. No we don't wish to complain
15. Pt 06. No we don't wish to complain
16. Ph 01. No oh gosh no I'm not here to hh hh upset or rock the boat about
16. Ph 01. anything hhm
17. Pt 06. I think they've done wonderfully to work out what I need to keep
18. Pt 06. me going and she ((GP)) too has been very good (0.2) but I think it started
19. Pt 06. with doctor (name) who seemed to take a real interest in it they worked very
20. Pt 06. hard to get the right mixture for me (0.2) and it seems to be doing very well

WHAT IS ALREADY KNOWN ON THIS TOPIC

No research has been published on pharmacists' communicative competence in their extended roles in the United Kingdom; meanwhile medication review services are being implemented nationwide

Pharmacists have not traditionally been trained in healthcare communication

WHAT THIS STUDY ADDS

Reception and acknowledgement of advice in medication review consultations with pharmacists is affected by context and communicative competence and may lead to negative health gain

The extended role of the pharmacist is uncertain in older patients' (80 or more) management of their medicines

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