



Pharmacy  
Practice  
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Trust

# Pharmacy Practice Research Trust, London

## Final Report

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### “Contextualising patient centred professionalism in pharmacy practice:

### Consulting with patients, professionals and stakeholders”

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## Executive Summary

The study sought to clarify the concept of 'patient-centred professionalism' in community pharmacy. It did so through a series of workshops with community pharmacists—both established and newly qualified—, pharmacy support staff, members of the public, and other stakeholders (including educators, policy developers, and policy implementers).

Seven workshops were held, with a total of thirty-nine research participants. The community pharmacists and support staff who took part in the study were drawn from the full spectrum of community pharmacies, including independents, regional chains, national chains, and supermarket-based pharmacies. The workshops took place in south west Wales, and utilized a range of qualitative and quantitative methods to clarify the concept of patient-centred professionalism.

During the course of the workshops, the research participants engaged in exemplar-building activities that endeavoured to disclose, through the Nominal Group Work technique, the key positive and challenging characteristics of patient-centred professionalism from the perspective of established community pharmacists, newly qualified community pharmacists, pharmacy support staff, members of the public, and other stakeholders, respectively. Nominal Group Work is a research method that systematically enables key characteristics to be disclosed, refined, and ordered.

The full set of characteristics that emerged from the workshops were synthesized and thematized, and each of the eleven themes placed within a template of positive and challenging aspects of patient-centred professionalism. The template structures and presents the themes according to their relative significance. The themes are:

- Safety.
- Professional characteristics.
- Relationships with patients.
- Confidentiality and privacy.
- Accessibility.
- Training
- Professional pressures.
- Services.
- Environment.
- Changing professional roles.
- Patient characteristics.

Taken as a totality, the template clarifies the concept of 'patient-centred professionalism' in community pharmacy, and situates it within a nexus of perspectives that spans community pharmacists, their support staff, members of the public, and other stakeholders.

The template is presented in a separate document entitled *A Template of Patient-Centred Professionalism in Community Pharmacy*, which accompanies this Final Report.

## Introduction

In this study we were tasked with clarifying the concept: ***'patient-centred professionalism'*** and its effect on community pharmacists and their working practices, in particular on newly qualified pharmacists, as the future leaders of the profession. This study is in line with the Pharmacy Practice Research Trust's Call (2008) for an examination of the notion patient-centred professionalism in modern-day practice. We undertook an in-depth, qualitative and quantitative study comprising half-day consultation workshops with: pharmacists, pharmacy support staff, the public and stakeholders to gain a wide-range of views to:

- 'show and tell' of a range of healthcare practices across different settings;
- indicate the pitfalls to patient-centred professionalism across different contexts;
- stimulate debate within and across patient and professional groups about improving patient-centred professionalism, with particular reference to the situated nature of practice.

The study aimed to:

- a) Clarify understanding of professionalism;
- b) Situate that knowledge through in-depth consultation with patients, professionals and stakeholders;
- c) Develop 'themes of positive and challenging aspects of patient-centred professionalism' from mixed datasets, personal experience and Nominal Group Work;
- d) Present 'themes' to newly qualified pharmacists, to develop a template for teaching, communication and dissemination purposes;
- e) Inform the literature on the value of using innovative, mixed-methods in pharmacy research.

By contextualising professionalism through 'in-situ' data, using examples from general practitioner (GP) and community pharmacist bio-photographic datasets from our previous research that speak about workspace, practice and self-identity, we aimed to highlight what is currently taking place in the community pharmacy context. These examples were considered during Session One of tri-sessional, extended, half-day consultation workshops with all study participants and helped stimulate exemplar-building activities and Nominal Group Work in the other two sessions. Outputs could lend themselves to teaching initiatives and policy developments as analysis of data and a Forum event in the latter part of the study led to a template of 'themes of positive and challenging practices' which we developed during the Forum with participants and other interested parties. The template could also be made available for wider dissemination through website development, which is currently ongoing at Swansea University, to assist user groups, to support teaching programmes and CPE materials and to inform policy developers.

The study was the first of its type to place current definitions in context in a very practical way whilst broadening understanding of professional and patient need and examining expectations about building trust and delivering patient-centred professionalism.

## Summary of project team

### ***Study team***

The study team (core team members: FR, MD, HH, and study Research Assistant (RA): CD then SW) have met on a regular basis, since the commencement of the study to support the RA, discuss the consultation workshops and Forum event and undertake group analysis. The group worked cohesively, putting forward ideas and agreeing all developments between themselves.

### ***Co-investigator group***

The Co-investigator group met on three occasions since the commencement of the study (September 2008), through face-to-face and audio conference meetings. Whilst the Co-investigators were widespread, based in Swansea, London and Cardiff, the meetings brought them into close contact with the work of the core team and study outputs, and enabled them to take an active part in certain aspects of data analysis and interpretation, staying closely involved in study design, implementation and outcome development.

### ***Steering Group***

The Steering Group met with the team on two occasions over the course of the study with a final meeting planned for March 2010, to discuss outputs. The PI has been in close contact with the Trust since the study began.

### ***Recruitment of a Research Assistant***

An RA (Grade 7, point 26, .6FTE) was recruited at the beginning of the study in September 2009 for 10 of the 16-month period, to cover day-to-day project duties (research and administrative) in particular those relating to the smooth-running of participant recruitment and data collection. Due to unforeseen circumstances, the RA (CD) left the study team at the end of February 2009. A replacement was successfully recruited (SW), and she commenced work at the beginning of April 2009.

## Achievements

- Recruitment of 39 study participants for seven extended, half-day consultation workshops;
- Conduct of seven extended, half-day consultation workshops;
- Interim Report that covered responses to workshops and exemplar-building activities (see *Appendices 1-7*);
- Conduct of a Forum event with study participants and study team (see *Appendix 7*);
- Development of a template of patient-centred professionalism in the form of eleven positive and more challenging themes defining and depicting the notion;
- Three publications: one in press, one published and one in review (see *Appendices 10 and 11*);
- Development of a website to house the template (ongoing).

## Summary of consultation workshops

### **Ethics**

Following funding from the Pharmacy Practice Research Trust, the Swansea and South West Wales Local Research Ethics Committee was contacted to clarify ethics. The Ethics Committee confirmed that ethical approval would not be required for this study as community pharmacists are not NHS employees. Nevertheless, to uphold the supporting University's ethical principles of research investigation, the study was brought to the attention of the University's School of Medicine Joint Scientific Review Board.

### **Study phases**

The study was in two phases:

**Phase I** comprised half-day consultation workshops with: community pharmacists (all seniorities, chosen to represent registered pharmacists and locums working in small independent pharmacy shops, small and large chains and multiple pharmacies), pharmacy staff, members of the public, and pharmacy stakeholders (teachers, educators, policy developers and policy implementers).

Following collation and organization of these datasets and individual and group analyses, **Phase II** expanded and refined definitions of patient-centred professionalism through coordinated feedback and data gathering with newly qualified pharmacists.

### **Consultation workshops: What are they?**

Consultation workshops are facilitated, extended group interactions comprising small group work, group discussion and individual activity. Facilitators provide direction and advice and often work in groups of twos or fours to allow for multiple activities to take place concurrently and to sustain participant interest (Chapple and Murphy, 1996). Facilitators pay close attention to group dynamics and group cohesion, as views change or are embellished over time. Consultation workshops are frequently staged, so that conversations that take place across one session can be taken forward into the next, and to allow complex tasks to follow one another in a logical order. The group's response may thus be considered as 'cumulative', as one session influences the next, and leads to a deeper clarity of vision (Claxton, Ritchie et al, 1980).

### **Consultation workshop management and makeup**

In keeping with the literature on the topic we aimed for an optimal sample of six participants in each consultation workshop (Chapple and Murphy, 1996; Bloor et al, 2001). The final recruitment figures can be found in Table 1, *Appendix 1*.

Workshops were developed as tri-sessional events, lasting approximately four hours. All consultation workshops were organised and run by the same four facilitators (FR, HH, MD and CD) to ensure consistent working practices. Each session was facilitated by a different team member with the other members taking notes, observing group interaction and working the tape-

recorder. The sessions followed a general introduction to the study topic with a welcome to the group, introductions and description of workshop 'rules of engagement'. These included speaking in turn, respecting each other's views and positively critiquing each other's ideas. Each group was given the opportunity to add their own rules of engagement to the list, and were asked whether there were any objections to the sessions being tape-recorded.

All workshops were designed to provide a final list of ten to twelve positive and challenging themes of patient-centred professionalism. These materials were further refined through a Forum event (see "**Forum event**" below) towards the end of data collection, with all workshop participants, wider stakeholder groups and other interested parties. The final list of themes was developed as a template of positive and challenging aspects of patient-centred professionalism (see accompanying booklet), which the Trust may wish to consider the team developing, as an extension to this study, into CPE materials. In view of this, a study website is in the process of being set up, to display the themed material to best effect.

### **Session breakdown**

**Session One** (FR facilitator) examined the 'in-situ' nature of community pharmacy practice in relation to patient-centred professionalism. Session One was supported by visual and textual data drawn from two previous studies of professionalism in practice presenting different situated practices of GPs and community pharmacists and personal experiences of both types of practitioner in both settings (Rapport, Doel et al, 2006; 2007; 2008a&b; 2009). Session One examined who might work in different healthcare spaces, what workspaces depicted and how they showed practice and patient-professional communication (see *Appendix 3* for more detail).

**Session Two** (HH facilitator) elicited storied examples of working within, or being supported by, community pharmacists, and led to definitions of competencies necessary for optimal patient-centred professionalism. These competencies were then refined in Session Three, through Nominal Group Work activities (Delbecq et al 1971; 1975, Chapple and Murphy, 1996). (See *Appendix 5* for quantitative workings).

**Session Three** (MD facilitator) enabled key indicators of positive and challenging patient-centred professionalism to be generated, discussed, listed and ranked by each individual in each group. Following Session Three, the study team conducted statistical analyses on the Nominal Group Work activities, to clarify the degree of consensus in ranking and scoring across the groups around essential aspects of the concept. See "**Quantitative Methodological Framework**" below for more detail.

## Qualitative and quantitative methodological frameworks

### *Qualitative Methodological Framework*

As **Session One** above has indicated the study employed mixed methods – namely extended consultation workshops, informed in the first of three sessions by data comprising digital photographs and object-orientated biographies of workspaces and practices in healthcare settings, and in the final session by quantitative data resulting from Nominal Group Work.

### **Consultation workshops**

(For a description of consultation workshops as a method see: “**Summary of consultation workshops**” above).

### **Bio-photographic material**

In the last ten years, still photography and biography have emerged as two important social scientific research methods that fit within a plethora of new techniques for exploring, describing and interpreting how we view the world (Rapport, 2004). New approaches to social action and its interpretation provide researchers with opportunities to move away from formulaic notions of how to conduct research (Crang, 2003), encouraging an interest in research that extends beyond belief in the ‘status of numbers’ (Doel, 2001). By broadening the scope of qualitative inquiry, methodologies have become more than ploys to elicit data in different ways. They have become alternative positions from which to view the world (Rapport et al., 2004; 2005). In healthcare research a movement away from the conventional has also come to be defined by regular forays into mixing methods. Most commonly, this refers to the mixing of quantitative and qualitative methods, much lauded in mainstream medical and health services research. But it can also refer to ‘within-method’ triangulation, with different qualitative datasets grouped or ‘triangulated’ to provide depth to understanding (Rapport et al, 2006).

In this study, we triangulated textual data from the consultation workshops with the quantitative data from the Nominal Group Work and paid account to the influence of bio-photographic data on people’s views and opinions. This helped clarify how the wider audience of participants reflected upon the notion of patient-centred professionalism. This level of depth to a triangulation approach not only enabled the team to compare one dataset with another (Stake, 2003), but also introduced the possibility of one dataset extending understanding of the other.

### **Biography in health research**

Writing, as a method of enquiry, offers a departure from standard social scientific practices. In the last ten years, biography has emerged as an important social scientific research method, complementing the notion that qualitative research is developing new and sophisticated methodologies. Biography gives insight into language-in-use and clarifies how we ‘word the world’ (Rose, 1992). It encourages revelation through the stories research participants tell of their lived experiences and provides participants with opportunities to recreate their worlds without the direct influence of the researcher. This is less likely to be the case with other data collection

methods, such as qualitative interviews. By stepping outside the study, participants can present their stories as ‘true stories’ – stories that really took place. In addition, the formal structure of the narrative can reveal a participant’s personal construction of his or her life experiences, values, perceptions and identities, created both textually and linguistically. Consequently, when participants in the consultation workshop reflected on the biographic writing they were able to consider it not only in terms of the ‘writer’s plot’, but also for the way in which the story was ‘staged’ for coherence, verisimilitude, and interest.

