

Usefulness of qualitative research

At a session organised by the Administrative Pharmacy Section on 6 September entitled "Evaluation studies as a basis for decision making",

Claire Anderson was one of the speakers. She reports the session here

Claire Anderson, professor of social pharmacy, University of Nottingham, talked about complex interventions in pharmacy. She began by explaining that the randomised controlled trial is taken as the gold standard of evidence. However, it may not always be possible to use an RCT and even when it is it may be important to use other methods like qualitative research alongside it to explain the results.

"The interventions that we often want to make in health services such as pharmacy," she said, "are often complex and, unlike in an RCT, the 'active ingredient' is difficult to define." She explained that if, for example, we wanted to evaluate pharmaceutical care compared with traditional advice about medicines, we would need to examine relationships with doctors and other health care professionals and relationships with patients as well as clinical outcomes.

Professor Anderson went on to explain that complex interventions are made up of a number of parts, including behaviours, parameters of behaviours (eg, frequency, timing) and methods of organising and delivering those behaviours (eg, type of pharmacist, setting, location). She told the audience about the UK Medicines Research Council's framework for

complex interventions (see www.mrc.ac.uk/prn/pdf-mrc_cpr.pdf). First, she said, the theoretical basis of the intervention needs to be established. This may be done by using a literature review and by exploring relevant theory. Secondly, or phase I, the different components of the intervention should be identified and the effects each might have on the final outcomes and on each other established. Different methodologies, such as economic modelling, computer simulations, case studies, observational studies, in depth interviews and focus groups, may be used.

The third step in the MRC framework, the exploratory trial (phase II), Professor Anderson said, is crucial to the whole study and it may be appropriate to test alternative forms of the intervention at this stage. It is also the time when outcome measures can be defined and suitable control groups identified. Finally phase III, or the main trial, can take place when the fully defined intervention can be compared with an appropriate alternative using a theoretically appropriate protocol. The final step, she explained, is to establish the long-term effect of the intervention, that is, to broaden its application outside a research context — a bit like post-marketing surveillance.

An important question to ask is whether others reliably replicate my intervention and results in uncontrolled settings over the long-term. Observational studies could be carried out here as could audits, audio or videotaping of consultations, mystery shopping, mentoring and feedback. Professor Anderson talked about the importance of using qualitative methods alongside quantitative ones especially when we want to explain unexpected negative outcomes.

Qualitative research, she told the audience, is used to understand events, actions, values and meanings from the individual's perspective rather than the researcher's. Qualitative researchers are interested in the process as well as the outcomes.

She concluded by talking about the Community Pharmacy Medicines Management Project. The trial, she explained, had quantified the effects of pharmacist interventions with coronary heart disease patients. Qualitative research was carried out with patients, doctor and pharmacists and this had led the research team to understand some of the difficulties the pharmacists had in providing the intervention, for example accessing patients' notes. They had then been able to make recommendations for future services.

Assessing remuneration for pharmacy services in Portugal

Suzete Costa, pharmacy-based disease management department manager at the Portuguese National Association of Pharmacies, spoke about remuneration of pharmacy services in Portugal. She said that evaluation studies are, sometimes, a basis for decision-making but that they are just one of the components of the decision-making process. A clear political vision for pharmacy practice and a strategy focused both on the professional and economic sustainability of pharmacy services are also crucial elements.

In 1998, an Agreement on Diabetes Care was signed between the National Association of Pharmacies (ANF), the Portuguese Pharmaceutical Society, wholesalers, the industry and the Ministry of Health through the National Health Service in Portugal. Community pharmacies accepted a no-profit deal on diabetes products in return for being allowed to dispense these exclusively.

The National Association of Pharmacies, she explained, had started to develop pharmacy-based disease management programmes for asthma/chronic obstructive airways disease, hypertension and diabetes in 1999. Their mission, she explained, was to develop methods and tools for community pharmacists, to support community pharmacists in providing this type of care and to assess the impact of care provided.

The service now provided is a combination of disease state management principles and a pharmaceutical care approach.

Pharmacists analyse possible patient complaints, measure blood glucose, blood pressure, cholesterol, etc, against target values and review drug therapy looking for drug-related problems for each patient at scheduled appointments, in between visits to a doctor.

Ms Costa told the audience that before expanding the programme, a pilot was run in several pharmacies in 2001–02. In September 2003 a new agreement was signed for diabetes. The scope of pharmacist's interventions, she explained, was expanded to an essential service performed in almost every pharmacy and the

diabetes management programme. A monthly fee was set per patient on an experimental basis, 75 per cent co-paid by the Ministry of Health and 25 per cent by the patient.

Ms Costa said that only a certified pharmacist may be the responsible person in the pharmacy and that certification is provided by the pharmaceutical association after completing an accredited training programme. By August 2005, 20 per cent of Portuguese pharmacies had at least one accredited pharmacist providing the diabetes service to nearly 1,700 patients. The pharmacists, she explained, have to keep records documenting their interventions and these are forwarded to the NHS for payment.

Ms Costa went on to say that most drug-related problems identified while providing the service are because drug therapeutic regimens seem to be not working because they are probably not the most suitable or because of too low dosage or poor compliance. Only 5 per cent of problems are related to safety problems, whether it is because of too high dosages, bad regimens or adverse effects. The remuneration, she explained, will be on trial until 31 December and an external evaluation will be commissioned by the NHS.

At the same time, the association plan to perform a definitive evaluation of the programme involving a mix of retrospective data analysis and a prospective intervention with a control group.

The process of implementation was also challenging, even when remuneration is already in place. Most new pharmacy services, she explained, are designed for innovators and early adopters because these are the first people to try them. Things often seem to be going smoothly at the beginning until they are implemented on a much larger scale, and that is when problems begin.

She concluded by saying that it is important to perceive the political and social environment around us and to prepare the ground for the implementation of future services and possible remuneration schemes.