

CHANGING PHARMACY PRACTICE: THE AUSTRALIAN EXPERIENCE

By *Abilio Neto, PhD*

This article takes readers through the current political environment in relation to non-prescription medicines in Australia, describes a new training methodology, and then compares the methodology to traditional methods of training community pharmacists

A new method has been successfully used to train community pharmacists across Australia on counselling techniques for monitoring the use of non-prescription medicines. This new training method has been pivotal in the fight against deregulation of non-prescription medicines in Australia. The method, which I developed while at the faculty of pharmacy, University of Sydney, has recently been used to implement standards of practice for non-prescription medicines. Approximately 2,500 pharmacies were involved in this project, which was conducted by Professor S. I. Benrimoj, dean, faculty of pharmacy, University of Sydney, and Associate Professor A. L. Gilbert, dean, college of pharmacy, University of South Australia.

CLASSIFICATION OF MEDICINES

In Australia medicines are classified as: general sales items, eg, Gaviscon liquid, packs of 12 or less paracetamol tablets (unscheduled medicines); pharmacy medicines, eg, ranitidine tablets, ibuprofen tablets (schedule 2); pharmacist only medicines, eg, isosorbide dinitrate 10mg tablets, salbutamol inhalers (schedule 3); and prescription medicines (schedule 4). Pharmacy essentially has a monopoly over the market for pharmacist only and pharmacy medicines in Australia.

The underlying assumption of the legislation that restricts the sale of these medicines to pharmacies is that pharmacists will monitor sales and intervene where necessary to ensure people use these medicines safely, appropriately and effectively.

In the past, pharmacists in Australia approached the legislation as a legal reminder about their professional responsibilities. However, with an increasing number of medicines being rescheduled from prescription to pharmacist only, pharmacists are required to assume a more significant counselling and medication-tracking role. Since reasonably potent drugs are no longer under medical surveillance, the Government is now putting pressure on the pharmacy profession to monitor the use of non-prescription medicines. The Industry Commission (1996) into the pharmaceutical industry recommended that: "The current scheduling for pharmacy (schedule 2) and pharmacist only (schedule 3) medication should only be retained, pending further research into the role of pharmacist counselling in ensuring improved health outcomes and the monitoring of the extent of such counselling."

In other words, the Australian government put the pharmacy profession on notice. Community pharmacists were told either to fulfil their counselling role on non-prescription medicines or the non-prescription market was going to be deregulated, ie, retail outlets other than community pharmacies would be allowed to sell these products.

More recently, pharmacy in Australia has been the subject of another inquiry, "The review of national competition policy of drugs and poisons legislation". The purpose of this inquiry is to make recommendations for any necessary changes to the current state and territory drugs, poisons and controlled substances legislation to ensure they comply with the principles of competition policy. In its "Options paper", the review accepted that "some pharmacists do provide good service to consumers who obtain pharmacy and pharmacist only medicines from them, but that the standard is not generally high, nor do all pharmacists always provide proper care".

CHANGE: THE NEW CHALLENGE

Community pharmacy was left with the challenge of changing practice behaviour in relation to non-prescription medicines, in a short period, if it were to retain the control of these medicines. The continued success of community pharmacy in Australia depended on the provision of a consistent level of information and advice to consumers of non-prescription medicines.

It is no surprise that this threat of deregulation has generated considerable efforts to train community pharmacists in counselling techniques and protocols aimed at monitoring the use of non-prescription products. Several programmes have been developed based on sound theoretical background using the latest techniques in the area of pharmacy practice.

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After many attempts to train community pharmacists it became clear that sustained change in practice behaviour was not going to be achieved by a single dose of anything, be it a workshop or a spectacularly good seminar. These approaches to training increased knowledge but did not necessarily translate into changes in behaviour. It was clear that a different approach to continuing professional education was needed.

Recent pharmacy practice research demonstrates that adequately trained educators can shape the behaviour of community pharmacists in relation to the monitoring of non-prescription medicines when a workshop is followed by ongoing training with immediate feedback and coaching through the use of pseudo-customers.

WHAT IS A PSEUDO-CUSTOMER?

A pseudo-customer, also known as mystery shopper, is an individual trained to go to a pharmacy and present particular scenarios. Staff whose work is being assessed are unaware of the pseudo-customer's identity.

HOW DOES IT WORK?

- The pseudo-customer method is negotiated with participating pharmacists
- Workshop training is carried out
- Pseudo-customer visits are conducted (the pseudo-customer enters the pharmacy and requests either the purchase of a non-prescription medicine or treatment for a symptom)
- The pseudo-customer accepts any advice given, makes a purchase, if recommended, and leaves the pharmacy

- The pseudo-customer reports immediately to the pharmacy educator, who waits outside, on how the sale was conducted
- The pharmacy educator enters the pharmacy to discuss the observations of the pseudo-customer with the pharmacist and staff and provides feedback and coaching (this usually occurs within five to 10 minutes of the pseudo-customer's visit)

The feedback provided by the pharmacy educator relates to how well the pharmacist performed and the coaching addresses what the pharmacist could do to improve his or her performance. To help with the feedback session, pharmacy educators give the pharmacist a feedback sheet, which highlights essential features of the target behaviours. Most of the pharmacy educators are pharmacists with many years of experience.