### **Photography in health research**

Within healthcare research, the role of the photograph has focused on data generation. In photo-interviews, for instance, photographs are said to give birth to stories and can, therefore, be employed as aids to data collection, rather than as ends in themselves (van Leeuwen and Jewitt, 2002). Photographs shown to research participants in new settings, such as that of a consultation workshop, can help identify people or places, and participants can offer their own commentary on the readings of the researchers. If we take as an example the work of Radley and Taylor (2003a, 2003b), where patients photographed aspects of the hospital ward that related to their experience of illness and recovery, these data were also discussed at a later stage through interviews to clarify people’s reflections on healthcare and recovery. Images have also been employed within Anthropology to serve as records of reality; ‘Documentary evidence of the people, places, things, actions and events they depict’ (van Leeuwen and Jewitt, 2002, p.5); and, less commonly, as aesthetic products or evocative images (Barthes, 1977). In our work, we used the photographs alongside the biographies to encourage participants to reflect on others’ views as well as their own and to stimulate an initial discussion about the kinds of people who work in different healthcare settings and the qualities evoked by the data relating to their patient-centred professionalism.

### **The source of the bio-photographic data**

The studies from which the photographic and biographic sample data were chosen were studies undertaken by the research team in the past five years that considered GP and community pharmacist responses to workspace, practice and lines of communication in terms of the situated nature of practice. By employing photographs and biographies, collected by the professionals themselves following their own personal reflections on their workspaces, and by considering how that data acted as a vehicle to knowledge, we were able to offer workshop participants material for consideration (before each workshop took place) that clearly revealed health professionals’ feelings, thoughts and memories, echoed in subsequent discussion with the study participants.

### **Process of analysis**

In order to analyse and triangulate the rich datasets from the mixed-method work, both through a within-method approach (response to bio-photographic data) and in terms of the quantitative data (from the Nominal Group Work and theme-building sessions) we held group analysis meetings between all team members once a fortnight. These commenced as data collection started. The

core analysis team comprising all four workshop facilitators (FR, MD, HH, CD), helped familiarise the process, and led to greater understanding of the dynamics and content of each consultation workshop (2x Newly Qualified Pharmacists, 2x Registered Pharmacists, 1x Public, 1x Stakeholder group, n=39). The qualitative data analysis was led by the PI (FR) and one of the Co-Applicants (MD) who had extensive experience in this area. The quantitative data analysis from Sessions Two and Three, including the Nominal Group Work, was led by the quantitative expert and Study Manager (HH). The team considered the notes all facilitators had taken during the three workshop sessions and compared those with the verbatim transcriptions of the workshops from tape-recordings taken during each event and with the scoring sheets and comment sheets. Exemplar themes and their concomitant categories emerged as the team read and re-read the workshop transcripts and discussed the notes. In addition, rankings from the Nominal Group Work that accompanied Session 3 of each workshop helped the team to define and refine those aspects of text that stood out as particularly important to participants within and across consultation groups. Consequently, while discussions were influenced by the bio-photographic data depicting workspaces, practices, communication with patients and professionals, and professionals' sense of self, they were also influenced by the quantitative data. These depicted emergent positive and challenging themes that had led, in each workshop, to a group response of ten to twelve themes of patient-centred professionalism. Triangulation is a slow process. The team members must 'come to know' their data and work together to discuss their relevance to the full data set as data is gathered in. The work depends on the ability of the team to arrive at a consensus of opinion whilst discussing and considering anomalies within the data and incongruent material.

Consistent with our previous research, this work enabled us to examine both theme and category, those aspects of the discussion, which helped frame and contextualise each theme supported by participant quotations (Robson, 2002). The group work was enriched by two meetings with the wider study team, which took place in Swansea University.

The wider team helped to refine the data into clearer themes and categories, organised according to individual themes, but in keeping with their interrelated qualities. This has also proved to be a flexible and effective method of working, clearly in keeping with the purpose of the study as defined within the study protocol. Furthermore, the method can be seen to help emphasise the close fit between 'end product' and 'research question', and the ability of these themes to encapsulate essential elements of data, which would otherwise lose their full coherence.

Whilst there are different ways of indicating the prevalence of a theme without quantification, the inductive method of triangulation and enquiry across qualitative and quantitative datasets has proved to be a particularly useful means of sense making in complex health research studies. This approach endorses the notion that the issues belying a text can emerge through data-driven discussion and in-depth interpretation, where people work together to

hone down data and expand personal understanding, revealing both surface meaning (semantic) and underlying notions of understanding (latent).

### **Quantitative Methodological Framework**

The quantitative analysis of the data comprised two major steps: the summary of data from each of the workshops to produce individual workshop positive and challenging themed lists and the process of reduction and thematisation of the complete exemplar lists into a single list of ranked themes (that encompassed both positive and challenging exemplars).

**Nominal Group Work – A definition** Nominal Group Work (NGW) was first developed by Delbecq et al in the 1970s as an organisational planning technique. The process of NGW normally involves four main phases. Phase One is the nominal or silent phase, during which individuals consider their personal responses to a defined question and write them down without discussion. Phase Two is the item generation phase, during which individual participants take turns to share their responses (related to the pre-specified research question) with the wider group. Items generated are recorded as succinct phrases on a flip chart but again are not discussed within the group. Phase Three involves a discussion and clarification phase, in which group members are allowed to ask questions in order to clarify items on the list and discuss their merits and demerits. During this process, items with similar meanings may be combined and duplicate items removed. The final phase, Phase Four, is the voting phase where each individual is asked to prioritise the listed items by assigning ranks to them. NGW encourages individual contributions and the inhibitory factors of group conformity are avoided with even the more reticent group members facilitated to participate in all phases.

### **Workshop NGW exercise**

The aim of the NGW exercise in our consultation workshops was to refine and condense issues raised in all of the first two workshop sessions into a list of approximately 10 positive and 10 challenging exemplars, and subsequently rank these in the order of their significance (Steps 1-7, leading to Output 1, *Appendix 8*).

The generation of the exemplar lists using NGW followed the approach outlined in previous literature on the methodology (Jones and Hunter, 1995; Chapple and Murphy, 1996)). The NGW exercise began by inviting participants to identify what they regarded as *positive* exemplars of patient-centred professionalism and to write their ideas down on paper. Each individual was then asked to volunteer an exemplar, each of which was written down on a flip chart. Participants were invited to divulge the exemplars on their list in turn, to ensure that every participant had an opportunity to contribute fully to the process of exemplar generation. This continued until everyone's exemplars were disclosed. The next phase involved group discussion and clarification of the resulting list of exemplars. The list was then refined by removing duplicates and amalgamating similar exemplars until the required number of approximately 10 exemplars had been reached. Each participant was then asked to copy the list onto a specially prepared proforma, and then rank the exemplars: with '1' representing the exemplar they regarded

as being most important, and subsequent ranks signifying that the exemplars were of diminishing importance (Steps 1-7 resulting in Output 1, *Appendix 8*). Participants were advised that they should only rank those exemplars that they regarded as being important to them and not to rank any that they regarded as unimportant. They were also told not to assign the same rank to more than one exemplar in a desire that they should discriminate between all of the exemplars. There was also space on the proforma to allow participants, should they so wish, to append a qualitative statement or comment alongside each of the ranks. This entire NGW process was then repeated for the *challenging* exemplars of patient-centred professionalism.

The data generated from the ranking exercises (Output 1, *Appendix 8*) were assimilated for each workshop. Median ranks with interquartile ranges (IQR) were calculated for each of the exemplars on the positive and challenging lists and a consensus ranked list was produced based on these final median ranks.

### **Generation of exemplars**

The NGW exercise was modified and extended to include an additional multi-group ranking round (Steps 10-12, *Appendix 8*). Following the completion of the six individual workshops rather than compiling a complete list of positive and challenging exemplars for further ranking, the final positive and challenging exemplar lists from each of the workshops were organised into a series of common themes (Step 8, Output 2, *Appendix 8*). The development of themes was done to ensure that all participants had an equal voice and that issues regarded as important by one group were not diluted by the greater participation of another group. Independently of each other, two of the study team (FR and HH) reviewed the complete set of exemplars (n= 64 positive and 66 challenging exemplars) and sought to identify themes that were thought to encompass both positive and the challenging exemplars. The thematisation involved reducing the number of items in the full set of exemplars. Exemplars that were duplicated across lists were amalgamated into a single exemplar. A third member of the study team (SW) then generated a final set of common themes based on the thematisations by FR and HH. Further condensing of the positive and challenging exemplars was undertaken by amalgamating similar exemplars and producing a new overarching statement for that exemplar if necessary.

## Demographics: seven consultation workshops

This section outlines demographic information regarding each group of workshop participants and details the recruitment strategy for the consultation workshops.

We recruited across South and Mid-West Wales Regions as indicated in the Study Protocol. Recruitment was purposively designed for patient and professional groups, to include a wide range of views and professional experience and knowledge across community pharmacy types: small independent pharmacy shops, small and large chains and multiple pharmacies.

Public members were recruited to include frequent and infrequent users, the old and the young, people with different needs and expectations, a mother/father of young children, a carer and someone with a long-term illness to cover the range of members of the public who use pharmacies. Stakeholders were recruited to include lecturers and education providers, policy developers and policy implementers.

Participants were contacted by letter by the RA and each potential participant was sent an information pack and consent form. Signed consent indicated willingness to participate. Participants were assured that all information would be anonymised and information would be treated according to the ethical principles of confidentiality. Following consent, all participants were contacted by the RA to arrange the consultation workshops and were sent the bi-photographic data two weeks ahead of their workshop. All consenting participants agreed to be tape-recorded during the consultation workshops.

Whilst we aimed for six study participants to each group there was both an under and an over-achievement of these numbers across the sample, whilst our overall figure was 39 out of a predicted 42-participant sample.

Under-achievement of predicted numbers (stakeholder, pharmacist 1 and newly qualified pharmacist 2 groups) was due to difficulties in accessing professionals, getting professionals to agree to attend daytime workshops or to spend the necessary four hours in consultation with team members (professionals, staff and stakeholders were particularly concerned to leave their jobs for that period of time, and pharmacists indicated that financial incentives would not be enough for locum cover). In addition, there were a number of non-attendees on the day.

Over-achievement was due to running two evening workshops, (Pharmacist 2 and newly qualified pharmacist 1 groups), great interest in the study topic and support for study team members. Please note: the predicted sample of pharmacists and members of the public was achieved across all public and pharmacist groups (24 pharmacists in total (registered and newly qualified), six members of the public in total). There was a slight underachievement of the stakeholder (n=5), and pharmacy support staff (n=4) samples.

**Groups involved: composition, numbers and recruitment**

- 1) **The public group** comprised six people, four female and two male: two retired women, one a former teacher who described herself as taking a lot of pills and the other with a heart complaint who was a frequent user, a woman with two small children who also made frequent use of the pharmacy, a middle aged woman not currently in employment who was an infrequent pharmacy user, a young male law student who had asthma and regularly visited the pharmacy and a male carer who was a regular visitor.
- 2) **The stakeholder group** comprised five people, two male and three female: The Head of Pharmacy for a Welsh Local Health Board, a representative of the Welsh College of Postgraduate Pharmacy Education, a Principal Policy Advisor for the Welsh Directorate of the RPSGB, a Welsh Pharmacy Board member and a pharmacy teacher.
- 3) **The first pharmacist group** comprised five people, three male and two female: a Locum, a manager of a chain who had worked in the same pharmacy for twenty years, a pharmacy manager of a chain who had previously worked with a number of nursing homes, a pharmacy manager working in a large pharmacy chain and a pharmacy manager working in a large multiple who had been qualified for three years.
- 4) **The second pharmacist group** comprised nine people, six female and three male: spread evenly across community pharmacy types and those working in supermarket chain pharmacies. This group included two locums.
- 5) **The pharmacy staff group** comprised four people, all female: two of whom worked for Multiple pharmacies and two of whom worked for large pharmacies.
- 6) **The first newly qualified pharmacist group** comprised nine people, two male and seven female, spanning all community pharmacy types. Participants covered a range of urban and rural practices and were from across Mid and South Wales areas.
- 7) **The second newly qualified pharmacist group** comprised one attendee, a male locum of long standing who was based in South East Wales.

## Study outcomes leading up to the Interim Report

The following study outcomes were achieved during the period of time between the project start date and the time of the submission of the Interim Report:

- Qualitative publications in preparation for the Interim Report;
- Lists of positive and more challenging aspects of patient-centred professionalism;
- Visualisation diagrams of all groups positive and challenging exemplar work;
- Complete list of exemplars.

The sections below, presented according to the three workshop sessions, describe in detail how the study outcomes leading up to the Interim Report were achieved, and provide the numbered Appendices where these outcomes can be considered in detail.

### Session One

The qualitative publications enclosed with this report (*Appendices 10 and 11*) detail the work of Session One, and describe data collection and analysis and how in-depth qualitative, thematic and content analysis of this session identified the following four major themes and sub themes:

- ***Building caring relationships***
  - Pressure in the workspace
- ***Managing external forces***
- ***The effects of environment***
  - The look of the community pharmacy
  - Consulting in the community pharmacy
- ***Different roles and expectations***
  - Differences in GP and community pharmacy roles

### Session Two

Study participants developed lists of positive and more challenging aspects of patient-centred professionalism during Session Two (facilitated by HH). In order to develop these lists participants extended their discussion of the examples presented in Session One around the kinds of people working in different workspaces and how workspace gave on to practice. Participants entered a general discussion around stressors and benefits of different spaces in terms of professional-patient communication, building trust with the public, relationships with other health professionals, personal and professional need, etc. Participants considered their own experience and the experience of others in thinking around these issues, describing why they perceived it to be important that patients had timely, appropriate and effective services provided.

Discussions were then given greater focus around eight headings presented to each group on flipcharts that enabled participants to clarify which aspects or categories related specifically to patient-centred professionalism. The original headings were derived from previous workspace and practice research (see: Rapport, Doel et al. 2006; 2007; 2008a&b; 2009), and with these as anchor points, discussions were lively and productive.

Headings were as follows:

- Relationships in practice
- Healthcare practice and notions of professionalism
- Patient and professional needs and expectations
- Interaction and communication
- Changing roles of pharmacists
- Changing healthcare spaces
- Building trust
- Organisation and management of space

**Appendix 2** highlights the views of participants in terms of headings and categories.

### **Session Three**

Session three (MD facilitator) was the final session of the workshop and concentrated on Nominal Group Work activities to clarify the group's views on the aspects of practice they disclosed in Session Two. Session Three also aimed to bring together the previous two sessions' outputs and to firm up group understanding on the topic under review. The facilitator provided participants with two pre-designed, blank proformas, one for positive exemplar lists and one for challenging exemplar lists (see *Appendix 3* which shows examples of completed proformas).

For the positive and challenging exemplars, a short paragraph was written defining the outcomes of the group (see *Appendix 4*) for a summary of the positive and challenging exemplars from each of the workshops). As can be seen from the summary paragraphs some of the groups had widely differing views regarding what they regarded as being positive and challenging examples of patient-centred professionalism.

### **Complete list of all exemplars**

*Appendix 5* is a complete list of all exemplars across participant groups. The list is illustrative of group views.

### **Newly qualified pharmacist workshops**

In the final two workshops with newly qualified pharmacists (2 groups, n=10), the sessions were organised differently across the workshops. Session One (previously the bio-photographic dataset session that looked at workspace and practice) was removed from the workshops to make way for a new session, added at the end of the workshops, which compared and contrasted the newly qualified pharmacists' lists of exemplars, exemplar scores and qualifying statements with previous groups' lists that had been developed

through their exemplar work. Thus Nominal Group Work with newly qualified pharmacists enabled them to not only devise their own lists, but once this activity was completed, consider the views of others and discuss differences and similarities in those views with the previous groups' views. In order to support the newly introduced Session Three (comparison of their views with others' views), Visualisation Diagrams of all the other groups' positive and challenging exemplars were produced (see *Appendix 6*, for example).

## Forum Event

Following the Interim Report and first Steering Group meeting with the Trust a Forum event was held on 14<sup>th</sup> July 2009, it was the final stage of the data collection phase for this Pharmacy project. All thirty-nine study participants who had attended one of the previous consultation focus groups were invited to attend the event. Twenty-two participants attended the Forum event, with good representation from each of the study's original workshops. These were: established pharmacists (n= 7); newly qualified pharmacists (n=2); pharmacy staff (n=3); stakeholders in pharmacy (n= 4) and members of the public (n= 6). In addition, members of the internal Swansea University project team, the wider co-applicant project team and a representative from The Trust attended the event. MD, HH and SW (Swansea University) were responsible for presenting and facilitating during the Forum event and the co-applicant project team members supported the event by capturing data and feedback through note taking.

The principal purpose of the Forum was to feedback the preliminary findings on the thematic groups of positive and challenging exemplars of patient-centred professionalism, which had been defined by the study team. Specifically, the event was a further opportunity to explore the importance and significance attributed to each of the thematic groups. The thematic groups had been elicited and developed by the study team based on analysis of the quantitative and qualitative data and the eleven themes were:

### Eleven themes

- Safety
- Professional characteristics
- Patient characteristics
- Professional pressures
- Environment
- Accessibility
- Training
- Relationship with patients
- Confidentiality & privacy
- Services
- Changing professional roles

Prior to the Forum event the study team decided it would be useful to engage the wider group of thirty-nine study participants in an exercise of ranking the thematic groups in order of significance. It was envisaged that the data collected from this activity would form the basis for discussion at the Forum event. Each study participant was sent a set of eleven cards to score. Instructions to participants were to score '1' for the most important theme through to '11' for the least important theme. Each card was related to one of the eleven themes (see above) and encompassed a list of both positive and challenging aspects of each theme. They were advised that they should only rank those themes that they regarded as important. Space was made available to provide qualitative information on the rank order if desired (Step 9,

Appendix 8). Participants were asked to return the ranked cards prior to their attendance. An example of this work is provided below:

<b>SAFETY</b>	
<b>Positive Examples</b>	<b>Challenging Examples</b>
Correct prescriptions for patients	Increased workloads and pressures compromise on quality of service to patients
Good hygiene	Mistakes in administering/delivery of medicines
Adherence to codes of conduct and accuracy of service in the interests of patient safety and welfare	
<b>RANK &amp; Comments</b>	

*Example of themed card sent to participants*

A total of twenty-four sets of scored cards were returned by the study participants, twenty-one of which were completed correctly and were used for analysis purposes. The outcome of this quantitative research activity was a consensual ranked list of the thematic groupings of the positive and challenging exemplars of patient-centred professionalism. Median ranks and interquartile ranges (IQR) were calculated for each of the themes, and a consensus ranked thematic list was produced based on these final median ranks. This list was presented at the Forum event for discussion.

<b>Rank (1 = most important)</b>	<b>Theme</b>
1	Professional characteristics
2	Safety
3	Relationship with patients
4	Services
5	Confidentiality and privacy
6	Training
7	Environment
8	Accessibility
9	Patient characteristics
10	Professional pressures
11	Changing professional roles

*Table illustrating consensual ranked list of thematic groupings of exemplars of patient-centred professionalism **before the Forum event.***

Attendees were arranged into three groups. The groups were organised to ensure a mix of pharmacists, newly qualified pharmacists, pharmacy staff, members of the public and stakeholders in each group. The event began with introductions by MD followed by a short presentation by HH who explained the

progress of the pharmacy project thus far, and presented the consensually ranked scores of themes (as above). Following this powerpoint presentation, each of the three groups commenced a facilitated discussion. The objective of the group discussions was to obtain reactions to the list of themes and their consolidated rank order; and to gain a deeper understanding of notions of patient-centred professionalism. Each group was asked at the outset of the discussion to nominate a spokesperson who could feedback the key points and outcomes from their discussion.

The rich qualitative data arising from these discussions was captured in notes by the co-applicant members of the team and from notes made on each group's flipcharts.

At the end of the group discussions, study participants were invited to individually re-score the themes based on their discussion. Each participant was given a personalised re-scoring sheet which was collected at the end of the event. This allowed the study team to perform a re-ranking of the themes and to assess whether the discussions brought about differing results.

Based on the re-scoring, a final consensus list was generated (Step 12 leading to Output 3, *Appendix 8*). Below is the consensual ranked list of themes, ***generated after the Forum event.***

<b>Rank (1 = most important)</b>	<b>Theme</b>
1	Safety
2	Professional characteristics
3	Relationship with patients
4	Confidentiality and Privacy
5	Accessibility
6	Training
7	Professional pressures
8	Services
9	Environment
10	Changing professional roles
11	Patient characteristics

*Table illustrating consensual ranked list of thematic groupings of exemplars of patient-centred professionalism **after the Forum event.***

Each of the groups spent a significant time discussing the themes and considering their importance for the pharmacy, pharmacists, and the public. *Appendix 9* provides a **summary of the qualitative data** collected at this event.

## Further Study Outcomes

Further project outcomes, achieved following the submission of the Interim Report include:

- A Template of Patient-Centred Professionalism (this template is presented as a separate booklet (attached) and includes an executive summary of the eleven themes)
- Publications

Published:

- *“Through the looking glass: public and professional perspectives on patient-centred professionalism in modern-day community pharmacy” (See Appendix 10)*

In Review:

- *“Obtaining consensus regarding patient-centred professionalism in community pharmacy: nominal group work activity with professionals and members of the public.” (See Appendix 11)*

- An additional publication on the themes from the exemplar building activities is in preparation.

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## Summary of Appendices

- Appendix 1 Summary of workshop participant sample
- Appendix 2 Response to Session 2 categories across all participant groups
- Appendix 3 Proforma used in to Session 2 of consultation workshops
- Appendix 4 Examples of exemplar-building, scoring and collation activity from the public and 'pharmacist 2' workshops.
- Appendix 5 Sessions 2 and 3, Outputs from Nominal Group Work: All exemplars
- Appendix 6 Appendix 6. Examples of Visualisation Diagrams for positive and most challenging aspects of patient-centred professionalism. (Positive exemplars from Public group)
- Appendix 7 Details of Forum Event Study Participants
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- Appendix 9 Summary of Forum Event Group Discussions.
- Appendix 10 Publication
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## Appendix 1.

### Summary of workshop participant sample

<b>Group name</b>	<b>No. of participants</b>	<b>Location</b>	<b>Pharmacy type or Role, function, characteristic</b>	<b>Male : Female ratio</b>
Members of public	6	3 x Cardiff 2 x Swansea 1 x Neath	1 x occasional user 1 x carer 1 x older person 1 x parent 1 x person with long-term condition 1 x teenager	2:4
Stakeholders	5	1 x Rhondda Valley 4 x Cardiff	2 x pharmacy teachers (Welsh School of Pharmacy Postgraduate Education & Teaching Fellow) 2 x policy developers (Welsh Directorate Royal Pharmaceutical Society & Welsh Pharmaceutical Board) 1 x policy implementer (Head of Pharmacy & member of a Local Health Board)	1:4
Pharmacy staff	4	2 x Swansea 2 x Neath	2 x pharmacists from large chains 2 x pharmacists from multiples	0:4
Pharmacist 1	5	5 x Swansea 1 x Neath	1 x locum 1 x pharmacist from an independent shop 2 x pharmacists from large chains 2 x pharmacists from multiples	3:2
Pharmacist 2	9	9 x Swansea	2 x locums 1 x pharmacist from independent shop 1 x pharmacist from multiple 5 x pharmacists from large chains	3:6
Newly qualified pharmacist 1	9	3 x Cardiff 2 x Llanelli 1 x Gwent 1 x Carmarthen 2 x Swansea	6 x pharmacists from large chains 1 x pharmacist from independent shop 1 x pharmacist from multiple 1 x locum	2:7
Newly qualified pharmacist 2	1	1 x Barry	1 x locum	Male

## Appendix 2.

### Study participants' responses to Session 2 of workshop based on key headings discussed

Category	Public	Stakeholder	Pharmacy 1	Pharmacy Staff	Pharmacy 2	Newly Qualified 1	Newly Qualified 2
<b>Relationships in practice</b>	<p>Less formal than a GP. Don't want a relationship with the pharmacist. Prefer a consulting role with GPs. Visiting pharmacists was better-more accessible, no time constraint. Role to play in the advice and treatment of minor ailments.</p>	<p>Pharmacy not generally well accepted within the healthcare process. Lack of respect of role and knowledge of the pharmacist. Feeling of demoralization. Undervalued and underutilised. Consistency of roles benefit relationships in practice.</p>	<p>Staff issues. Managers responsible for pharmacies. Need for adaptable and trained staff.</p>	<p>Good personal and professional relationships. Team working within individual pharmacies. Less familiarity across other healthcare professions. Poor relations between pharmacy staff and 'shop' staff.</p>	<p>Knowing the patient. Staff shortages due to profit-related issues. Having less time to spend with patients due to increased work tasks.</p>	<p>Lack of training of pharmacy staff. Pharmacy staff – front line-pressure being taken away from pharmacist. Difficult relationship with pharmacy staff. Relationships with some GP's may be difficult-question pharmacists' judgment. Like the patient focused job. Better relationship with h-c professionals needed. Some GP's do not want a relationship with pharmacists.</p>	<p>Locums – essential role but cannot provide same services. Trust between patient and pharmacist develops over time. Reinforcing GP, for example, pharmacist has better understanding of medicine. Bonus for patients, and can provide reassurance. Limited need to build relationship with GP.</p>
<b>Healthcare practices &amp; notions of professionalism</b>	<p>Pharmacists not viewed in the same way as GPs. Different role- lack privacy, patient knowledge, more varied role. Commercial and budgetary controls impacted on professionalism.</p>	<p>Development of people skills. Recognition of patients' need and expectations. Training in communication. Enhanced respect from both patients and professionals. Accountable for prescribing. Conflict of professionalism vs. income. Personal notions of ethics.</p>	<p>More rigid working practices. More similarity across different pharmacy types. Legal implications. Conflict between commercialism and professionalism. Need to increase sales. Inability to influence change. Need to separate the retail and clinical role.</p>	<p>Behaving in an appropriate manner for the job. Thinking about the patient and their 'care' first. Training. Lack of time and/or staff could have a negative impact on working practices.</p>	<p>More diverse role. Pharmacy training more clinically focused. Due to time factors role has less depth.</p>	<p>Lack of interaction between h-c professionals leading to lack of understanding of patients. (GP not relaying to patients about what pharmacists do)</p>	<p>Expectation of being professional (assumed). Responding to patients' needs and expectations. Outsourcing may affect professionalism. Ethics vs. commercialism. Considerations, future? Reinforcement, reassurance from pharmacist to supplement GP source.</p>