The concept of pseudo-customers is presented to pharmacists and staff as an integral part of the training programme with the purpose of coaching them in developing skills taught at the initial workshop. In direct contrast to the traditional use of pseudo-customers in pharmacy, pharmacists accept the training procedure because the involvement of pseudo-customers is negotiated from the beginning — there is no sense of betrayal. All pseudo-customers are required to sign confidentiality statements.

Previously the focus of pseudo-customer methodology has been primarily on assessment of the practitioners' skills, usually in a punitive and negative manner. In Australia the assessment strengths of the pseudo-customer methodology are incorporated, but further skill development is also promoted. Pharmacy educators are trained to provide the feedback in a non-confrontational manner.

COMPARISON WITH TRADITIONAL TRAINING METHODS

Traditionally, continuing education programmes tend to rely on workshop training as a primary means of skill development despite the fact that, in general, measurements of clinical behaviour in the health area indicate that workshops alone are not sufficient to induce behaviour change. Simply conducting workshops and providing pharmacists with written protocols for the sale of non-prescription medicines is not sufficient to change pharmacists' practice.

In Australia, pharmacy practice research reinforces the notion that a keen group of participants and practical procedures are not enough to ensure continued application at work of skills taught and practised in workshop training. For example, in a recent study conducted in Australia, community pharmacists failed to recall a brief cognitive-behavioural intervention specific for non-prescription medicines a week after they had demonstrated proficiency in a workshop. Despite workshop evaluation indicating that participants perceived the intervention strategies as highly relevant to their prac-

tice, pharmacists failed to put into practice the newly acquired skills and consequently lost their proficiency.

Limitations of workshops The provision of a single workshop has serious limitations. It is easier for learning to take place when training is spread over a series of small sessions during a number of weeks. Moreover, reinforcement and feedback seem to be necessary to transfer skills acquired in workshops to the practice setting.

Another disadvantage of workshop training is that it may not include sufficient opportunity to practise skills and receive corrective feedback or, more importantly, practice of skills may not be in a sufficiently similar context.

Feedback and coaching from the educator in the pseudo-customer technique allow for gradual and ongoing fine-tuning of behaviour. In addition, practice in the natural setting, with corrective feedback, facilitates the transfer of skills acquired in workshops to practice.

Immediate feedback Behavioural theorists argue that it is critical for a person to receive information about the closeness of his or her performance to a predefined desired behaviour. In the context of pharmacy education, our research shows that feedback is more effective when provided immediately after the behaviour. At this time, pharmacists and their staff still have a clear recollection of their performance.

Direct observation has a number of strengths as an assessment tool:

- It is conducted in the natural environment, rather than in an artificial one (such as role-played assessments in a workshop)
- It focuses on the key behaviours to be tested, rather than on proxy measures, such as file records or interventions that are made by the practitioner
- When the practitioner is unaware that the person is not a real patient, the method also minimises the risk of the assessment being reactive, as can occur when an observer is present or the interaction is being taped

When pseudo-customer assessments are fully integrated into training, we are not only able to derive an accurate assessment of changes in clinical practice, but can use feedback from the assessments as a basis for further skills acquisition.

Moreover, when feedback from the educator emphasises positive attainment as well as providing some corrective information, it increases participants' confidence in their skills and helps maintain their commitment to the training programme.

Incentives to put skills into practice In workshop training there may be insufficient incentives for skills implementation when participants return to their community pharmacies. Change requires effort and it is often easier not to change. Participants are likely to go back to their community phar-

macies and continue practising the way they have always done.

In contrast, with the pseudo-customer method, the immediate feedback from the educator not only helps pharmacists refine their skills, it also acts as a powerful incentive to continue applying the skills, especially if they cannot easily predict when an assessment will take place.

Cognitive dissonance Another powerful feature of the pseudo-customer methodology is that it makes use of the phenomenon of "cognitive dissonance".

Cognitive dissonance is a state of psychological discomfort created when an individual's behaviour (eg, not providing information on potent analgesics) is discrepant with his or her beliefs, attitudes and feelings about him or herself (eg, I am a good professional and I do provide information to consumers who purchase potent analgesics from me).

When the interaction with the pseudo-customer is not a good one, it is reasonable to assume that a condition emerges (psychological discomfort) which motivates the individual to bring about change to the framework in order to restore consistency. With the pseudo-customer method, the feedback and coaching provided by the educator heightens the cognitive dissonance by highlighting the inconsistency between behaviour and beliefs and then directs the dissonance so that the result is changed behaviour rather than modified beliefs.

This psychological discomfort created by contrasting the individual's behaviour with his or her attitude is one of the forces that helps the individual to bring about change. In a workshop session when the scenario is not a true-to-life one the phenomenon of cognitive dissonance is not created.

SHAPING PRACTICE BEHAVIOUR

Researchers have been able to shape practice across a range of behaviours using pseudo-customer methods. Some of these behaviours include:

- Implementation of a pharmacy-based protocol for non-prescription analgesic products containing codeine and an antihistamine
- Training of pharmacy assistants on protocols for non-prescription medicines
- Training pharmacists to switch consumers of antacids and anti-reflux agents for the treatment of heartburn and indigestion to more effective medication like H₂-antagonists, when appropriate
- Most importantly, it has been used to implement standards of practice for non-prescription medicines across Australia. This has been pivotal in our fight against deregulation

The pseudo-customer methodology is now widely used by the Pharmaceutical Society of Australia (New South Wales Branch) to train community pharmacists on the provision of pharmacy and pharmacist only medicines.