Category	Public	Stakeholder	Pharmacy 1	Pharmacy Staff	Pharmacy 2	Newly Qualified 1	Newly Qualified 2
<b>Patients &amp; professional needs &amp; expectations</b>	Limited patient knowledge. Role centred around dispensing. May have a role with limits on GPs time. White coat =professionalism? Look of authority.	Supply. Recognition of different patient needs- consultation vs. speed. Patient self-care and autonomy vs. dependency on pharmacist. Patient education needs. Speed and quality of service.	Inequitable service across different pharmacies. Patients expect an immediate and accessible service. Disrespectful behaviour. Increased visibility. Need for increased promotion of services. Patient education.	Efficient well run and staffed pharmacies. Patients expect or want to see a pharmacist. Patients expect good and efficient service. Good academic ability. Younger, newer pharmacists more up-to-date knowledge. Familiarity showed professionalism. Achieving company targets may or may not affect patient care.	Increased patient knowledge. Increased patient expectations. Patients expect a return. Patients sicker and more stressed. Lack of family infrastructure. Volume of prescriptions increased. Training inadequate.	First port of call for patients. Having to multi-task. More stress. Lack of patient understanding of role. Size of practice affects relationship with GP's. GP's dislike MUR's. May create difficult relationships with GP's. Some patients don't want MUR's, or other services Patients don't understand the need for consultation room. Patients expect more than just medicine	Different patient expectations. Regulars want service about specific personal problems. Ad hoc expect knowledge about all types of medication. Often first port of call, particularly for patients who don't like GPs. Speedy and accessible service (convenience).
<b>Interaction &amp; communication</b>	Offer caring and community-oriented role. Lack communication and interaction role with patients. Lack of visibility an issue. Medicine reviews- positive role in improving interaction.	Enhanced training in communication skills. Greater, more defined and earlier exposure to patients in training. Good eye contact with patients. Good communication, listening and speaking skills. Understanding the expectations of the patient. Enhanced electronic and written information skills.	Effective and efficient communication with staff and patients. Staff training. Managing patient expectations.	Presenting a 'public face' to patients. Patients can sense a lack of approachability/professionalism in the way staff acted. Open communication with colleagues. Educating patients regarding the roles of the pharmacist and staff. Local pharmacies that interact more with patients may have less time to achieve targets.	Need to be honest with the patient. Communicate with patients regarding workload and waiting times.	MUR review has served to educate patients. Role of pharmacist has been promoted in a business fashion rather than a clinical fashion. GP's not relaying info about pharmacists to patients. Getting past GP reception is difficult.	Responding to individual patient's needs. Being able to recognize symptomatology through patient approach – forensic analysis. More patient interactions in community. Community requires 'learning' process of communication. Lack of consultation room affects ability to interact with patients effectively.

Category	Public	Stakeholder	Pharmacy 1	Pharmacy Staff	Pharmacy 2	Newly Qualified 1	Newly Qualified 2
<b>Changing role of pharmacist</b>	Medication reviews. Lack of promotion of services.	More clinical role. Promotion and education changing role. Need to create an interactive team within pharmacy. Need to work more closely with other healthcare professionals. Conflict of funding vs. prescribing.	Implementation of company changes. Removal of personal autonomy. Pressure to meet business targets. New roles, new contracts and legal responsibilities. Increased anxiety levels.	MURs have effects on other staff. Removal of pharmacist from the dispensary. Loss of customer service. Increased pressure due to increased company targets. More structured roles for pharmacy staff such as ACTs. Level playing field with less hierarchy	Diverse role, e.g in the provision of MURs. Subjected to increased work pressure (both company and financial). Managers and pharmacists. Organisation development profit-based. Working to governmental and contractual Pharmacy delivery does not offer a patient-centred approach. Lack of practical training.	Only 'paperwork' roles are paid for. Shop manager as well as pharmacist (financial responsibility). Managing people. More patient- focused role, MURs, consultations etc. Lack of time, staff with changing role. Changing roles lead to higher stress. Business targets. Profits Business monitoring Lack of company support. Limited time for CPE	In-house clinics (eg. Specialized testing and prescribing) would lower need for GP visit. Foresight necessary, and adapt accordingly. New contract and financial considerations. MURs are a starting point to improve pharmacist's skills. Good for the future. MURs are worthwhile, especially where trust is needed.
<b>Changing healthcare spaces</b>	Too busy/ inappropriate for consulting. Visually separate spaces for different aspects of pharmacy. Dedicated consultation space.	Need for a private consultation room. Prescribing areas more clearly separated from shop areas. More use of the supply transaction.	Some changes possible. Increased visibility. Greater accessibility. Less privacy. Commercial issues.	Physically change the layout of the pharmacy in order to carry out MURs.	Provision of consultation rooms.	Consultation rooms – some are designed better than others.	Move to outsourcing of services in some clinical areas.

Category	Public	Stakeholder	Pharmacy 1	Pharmacy Staff	Pharmacy 2	Newly Qualified 1	Newly Qualified 2
<b>Building trust</b>		Giving the patients the results that they expect. Using information effectively. Promoting the capacity of the pharmacist.	Authoritarian implementation. Increased patient contact through consultation.	Making patients feel safe, comfortable and relaxed. Building rapport. Approach with patients more relaxed.	Resistance to change. Concerns about litigation. Consultation process.	Spending more time with patients through changing roles. MURs mostly positive, and patient education and communication improved.	Relationship over time, and permanent locum can do this better with his/her relationship to patient. Respect. MUR's Regularity builds trust and patient benefits from better health-care.
<b>Organisation &amp; management of space</b>	Having to keep 'one eye on dispensing and one eye on the shop'.	Need for prescription journey to be safe and efficient. Optimal utilisation of space and a better more professional layout. Distinction between retail and prescribing. Accessibility. Better use of space within the High street. Balance between professionalism.	The need to work to pre-designed SOPs. Clear audit trails. The impact of legislation, contracts, clinical governance and ethics	Efficient organisation and management of space allows targets to be met. Separate dedicated dispensary. Patient expectations may differ. Numbers of available.	Consultation rooms may be too small. Organisation of space may be different within different companies. The management and tidiness of space.	Some pharmacists more clinical. Removal of additional products.	Lack of consultation room. Lack of privacy.

### Appendix 3.

#### Proforma document used in to Session 3 of consultation workshops (actual data from workshop with the Public)

Study participants were given the following instructions:

Please **rank** the examples in order of **significance** (Rank 1 = *most* significant; Rank 2 = next most significant; ... Rank 10 = *least* significant).

Rank as few or as many as you think appropriate. **Avoid** joint ranks. Add a brief **comment** to explain or emphasize your ranking if you wish.

#### 1. Examples of POSITIVE patient-centred professional practice in community pharmacy.

Example	Short description (keywords)	Rank	Comment
1	Correct prescriptions	1	Customers will go elsewhere without this
2	Quick efficient services	2	
3	Accessible	4	Primary objective of role
4	Dedicated dispensary	3	Pharmacies need to market these to public
5	Good hygiene	7	
6	List of services on offer	6	
7	Personable	5	Important to have 'people skills'
8	Work with GP	8	In terms of location/hours/consultancy role
9	Relationship with equals	9	
10	Taking one new roles	10	

**2. Examples of CHALLENGING patient-centred professional practice in community pharmacy.**

<b>Example</b>	<b>Short description (keywords)</b>	<b>Rank</b>	<b>Comment</b>
1	Mistakes in administering/delivering medicines	1	Corresponds with C on above list – critical
2	Long waits for prescriptions	2	Corresponds with A above
3	Too busy, problems with multi-tasking	3	Therefore not patient centred
4	Lack of confidentiality	5	
5	Lack of patient history	8	
6	Stress related to heavy workloads	4	Which could lead to mistakes
7	Indistinct environment	6	
8	Lack of clarity of roles and services	7	Improved marketing needed
9	Too commercial	9	
10	Captive pricing	10	

## Appendix 4.

### Examples of exemplar-building, scoring and collation activity from the public and 'pharmacist 2' workshops

EXEMPLAR	Total	Frequency	Average Score (Total/Freq)	Rank	Qualitative comments
C. Correct prescriptions	6	6	1	1	Primary objective of role; If mistakes happen- what is the purpose of pharmacist? Obvious- but I have never had reason to doubt this. Important. Imperative.
A. Quick, efficient services	15	6	2.5	2	Customers will go elsewhere without this. No need to wait for appointments. All part of the customer experience/service. Important.
H. Accessible	27	6	4.5	3	In terms of location/hours/consultancy role. Easy to see (as A). Important.
B. Dedicated dispensary	25	5	5	4	Less mistakes. Environment naturally offers a more professional service. Important.
F. Good hygiene	25	5	5	5	Important.
D. List of services on offer	29	5	5.8	6	Pharmacies need to market these to public. What is available. Very useful for people who only visit occasionally. Important.
G. Personable	36	6	6	7	Important to have "people skills". Feel can talk openly/no hierarchy (see I). It is always more pleasant to be helped by personable staff. Important.
E. Work with GP	37	6	6.17	8	For referrals/areas of concern. Makes life easier for the patient For more knowledge about patients. Important.
I. Relationship of equals	35	4	8.75	9	Important.
J. Taking on new roles	36	4	9	10	Important.

*Positive exemplars summary- Public Group (n=6)*

The first three positive exemplars that were classified as being most important to the public group were related to the dispensing pharmacy role, i.e. ensuring that prescriptions were correct, the service was efficient and that the pharmacy was accessible (both socially and in terms of opening hours). These ranks mirrored the challenging exemplar findings. Other issues that were regarded as positive exemplars but were of least importance to the

public group were related to relationships of equals, working with the GPs and taking on new roles.

#### Appendix 4 (cont'd.)

It appears that the public group regard the dispensing role of the pharmacist as being the most important issue and are far less interested in the commercial aspects of pharmacies, their links with GPs and new roles that are emerging within pharmacy. These issues were reflected in both the positive and challenging exemplars.

EXEMPLAR	Total	Frequency	Average Score (Total/Freq)	Rank	Qualitative comments
A. Mistakes in administering/delivering medicines	5	5	1	1	corresponds with C on above list- critical; if mistakes happen- what is purpose?; unpardonable!; critical
C. Long waits for prescriptions	19	5	3.8	2	corresponds with A above (Positive eggs); important for a busy person;
D. Too busy, problems with multi-tasking	24	6	4.0	3	therefore not patient-centred; leading to mistakes being made; very important issue;
H. Lack of confidentiality	25	5	5	4	
I. Lack of patient history	25	5	5	5	very important
E. Stress related to heavy workloads	33	6	5.5	6	which could lead to mistakes; pharmacists will become stressed as GPs are now; can lead to irritability and stress; affects pharmacist more than patient
B. Indistinct environment	24	4	6	7	staff and customers unsure of roles/purpose of visit
G. Lack of clarity of roles and services	24	4	6	8	improved marketing needed;
F. Too commercial	31	4	7.75	9	confused with patient centred professionalism
J. Captive pricing	31	4	7.75	10	

*Challenging exemplars summary- Public Group (n=6)*

The three challenging exemplars that were classified as being most important to the public group were related to the dispensing pharmacy role, i.e. ensuring that prescriptions were correct, they were delivered in a timely fashion and that pharmacists were not involved with multiple tasks that could potentially lead to incorrect prescribing. The issues that were ranked as least important to the public were issues related to the commercial aspects of pharmacy, i.e. other retail roles (selling shampoos, photography etc) and captive pricing.

## Appendix 4 (cont'd.)

EXEMPLAR	Total	Frequency	Average Score (Total/Freq)	Rank	Qualitative comments
J. Patient safety	12	9	1.33	1	Vital at all times. Essential, con activity, its what we are. No hope if this not important factor. Paramount to the profession. Should always be prime concern in all aspects of work. Should be our main priority. Main priority and job of pharmacist. Very important to be able to access a pharmacy.
D. Knowledgeable	32	9	3.56	2	Must know how to act. Excellent knowledge= confident pharmacist. Very important to keep up to date- rapidly changing profession. Important in order to maximise patient safety.
I. Accessibility	34	8	4.25	3	Approachable. Easy to access pharmacist important (plus hours of opening, out of normal hours). No discrimination, all public should have equal access to services provided. Our best advert. Important to be able to access services easily.
K. Service and time	43	9	4.78	4	Most important to give what patient needs. Its all about the patient at the end of the day. Quality of services important as well as time to offer/provide them.
F. Training of support staff	50	9	5.56	5	To support each other. Support staff are essential to providing an efficient service. Important to enable pharmacist to delegate safely. Training in order to provide services.
B. Personable (yourself and staff)	50	9	5.56	5	Very important. Must be approachable or patients go elsewhere. Builds rapport with patients. Need to be approachable.
C. A range of services	39	7	5.57	7	Need to provide services to meet patient needs. Extra services do allow patients to come in.
H. A community pharmacist	50	7	7.14	8	Doing a service to the community. Pharmacy often only point of contact during the week for the elderly. Depends on location!!! If supermarkets, high street, city centre.

L. Integrated with other healthcare professionals	65	8	8.13	9	Need others to help patients. Integrated with other healthcare professionals. Important to drive services.
A. Environment	58	7	8.29	10	Not at top, patients not that bothered if get good quality service from personable staff. Should be covered by health and safety. Important but not the main reason why people use pharmacy. Important to have suitable consultation room for confidentiality.
G. Self caring responsible patients	89	9	9.89	11	Need to be able to keep up with demand.
E. Disalienated	77	7	11	12	Finding other ways to engage with other pharmacists.

*Positive exemplars summary- Pharmacy 2 Group (n=9)*

The first two positive exemplars were related to professionalism, ensuring that patient safety was at the forefront of the pharmacist's mind and that pharmacists had up to date knowledge in order to maintain this patient safety. The following six exemplars all related to providing the patients with a good service in terms of: being accessible, providing efficient and quality service, having well-trained support staff to provide a good service to patient, providing a range of services to patients and taking on a role in the community. The least important positive exemplars related to being integrated with other healthcare professionals, the pharmacy environment, making patients more responsible for their own care and feeling disalienated from other pharmacists.

## Appendix 4 (cont'd.)

EXEMPLAR	Total	Frequency	Average Score (Total/Freq)	Rank	Qualitative comments
N. Compromised quality and safety	17	9	1.89	1	Patient dissatisfaction. Volume of work can lead to reduced patient safety/quality of services. Often work eight hours without a break. Error danger, quality of service. Again can be managed. This could lead to biggest problem in patient centred professionalism. Compromise of quality.
M. Time constraints and stress	28	9	3.11	2	Never enough time. Stress makes it harder to become. Ever increasing workload. Can be improved with managing staff levels. This also contributes to errors, potentially resulting in death of patient.
K. Insufficient staff	40	9	4.44	3	Need enough people to physically work. Staff levels affect everything: in company shops levels are chosen by people not working in that environment. Often due to monetary issues. No fallback when staff are absent through sickness/holidays. Puts more pressure on pharmacist to complete necessary tasks. With improving staff levels work load and stress can be reduced. Increase workload and pressure on pharmacist.
Q. Disidentification/ inappropriate attitudes	39	8	4.88	4	Poor attitude. Important- successful pharmacies have got good relationships with customers. Depends on pharmacist!.
O. Competing demands on professionalism	44	9	4.89	5	Driven instead of by patient need. Profit led, us patient led. Result of remuneration system. Targets leading practice. Is it best for the patient or for the pharmacy? Multiples have some ideas that don't work in practice. Depends on company you work for.
S. Lack of appropriate training	43	8	5.38	6	Need high quality relevant training. No protected learning time.

					In own hands to increase this knowledge. Staff need to be adequately trained to perform job and assist pharmacist.
W. Depending on others	65	9	7.22	7	Bad surgery attitude doesn't help patients. GP surgeries. Better relationships would make life easier.
P. Negative environment	50	6	8.33	8	More refits are being done to increase work area.
R. Locums, continuity problems	61	7	8.71	9	Good locum carries on as normal, not opposes things. Levels of continuity lead to lack of patient trust. Can have a big impact on patients.
T. Isolation	73	8	9.13	10	Need to learn from others. Only one pharmacist per pharmacy. Do not learn from best practice. Missing out on best practice.
U. Negative accessibility	67	7	9.57	11	Must be able to be near a pharmacy. Most pharmacies easily accessible. Making it difficult for patients to gain access to pharmacy/pharmacist.
L. Legal restrictions	79	8	9.88	12	Need more freedom to act in best interest of patients. Many in place due to patient safety. Often cannot offer patient the best treatment available due to legal reasons. Are improving.
V. Demanding patients	65	6	10.83	13	Too much expectation. Will always have demanding.

*Challenging exemplars summary- Pharmacy 2 Group (n=9)*

The challenging exemplars were predominately related to patient issues and were generally the reverse of the positive exemplars. The most important related to compromising patient safety due to volume of work, time constraints and insufficient staff. Disidentification was tied in with the first three exemplars in that inappropriate attitudes could lead to poor customer relationships. Pressure to make money was found to be a compromise to pharmacy professionalism and was regarded as one of the important challenging exemplars. Lack of appropriate training for staff having better relationships with other professionals, negative environments and issues of continuity related to locums were also thought to impact on patient service and care. Feeling isolated from other pharmacists resulting in inability to learn from best practice was much lower on the list as was lack of accessibility to patients. Despite the legal implications of bad practice being discussed at length this appeared as one of the lowest issues on the challenging exemplar list. Although 'demanding patients' were listed as a challenging exemplar, this pharmacy group regarded this issue as being lowest on the list.

## Appendix 5.

### Sessions 2 and 3, Outputs from Nominal Group Work: All exemplars

#### Key to table:

PS = Pharmacy staff

PH1 = Pharmacist group 1

PH2 = Pharmacist group 2

ST = Stakeholders

PU = Public

NQ = Newly Qualified

#### Positive Exemplars

Group	Results	Group	Results
PS	Accessibility issues	ST	Patient safety
PS	Welcoming	ST	Building trust
PS	Knowledgeable, trained staff	ST	Patient needs, wants and expectations
PS	Availability of goods and services	ST	People skills
PS	Rapport	ST	Professionalism?
PS	Helpful and attentive	ST	Respect
PS	Working to a script	ST	Collective team working/support
PS	Comfortable, friendly environment	ST	Balance commercial vs. professional
PS	Confidentiality	ST	Accountability
PS	To leave happy	ST	Profile of pharmacy team
PH1	Demonstrate care/concern/interest to individual	ST	Spatial separation
PH1	Training to communicate	PU	Correct prescriptions
PH1	Education of patients	PU	Quick, efficient services
PH1	CPE	PU	Accessible
PH1	Professional image of workspace	PU	Dedicated dispensary
PH1	Convey a personal professional image	PU	Good hygiene
PH1	Access to privacy/confidentiality	PU	List of services on offer
PH1	More time to consult	PU	Personable
PH1	Separation of healthcare and management roles	PU	Work with GP
PH1	Good relations with other healthcare professionals	PU	Relationship of equals
PH2	Patient safety	PU	Taking on new roles
PH2	Knowledgeable	NQ1	MURs
PH2	Accessibility	NQ1	First port of call for minor ailments
PH2	Service and time	NQ1	Accessible
PH2	Personable (yourself and staff)	NQ1	Building loyalty
PH2	Training of support staff	NQ1	Delivery of accurate information

PH2	A range of services	NQ1	Friendship with patients
PH2	A community pharmacist	NQ1	Good communication
PH2	Integrated with other healthcare professionals	NQ1	Caring
PH2	Environment	NQ1	Happy Customer
PH2	Selfcaring responsible patients	NQ1	Thinking about the patient first
PH2	Disalienated	NQ1	Automatically professional

## Appendix 5. (cont'd.)

### Challenging Exemplars

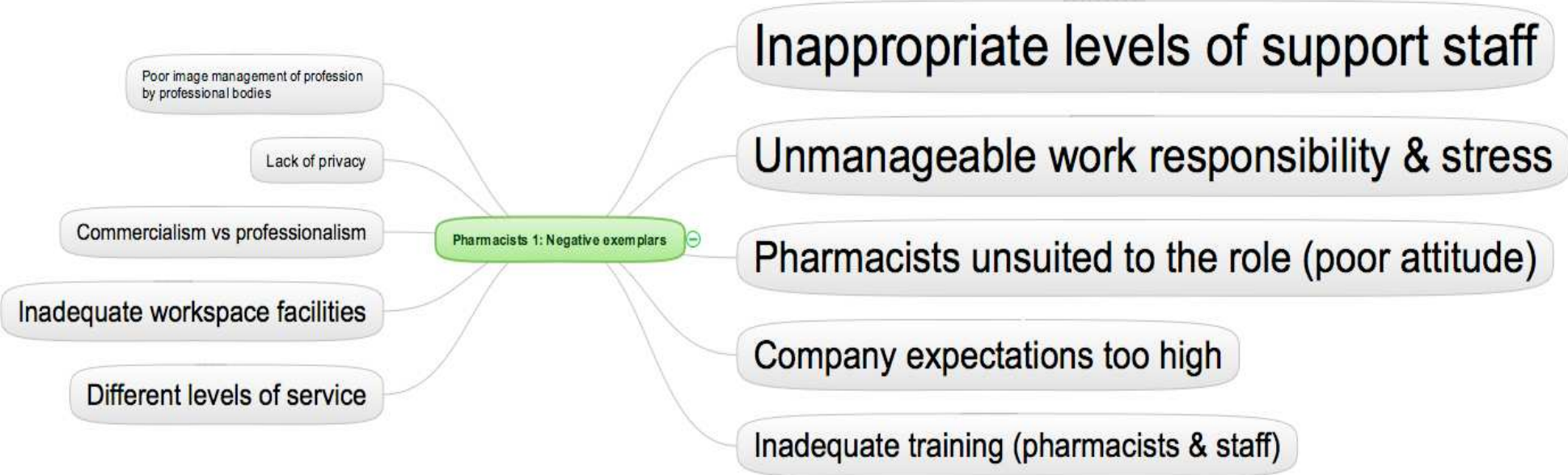
Group	Results	Group	Results
PS	Insufficient staff and time	ST	NHS contract/funding
PS	Unappreciated by management	ST	Time poverty
PS	Insufficient pharmacists	ST	Specific commercial targets and budgets
PS	Management pressure to perform, unrealistic targets	ST	Generic commercial business
PS	Insufficient ACTs	ST	Resistance from other healthcare professionals
PS	Customer pressure, esp. waiting	ST	A need to change patient mindset
PS	Low morale/ being demotivated	ST	Resistance within the profession
PS	Unavailability of stock	ST	Time to train oneself and staff
PS	Lack of company support	ST	Constraints of government policy
PS	MURs shouldn't be separated out from work	ST	Lack of qualified staff
PS	Burden of bureaucracy, burden of paperwork	ST	Clarity and visibility to role
PH1	Inappropriate levels of support staff	ST	Limited space
PH1	Unmanageable work responsibility linked to stress levels	ST	Personal ethics and beliefs
PH1	Role unsuitability	PU	Mistakes in administering/delivering medicines
PH1	Company expectations too high	PU	Long waits for prescriptions
PH1	Inadequate training both pharmacists and staff	PU	Too busy, problems with multi-tasking
PH1	Different levels of service	PU	Lack of confidentiality
PH1	Inadequate workspace facilities	PU	Lack of patient history
PH1	Commercialism vs. Professionalism	PU	Stress related to heavy workloads
PH1	Lack of privacy	PU	Indistinct environment
PH1	Image management of Profession by professional bodies	PU	Lack of clarity of roles and services
PH2	Compromised quality and safety	PU	Too commercial
PH2	Time constraints and stress	PU	Captive pricing
PH2	Insufficient staff	NQ1	Nice to everyone
PH2	Disidentification/	NQ1	Public perception

	inappropriate attitudes		
PH2	Competing demands on professionalism	NQ1	Relationship with GPs
PH2	Lack of appropriate training	NQ1	Other healthcare perceptions
PH2	Depending on others	NQ1	Lack of promotion
PH2	Negative environment	NQ1	Company targets
PH2	Locums, continuity problems	NQ1	Timing
PH2	Isolation	NQ1	Lack of support
PH2	Negative accessibility	NQ1	Changing roles increasing stress
PH2	Legal restrictions		
PH2	Demanding patients		

Appendix 6. Examples of Visualisation Diagrams for positive and most challenging aspects of patient-centred professionalism. (Positive exemplars from Public group)



Appendix 6 (cont'd...) Challenging exemplars from Pharmacist 1 group

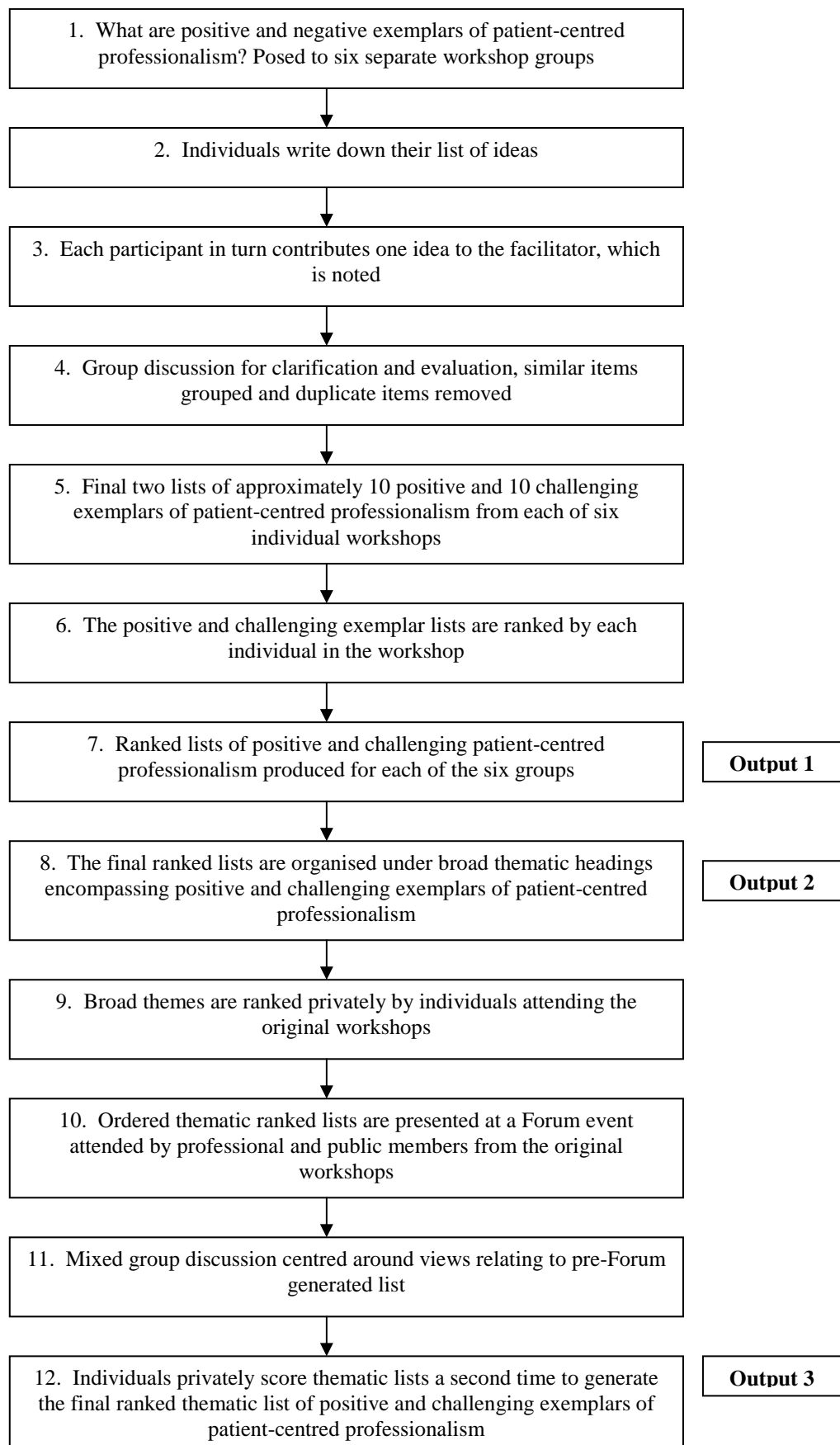


## Details of Forum Event Study Participants

Group name	Participant number	Pharmacy type or role, function, characteristic	Male : Female ratio
Members of public	6	1 x occasional user 1 x carer 1 x older person 1 x parent 1 x long-term condition 1 x teenager	2:4
Stakeholders	4	1 x pharmacy teachers 2 x policy developers (Welsh Directorate Royal Pharmaceutical Society & Welsh Pharmaceutical Board) 1 x policy implementer (Head of Pharmacy & member of a Local Health Board)	1:3
Pharmacy staff	3	1 x pharmacist from large chain 2 x pharmacists from multiples	0:3
Pharmacists	8		5:3
Newly qualified pharmacist 1	2	1 x pharmacist from large chain 1 x pharmacist from multiple	0:2

## Appendix 8.

### Flow diagram steps (1-12) involved in the NGW exercise of the study



## Appendix 9.

### Summary of Forum Event Group Discussions.

The summary of data for each theme is based on the extensive notes made by the co-applicant members of the project team and italicized text represents verbatim comments made by the study participants.

#### 1. Safety

- All study participants in all three focus groups commented on their surprise that safety had not been ranked as number 1 in terms of importance. All study participants confirmed that this should be the most important theme and that it underpinned many of the other themes, which they were asked to discuss and rank in importance. Safety was considered to be a taken-for-granted notion of patient-centred professionalism and more specifically considered as encompassed in the code of ethics set out by the Royal Pharmaceutical Society. It was also considered that safety was inextricably linked to other themes of patient-centred professionalism. For example, a participant in group three commented that increased professional pressures for a pharmacist in practice could compromise patient safety.
- Some members of focus group two discussed the nature of safety, particularly questioning: “What is safe? What is unsafe? Who defines these definitions?” It was concluded within this group that an understanding of safety is defined through a balance of the pharmacist’s own judgement and the code of ethics of the Royal Pharmaceutical Society.
- Some participants in group two also commented on the way in which the patient plays a role in scrutinising the competency of the pharmacist in their dispensary role. There was a suggestion that many patients “are vigilant of their own prescriptions and check what they receive from the pharmacist is what their doctor prescribed.” Thus suggesting that the patient plays a role in ensuring their own safety.

#### 2. Professional characteristics

- Study participants in group two considered that professional qualifications and continued lifelong learning were an assumed given for pharmacists. In addition, the appearance of a pharmacist, in terms of their dress and demeanour, were considered of equal importance. Participants suggested that this could potentially affect levels of public confidence in a pharmacist.
- It was agreed, within group two, that regardless of patients’ characteristics or behaviour, pharmacists were obliged as a professional to treat all patients in the same professional manner. As such, it was felt that it was not necessary to isolate patient characteristics as a theme as it was absorbed within professional characteristics.

- Some members of Group one considered a pharmacist's personality an important aspect of their professional characteristics. For example, "What if a pharmacist is 100% reliable and safe but a pharmacist is miserable – wouldn't matter to me but it might to others". Countering this argument, other members of group one commented that "a key outcome for patients is the reliable safe delivery of final produce, [the] personality of the pharmacist is less relevant."
- Respect for a pharmacist was considered to be an 'earned' attribute. (Group one)

- **Professional relationships and relationships with patients**

- Two members of group two commented that they felt an appealing attribute of the relationship between a pharmacist and a patient is pharmacists' approachability and "personability" in dealing with questions and self-care suggestions for minor ailments.
- There was considerable discussion and comment made regarding the relationship between pharmacists and GPs. Collectively it was felt that each profession need to work at this relationship in terms of understanding each others' roles and in their endeavour to work collaboratively.
- Group two discussed the importance of trust in their relationship and also in the relationship between patient and pharmacy staff. This was endorsed by discussions in group three. Study participants, both pharmacists and patients, expressed that a good working and trusting relationship with each other was necessary in order to maximise the benefits of using a pharmacy for self-care and advice.  
*"it is important to keep the patient-pharmacist relationship strong and based on trust, so the offer of going into a consultation room does not cause any discomfort or awkward social situations..."*
- Group one also commented that 'trust' was intrinsic in terms of the service pharmacists or the pharmacy provide - therefore on both a people and system level. Specifically, participants indicated that they "would change pharmacy if there was a breakdown in their relationship."
- Group one were asked to consider the extent to which 'enjoyment' was part of the experience of using a pharmacy. This group commented that it was likely that individuals with more time were "interested in social interaction but working population more interested in fast efficient service".
- Participants in group one also considered why they used the same pharmacy. Responses included "...loyalty, habit and confidence in the same pharmacy". Furthermore, the discussion in group three ascertained that: *"Different people form different relationships with pharmacists, depending on the illness they have got; individual patient needs demand different levels of professionalism in responding to the patient."*

### **3. Confidentiality and privacy**

- Study participants commented that confidentiality and privacy were a 'given' and an 'inbuilt' aspect of pharmacy practice. *"I assume my pharmacist is going to be confidential"*.
- Several study participants (members of the public) commented on a lack of awareness of the existence of private areas or consultation rooms in a pharmacy. They also questioned the frequency or need for using these. In particular, one member of the public (group three) suggested that: *"Making patients aware of consultation rooms should depend on the illness the purpose of a patient going into a pharmacy"*.

There was also a suggestion that there could be a stigma attached to the use of the consultation room: other customers in the pharmacy might: *"Wonder what might be wrong with them."* (Group three).

### **4. Accessibility**

- Immediate access to healthcare advice and solutions from a pharmacist was considered to be of utmost value, especially at weekends when GP surgeries are closed.
- The importance of close geographical accessibility and proximity to a pharmacy was commented upon within all group discussions. Specifically, it was felt that a pharmacy in close proximity to a patient's GP surgery was most favourable.

### **5. Training**

- Study participants in group one suggested that training was expected and assumed of a pharmacist. This resonated across all three groups. As such it was considered very important but was taken for granted.

### **6. Professional pressures**

- Study participants recognised that professional pressures experienced by community pharmacists could impact on patient safety. Patients may not be aware of the professional pressure which pharmacists must manage and therefore may not consider it significant.

### **7. Services**

- The range of services offered within a pharmacy was considered to be important by all groups. The study participants concluded that the availability of professional services; products in a pharmacy; competitive pricing and a good relationship with the pharmacist influenced how people choose one pharmacy over another.

### **8. Environment**

- Study participants agreed that the space and place of a pharmacy should be: *"Clean, well-stocked and there should be things to look at"* and they also acknowledged and accepted that the environment within a pharmacy may vary according to the type of pharmacy or

the type of services offered within a pharmacy. For example: *“Local pharmacies are different to chains – they reflect what a pharmacist wants their pharmacy to look like”*.

## **9. Changing Professional Roles**

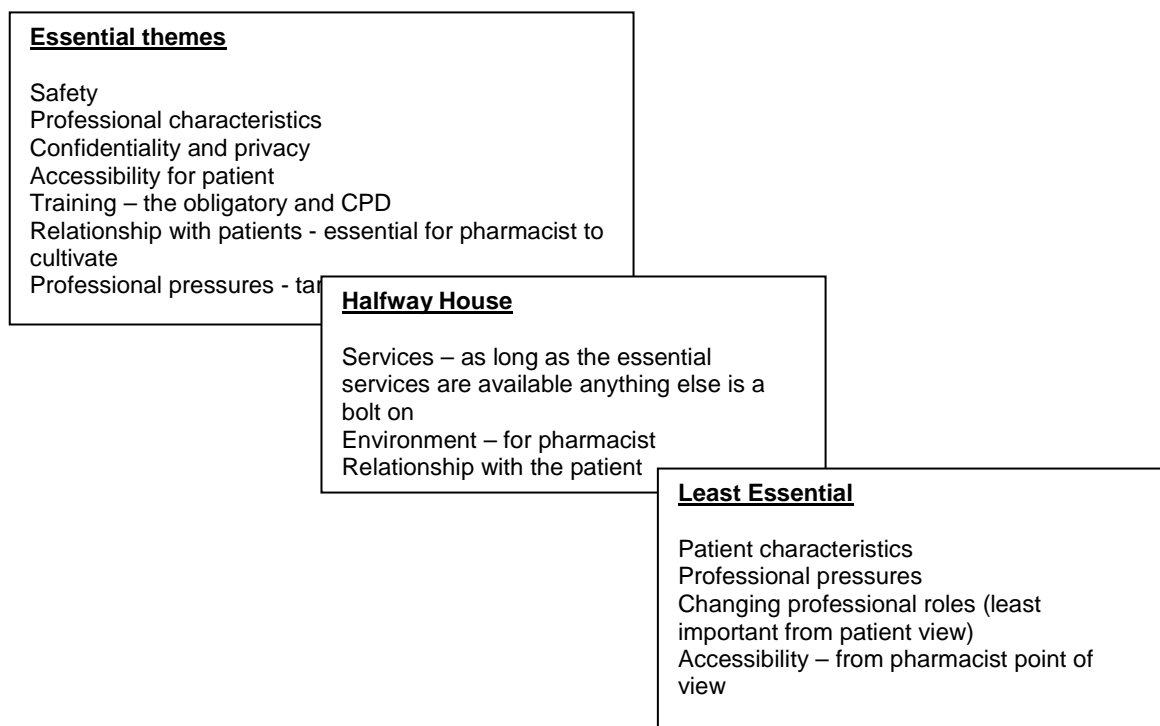
- The perception of importance associated with this theme varied from patient and professional perspective. For patients: study participants questioned how many patients were aware of changes occurring within the pharmacy profession and of their impact for the patient. One study participant, a member of the public, highlighted that a concern for patients might be that an expanded role and remit for a pharmacist could reduce their availability and approachability. From the pharmacists' perspective, the changing nature of their role could potentially increase the burden of work pressures, especially when tied to corporate demands (particularly for those pharmacists working for a national chain of pharmacies).
- There was also a suggestion from members of group three that differing perceptions of pharmacists are held by individuals from different generations.

## **10. Patient characteristics**

- Some study participants (group three) commented that patient characteristics was the only theme which could not be particularly influential. More specifically, patient behaviour is based on: *“Past and current experiences and these sorts of expectations shape their interaction with pharmacists.”* The notes from the individual groups suggest that pharmacists' expect and accept patients' characteristics to vary and particularly feel: *“That patients are the ones that make their work interesting. There are a lot of lovely people and a few odd ones.”*

## **Suggested Clustering Approach to understanding importance of themes of patient-centred professionalism**

Several remarks were made during the group discussions regarding the appropriateness and associated difficulties of ranking each of the eleven themes. Within each group, individuals commented that it was difficult to define and understand each theme without referring to others at the same time, as each theme was inextricably linked to another. As such, group three suggested a clustering approach to ordering the themes in terms of significance. Specifically, members of this group felt that the list of themes did not fit into the neat hierarchy of scoring one to eleven. Instead they designed a flow chart which illustrates a clustered approach to understanding notions of patient-centred professionalism.



## Appendix 10

**Vicky can you insert the PDF of this publication – Frances said you will have it.**

**Through the looking glass: public and professional perspectives on patient-centred professionalism in modern-day community pharmacy**

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**Abstract (255 words)**

This paper presents the results of five extended consultation workshops with twenty-nine community pharmacists, stakeholders and patients, in order to examine the concept 'patient-centred professionalism' in the context of a pharmacists' working day and work environment. Patient-centred professionalism is a concept that is ill-defined in both medical and pharmacy literature and this study aimed to clarify the situated nature of the term for patients and health professionals working across a range of community pharmacy settings. The workshops were supported by bio-photographic datasets of 'in-situ' health professional practice and Nominal Group Work activities. The paper reports the qualitative elements of data capture and analysis. It presents demographic details of the workshops and thematic content analyses under the themes: building caring relationships; managing external forces; the effects of space and environment, and different roles and expectations. The study revealed that patient-centred professionalism cannot be defined in any singular or stationary sense, but rather should be seen as a 'moving feast', best understood through the everyday examples of practice and interaction, in relation to whose experience is being expressed, and whose needs are being considered. The phrase is being mobilized by a whole series of interests and stakeholders to reshape practice, the effect of which remains both uncertain and contested. Whilst patients, for example, clearly prioritise a quick and efficient dispensing service provided by knowledgeable pharmacists, pharmacists rail against the increasing demands of the public and overtly formalized consultations that take them away from the dispensary where they feel the defining aspects of their professionalism lie.

**Keywords** patient-centred professionalism, UK community pharmacy, public and professional perspectives, bio-photographic data, consultation workshops  
**Paper word count 7,743**

[In this paper the terms: public, customer, patient and client are used interchangeably]

## **Through the looking glass: public and professional perspectives on patient-centred professionalism in modern-day community pharmacy**

### **Rationale**

This paper reports on a study using extended consultation workshops with a range of health professionals and patients in Wales, UK, to gain a greater understanding of the concept 'patient-centred professionalism' in modern-day community pharmacy. The study aimed to clarify what patient-centred professionalism meant to different groups of people in the context of the pharmacist's working day and work environment. Understanding was enriched with bio-photographic data contextualising the study and offering examples of the 'in-situ' nature of practice in different work environments, utilised from two previous studies of general practitioner (GP) and community pharmacy settings (Rapport et al., 2006; 2007; 2008a&b).

### **Patient-centred professionalism**

The pharmacy literature provides little insight into the concept patient-centred professionalism in the community, despite renewed interest in the topic (Droege, 2003; Williams, 2007; Pharmacy Practice Research Trust (PPRT), 2009). The broader healthcare and medical literature describes patient-centred professionalism as central to a vision of healthcare evolving appropriately within society (Bohm, 2004; Picker Institute 2008,). This includes instilling good professional values and standards at an early stage in professionals' training and ensuring greater awareness of patient safety issues, in line with a clear professional Code of Ethics (Gordon, 2003; Royal Pharmaceutical Society of Great Britain (RPSGB), 2007a). Dame Janet Smith commented that enhancing knowledge and skills takes place during career development, but fundamental to that, are professional ethical standards and attitudes which must be instilled during training (General Medical Council, 2005). However, there has been little guidance on to instil such attitudes and, more fundamentally, what the notion might mean to health professionals and patients, despite the wide variety of definitions that abound (see for example: Epstein and Hundert, 2002; RPSGB, 2007b). Epstein and Hundert (2002) suggest the notion is predicated on a range of professional and technical competencies, including communication, knowledge, technical skill, emotionality and clinical reasoning.

The study we describe in this paper was based on the premise that to nurture positive professional values and practices, through well-designed teaching

and learning initiatives to create the key pharmacy leaders of the future, one must first understand the notion 'patient-centred professionalism' more clearly. This can be achieved by close observation of professionals in the workplace or, as in this study, through in-depth discussion with patients and professionals to clarify what influences people's understanding. We undertook workshops with: pharmacists (both experienced and newly registered), stakeholders (lecturers, policy developers and implementers), pharmacy staff and the public, to understand how the concept affected personal function, working practice, skill development and formal and informal communication. Pharmacists and pharmacy staff were chosen to represent a range of community pharmacy settings and environments from small independent shops through to large specialist stores and pharmacies in multi-national supermarket outlets.

### **Background to community pharmacy practice**

Community pharmacy in England and Wales has undergone considerable change in recent years resulting from the new National Health Service (NHS) contract and policy framework for service provision (Department of Health (DoH), 2005; Welsh Assembly Government, 2005). The framework included a new, three-tiered community pharmacy service, comprising essential, advanced and enhanced services. Essential services included medicine dispensing, and promotion of healthy lifestyles. Advanced services included Medicine Use Reviews (MURs) (how patients use their medication), and prescription intervention services. Enhanced services, included smoking cessation programmes and supplementary prescribing, such as emergency contraception and Chlamydia screening and treatment. The new services enabled some pharmacists to qualify as supplementary or independent prescribers to help broaden services, increase pharmacists' availability and accessibility and promote healthcare within the community (DoH, 2008).

As a result, consultation rooms were brought into all community pharmacies for confidential discussion and pharmacists began to have timetabled consultations with the public (Blenkinsopp et al 2008; DoH 2005; 2008). According to Pike (2007), however, whilst consultation rooms increased sales of specific items such as incontinence products, they also reduced the pharmacy floor space, and, consequently, income from retail sales. al., 2007 survey commissioned by the Pharmacy Practice Research Trust (Blenkinsopp et al., 2007), indicated that the new contract also increased workload and raised issues about delegation of tasks to staff. Pharmacists were said to be uncertain about how much information to share with members of the public and, with lack of clarity about the specific components of advanced or enhanced services, reluctant to offer services widely. Furthermore, whilst direct contact continued to intensify, there was little clarity about the nature of interaction, which had previously fallen within a *professional dominance model* (Skoglund et al., 2003).

## Study aim

In view of these changes and their reported impact, this study aimed to:

- ❖ Clarify situated understanding of patient-centred professionalism across a range of settings;
- ❖ Position that knowledge in a modern-day environment, accessing the opinions and experiences of patients and professionals;
- ❖ Inform the literature on the value of consultation workshops within the community care context.

## Method

The study was conducted in two phases: Phase I involved half-day consultation workshops with community pharmacists (all seniorities), pharmacy staff, patients and pharmacy stakeholders. Following collation and organization of those datasets and individual and group analyses, Phase II expanded and refined definitions of patient-centred professionalism through coordinated feedback and data gathering workshops with newly qualified pharmacists. Each workshop was tri-sessional, but this paper reports the outcomes of Phase I, Session 1 only to convey the distinctiveness and richness of Session 1 data.

## Recruitment and sampling

*Pharmacists and pharmacy staff* were recruited through a purposive sampling approach (Quinn Patton, 1990) according to: the full range of community pharmacy types from independent pharmacies to large chains including those in supermarket stores. The Team had already made extensive links within the local communities in South and Mid-West Wales and added to this with local stakeholder meetings and LHB lists of pharmacists registered across Regions. By concentrating on community pharmacists rather than hospital pharmacists who practice in environments with completely different dynamics, the team could ensure that those most isolated in practice and less supported by their peers and other healthcare professionals were involved. Similarly, the sample included pharmacy Locums (temporarily fulfilling the duties of a pharmacist), who frequently work across settings with different professionals.

*Patients* were recruited across Regions purposively, to ensure a breadth of views including those of: frequent and infrequent users, the elderly and teenagers, carers, long-term illness sufferers and parents of young children. Patients were recruited through pharmacy contacts, Expert Patient Panels, team contacts and by word-of-mouth using snowballing techniques.

*Stakeholders* were recruited across the Regions with the support of LHB lists and contacts with major pharmacy companies. Stakeholders represented: lecturers and educators, major pharmacy and regulatory bodies, policy developers and implementers.

Once identified, potential participants were sent information packs, defining the study and explaining about data confidentiality and anonymity, and consent forms, which they signed and returned to indicate willingness to participate. Participants agreed to notes being taken and workshops being tape recorded.

### **Consultation workshops**

Consultation workshops are facilitated, extended group interactions comprising small group work and individual activity. Facilitators provide direction and advice and often work together to enable multiple activities to take place (Chapple & Murphy, 1996). Facilitators pay close attention to group dynamics and group cohesion, the way conversations develop across sessions and how complex tasks follow on from each other. The group's response may be considered 'cumulative', as one session influences the next and leads to a deeper clarity of understanding (Claxton et al., 1980).

In line with the literature (Chapple & Murphy, 1996; Bloor et al., 2001), we aimed for an optimal sample of six participants to each tri-session workshop. Workshops lasted for approximately four hours. Session 1 examined the 'in-situ' nature of community pharmacy practice in relation to patient-centred professionalism. This session was supported by visual and textual data from two previous studies of professionalism in practice (GP and community pharmacy settings; Rapport et al., 2006; 2007; 2008a&b). Session Two elicited storied examples of working within, or being supported by, community pharmacy, and led to lists of competencies and other elements necessary for optimal patient-centred professionalism. These were refined during Session Three through Nominal Group Work (Delbecq et al., 1975; Chapple & Murphy, 1996, Lloyd-Jones et al., 2002), where aspects of positive and challenging patient-centred professionalism were identified, discussed, listed and ranked, to arrive at a consensus of opinion about the essential character of the concept (this work will be reported elsewhere). All consultation workshops were organised and run by the same facilitators (FR, HH, MD and CD) to ensure consistent working practice. All workshops were designed to provide a final list of ten positive and ten challenging aspects for consideration by newly qualified pharmacists and refinement into CPD materials. This part of the study is ongoing.

### ***Session 1 Phase I: data gathering***

In line with the literature (Kearns, 1991; Radley & Taylor, 2003), anonymised, bio-photographic datasets reflecting GPs and community pharmacists' own views and images of their workspace, were sent to participants to ground their views and contextualize their experience. Participants were asked to reflect upon the datasets before the workshops, considering their content and implications, and the situated nature of practice. The brief was left purposefully broad to reduce researcher intervention (Rose, 2000). Participants were told that datasets were there to stimulate lively, informed conversation, rather than as an end in themselves.

Session 1 was facilitated by one team member two others taking notes and observing interaction. A fourth member recorded the event. The session followed a general introduction that included some 'rules of engagement', one person to speak at a time, respecting one another's point of view, and positively critiquing one another's ideas. The group was given the opportunity to add their own rules to the list, and asked whether they objected to being taped.

Session 1 commenced with a lengthy discussion of workspace and practice stimulated by the datasets leading to more directed questions around the nature of patient-centred professionalism in different community healthcare environments. Participants were asked who might work in such spaces and talked about the visualization of space and the ability of photographs to extend verbal understanding. They discussed roles and responsibilities, what it meant to be a professional, how trust was developed, shared and individual tasks, different aspects of practice and differences between GP and community pharmacy workspace. Participants discussed qualities of patient-centred professionalism and how these were evoked. Participants provided examples of their own work and competencies, changes in their practice and their experience of entering a pharmacy as a member of the public or a professional.

## **Analysis**

Consistent with our previous research, analysis was conducted at two levels, individually and as a group. Using thematic content analysis we searched for initial themes and categories (Robson, 2002). These were identified and listed before the group came together on two occasions to discuss them in more detail and examine defining elements of the session. Workshop facilitators made copious notes during and after the event and these supported the analysis and informed a further two meetings with the wider study team to refine the data into clearer themes and categories. Individuals organised themes into schematic frames of reference, and, like grounded theory work, clarified interrelated concepts (Strauss & Corbin, 1998).

Thematic analysis, which has been described as including flexibility of method and purpose (Braun & Clarke, 2006), emphasises the relationship between theme and research question and the ability of themes to encapsulate essential elements of the data which would otherwise lose their full coherence. Whilst there are different ways of indicating the prevalence of a theme without quantification, this study used an inductive method which has been used extensively by other qualitative researchers (see: Pope et al., 2000; Miles & Huberman, 2004). Inductive methods allow the major themes belying the text to emerge through data-driven discussion and in-depth interpretation. People work together to hone down categories and expand others, to reveal overall surface meaning (semantic meaning) and underlying notions of understanding (latent meaning) (Braun & Clarke, 2006). The process is iterative, beginning when data are first collected and ending after the final dataset have been collected. Significant statements are clarified

through detailed example (including verbatim quotation), and patterns of meaning and outlier positions are disclosed.

## **Findings**

### **Demographics of five consultation workshops**

Twenty-nine participants took place in five consultation workshops. Participants were spread across Mid and West Wales Regions, across urban and rural communities and groups included both men and women.

***The public group*** comprised six people, four female and two male: two retired women, one a former teacher who described herself as taking a lot of pills and the other with a heart complaint who was a frequent pharmacy user, a woman with two small children also a frequent pharmacy user, a middle aged woman not currently in employment who was an infrequent pharmacy user, a young male law student who had asthma and regularly visited the pharmacy and a male carer who was a regular visitor.

***The stakeholder group*** comprised five people, two male and three female: a head of pharmacy for one of the LHBs, a representative of a professional education body, a policy advisor, a pharmacy board member and a pharmacy lecturer.

***Pharmacist group 1*** comprised five people, three male and two female: a Locum, a pharmacy manager who had worked in the same chain of pharmacies for twenty years, a pharmacy manager who had previously worked with a number of nursing homes, a manager from a pharmacy in a large supermarket chain and a pharmacy manager who had been qualified for three years.

***Pharmacist group 2*** comprised nine people, six female and three male: spread evenly across different community pharmacy types including those in large supermarket chains and smaller national chains. This group included two Locums.

***The pharmacy staff group*** comprised four people, all female: two of whom worked for large pharmacy chains and two of whom worked for smaller pharmacy chains. The participants were spread across Mid and West Wales Regions, and across urban and rural communities.

### **Patient-centred professionalism – thematic findings**

Findings are presented according to the major themes that support or hinder community pharmacists from taking a patient-centred professionalism approach in their work, to shed light on the issues that define a contextualised understanding of the concept for these groups. Quotations are presented according to each group's name, followed by group and participant number (allocated as participants were recruited into the study, for example: patient 1/5, pharmacist 1/4, pharmacist 2/4).

### ***Patient-centred professionalism – building caring relationships***

One of the most striking aspects of the pharmacist and pharmacy staff sessions was the notion of pride expressed – in upholding professional standards, managing work and caring appropriately for the public, and wanting to provide them with an excellent service. For pharmacists, the caring role was synonymous with a strongly individualised understanding of what it means to be a professional and, at the same time, a belief in one's own competency. However, by caring, pharmacists saw themselves as: “victims of our own success” (Pharmacist 2/1). By being so open and accessible they were too much in demand leaving them feeling anxious and put upon by patients who had unrealistic expectations of the services they could deliver. Consequently, whilst pharmacists wanted to be available: “accessibility is our greatest asset” (Pharmacist 2/1) and delegate tasks wherever possible, they felt they were losing control of the overall function of the pharmacy, and found it progressively difficult to achieve balance in their jobs.

Pharmacists recognised the need for good quality “quiet time” (Pharmacist 2/3) with patients, to work with them to ascertain their expectations and ensure the minimum MUR requirements were fulfilled to the correct standard. They were also aware that patients prioritised accurate and speedy medication dispensing over all else, and that this aspect of their work was what was most appreciated. According to pharmacists and stakeholders until the introduction of the new pharmacy contract, dispensing and informal discussion around drug regimes had ensured strong relationships, built gradually over time, through trust and respect: “advice-giving builds up a relationship” (stakeholder 1/2). Pharmacists in particular were keen to stress that they still considered dispensing the mainstay of their job. Trust was linked to: “getting dispensing out of the dispensary” (pharmacist 2/7). This was supported by patients, who said: “the pharmacist's primary objective should be to dispense” (Patient 1/1).

However, under the new NHS contract conflicting demands mean pharmacists have to spend more time consulting. The problem of how best to change their outlook and divide time more appropriately concerns them greatly. Whilst they wish to continue to work in a familiar and comfortable way, they are aware of the new demands for consultation that they see as taking time away from enhancing technical skills towards formal patient interactions that have to be logged and assessed on a weekly basis. It has also been impressed upon those working for large companies that they must be more visible in their work. Consequently, many companies have changed the look of the workspace, introducing open-plan areas and glass consultation booths. Whilst this brings financial benefits, it also places pharmacists in less-familiar territory, and raises their workload. Tasks have also become more complex, and it takes them longer to conduct a consultation in a booth. Ironically, visibility has to their mind detracted from the public's perception of their competency: “they think it is less professional because you are on view”

(pharmacist1/3): “you can’t give your full concentration to the job” (pharmacists 1/4). One of the long-standing pharmacists summed it up thus:

The job has changed dramatically over the last five to ten years. We now have more diversity of role. Before we were just dispensing. We could speak to people and we were not under so much pressure. We are now expected to do MURs and our increase in workload is reflected in the number of tasks we now undertake. There is, amongst the older generation of pharmacists, resistance to change. It is ingrained in many of us that the essential element of our role is to dispense. (Pharmacist 2/2)

However, whilst pharmacy staff discussed the need to support pharmacists during this period of change, “I am an Accredited Checking Technician (ACT), trying to take pressure off the pharmacist” (pharmacy staff 1/2), opportunities to delegate were considered limited. This was due in part to pharmacists’ uncertainty about staffs’ ability to manage all aspects of the workload and pharmacists’ sense of overall (and especially legal) responsibility: “we remain can-carriers” (pharmacist 2/1). It also reflected the external pressures of stringent new policy regulation and Government targets (see forthcoming theme: ‘Managing External Forces’). Pharmacists repeatedly described themselves as “anxious” and “demoralised” (pharmacist 1/3), disliking the new administrative aspects of their job: “if you choose to work for a particular company you have to abide by their rules, but there is a lack of support. You have to give time up to devote to issues like payroll. This is constant and takes you away from professionalism” (pharmacist 1/2). Consequently, many pharmacists have changed jobs to become Locums, or part-time pharmacists, to alleviate administrative responsibilities.

**Box 1. Pressures in the workplace that impact on building caring relationships**

We need to speak to patients, but we may not have the time (pharmacist 2/9).

[Whilst] dispensing a prescription, customers may call over. The prescription is then waiting, the train of thought is interrupted (pharmacy staff 1/4).

We have to do everything. We are getting spread thinner and thinner (pharmacist 2/2).

I hate it from the patient perspective. I always go to see a patient if they want something, but they must see the annoyance on my face if I am busy. I shouldn’t have to pass that feeling on to them (pharmacist 1/4).

We can’t relax from checking (pharmacist 2/4).

Patients expect to see us in 5-10 minutes. This is frustrating. They don't understand (pharmacist 2/7).

I feel diluted as a professional, because dispensing requires 100% attention, leading to conflict at the degree of visibility we have (pharmacist 1/3).

Pharmacists should be consulting and advising but have to check dispensing also. The role needs to be separated (pharmacist 1/4).

### ***Patient-centred professionalism – managing external forces***

According to pharmacy staff, Standard Operating Procedures (SOPs) in each pharmacy must be adhered to in all circumstances, in order to be accountable for one's actions: "[company name] always follow SOPs. If anything goes wrong they refer back. The system must be followed" (pharmacy staff 1/2). Pharmacists, particularly those working for larger Dedicated or Multiple stores, saw work as under corporate control, paid according to corporate financial structures, with jobs that evolved according to output-oriented measures. Within the larger companies, professionalism was synonymous with good management, and pharmacists and their staff expected to reprioritise tasks to achieve competitive retail figures, whilst complying with company policy. Patients are aware of the dual nature of the pharmacist's role and some of the pressures companies place upon pharmacists: "pharmacists are trying to balance retail and dispensing" (patient 1/4) as well as the impact that this can have on patient-centred services: "they have to compromise patient-centred professionalism to do both aspects of the job" (patient 1/4). However, this appears less at the forefront of the patient's mind than that of the professional's, and pharmacists link policy-drivers directly to problems of balance between healthcare and commerce.

Stakeholders described the constant pressure on pharmacists to comply with company rules and achieve corporate targets: "pharmacists must think about business and the pharmacy in making money" (stakeholder 1/4). Moreover, pharmacy staff railed against companies dictating to practices in individual premises, noting that it was the pharmacy manager or support staff, not the company, who knew what was best for the local community. They suggested companies were making mistakes in their decisions about the use of space and working practices, giving as an example the large stock of sales items that normally ended up on the shelves:

Managers know their customers well. They should have more control. We were told to stock certain things then we end up selling them at half price, throwing good money away.  
(Pharmacy staff 1/4)

Pharmacists described the difficulties of balancing expectations of patients and companies. Whilst SOPs provided a framework for their work, being flexible enough to incorporate them and patient-centred professionalism at

one and the same time was challenging. Some of the longer-standing pharmacists reflected that twenty-five years ago the Code of Ethics (Dale & Appelbe, 1989) had brought flexibility into the workplace. Currently (RPSGB 2008) it introduced rigidity and underplayed their independent nature. This was exacerbated by companies being too prescriptive:

Everything about my job is following the guidelines and rules. While that means I am able to do my job easily, I am not being creative or innovative, especially in dispensing. (Pharmacist 1/1)

Pharmacists were concerned that policies and guidelines were misleading and counter-productive, impinging on patient consultation. For example, pharmacists were expected to value the consultation but at the same time minimize interaction in order to maximize profit. Consequently, guidelines that used to be professionally driven were now enforced externally to little effect. This not only reduced pharmacists' professional freedom, it also diminished their autonomy and interest in the job. Within the context of ever growing legislation and concerns about litigation, pharmacists felt: "anxious" (pharmacist 1/2): "isolated" (pharmacist 1/3).

### ***Patient-centred professionalism – The effects of space and environment***

Having considered the bio-photographic material, participants saw the influence of environment on patient-centred professionalism very differently. Pharmacy staff, for example, discussed their impressions of space in relation to both the people working in those spaces and the population groups they served: "rural or urban, rural need to keep more things in the shop for convenience" (pharmacy staff 1/4), "it depends on the people coming through the door; in affluent areas the homely, less-clinical look may be better" (pharmacy staff 1/3). For the pharmacy staff, spatial arrangements and impressions of space were clearly linked to the populations being served.

Patients, on the other hand, considered environment in relation to the different kinds of people who worked in different healthcare settings, not the different members of the public entering those settings, or urban rural considerations. They were less concerned about the look of the premises and sceptical about whether pharmacists could ever display a fully patient-centred professionalism approach in their work, despite changing the pharmacy arrangement and function. Patients described the pharmacist as immersed in medication provision and medication development. It was about the, "nuts and bolts, pills and potions, working with materials which years of research have produced" (patient 1/4). GPs, on the other hand, were involved in a job that was, "person-oriented. They think about the physiology and what is wrong with the person. I wouldn't want to be a pharmacist. They do a job with no initiative" (patient 1/4).

As with the pharmacy staff, stakeholders recognised that pharmacies and GP surgeries attracted very different kinds of people, and, to a degree, professionalism was based on who came through the door. However, unlike pharmacy staff and patients, stakeholders valued the spatial arrangement and

function, contending that it was the environment that had the major impact on professionalism. In general practice, spatial arrangement developed through clearly delineated workspaces and clear professional hierarchies, and differentiated roles: “everyone knows what the GP does, they see them on TV in soaps; they save lives” (stakeholder 1/5). Community pharmacies, on the other hand, developed according to unclear boundaries and unclear roles: “what the pharmacist does is never seen” (stakeholder 1/5). This situation has been exacerbated by the new contract which has led, particularly in larger establishments, to open-plan spaces: “you can ask anything, see anyone” (stakeholder 1/3). Stakeholders and pharmacists described the breaking down of boundaries as unintentionally detracting from patient-centred professionalism, leading to public perceptions that all staff are interchangeable: “the customer picks the person who makes eye contact... They just want to speak to someone, not specifically the pharmacist” (stakeholder 1/4): “pharmacists observe patients and patients observe pharmacists” (pharmacy 1/6). Consequently, pharmacists were seen as less professional than their GP counterparts, with accessibility counterintuitively detracting from, rather than encouraging, patient-centred professionalism.

Stakeholders also pointed to the emphasis on retail sales, in the pharmacy workspace, with a mixed-bag of display items on the counter and shop floor, unlike the GP surgery. Whilst pharmacists could do little more than present themselves as shopkeepers, GPs could present themselves as diagnosticians and consultants:

[UK] Pharmacists don't help themselves in one way. They have bargain bins, it is not professional. The first image is of a shopkeeper, not a health professional. Pharmacies in [mainland] Europe are much better. They are dispensaries with health related products. (Stakeholder 1/1)

GPs are making money but it doesn't feel like it. Pharmacists think about business and the pharmacy making money and it shows. That is a huge perception difference. (Stakeholder 1/4)

All groups talked at length about the look of the premises, particularly their shoddy, cluttered and claustrophobic appearance and in many instances, especially in single owner-manager, Independent outfits, their old-fashioned ambiance. This was particularly evident in more rural areas, as well as some of the smaller, urban shops, where items were piled high in every conceivable space. To some extent patients accepted that it had to be like this because of the pharmacist's retail requirements. Patients justified this approach in relation to the two professions' very different roles: “I am surprised that GP and pharmacist should be related. I see them as two distinct roles. I would not expect the same relationship with GPs and pharmacists... I want different things to take place and I am surprised that the professions should be regarded as equal” (patient 1/1). However, patients remarked on how cluttered space did not appear professional: “pharmacists have lots of ‘goods’ and you have a different impression of pharmacists, which lessens the importance of the pharmacist as a medical man” (patient 1/4).

## **Box 2. The look of the community pharmacy**

There is litter on the floor. That is not a professional image. You have to make the area look professional if you want to be treated professionally (stakeholder 1/1).

Depressing, dark, dismal, too cluttered, can't see customers. I wouldn't like to work there (pharmacy staff 1/1).

Horrendous, very claustrophobic, some of the conditions are so cramped. I wouldn't want to work in these conditions. My pharmacy is very open. We know our roles. Everything is efficient. I can't see that here (pharmacy staff 1/2).

[The bio-photographic data were] surprising. A little depressing in t1, frustrating, they sounded negative about their feelings, space and pressure, more so [with the] pharmacists than [with the] GPs (patient 1/2).

The pharmacy is very cramped. All the medicines there [pointing to the photograph]. Pharmacists seem to be very self-important, seeing customers as an intrusion to work. They should have 1 person to sell and the pharmacist should be behind the counter (patient 1/1).

Pharmacists want to make a profit. They pay out less on their environment (patient 1/3).

GPs see patients as a whole, with all their ailments. Pharmacists are just delivering medication, based on the GP visit (patient 1/5).

[Pharmacist] has a 'virtual' barrier. They have separated from the patient as they have to do their work. They have to compromise patient-centred professionalism to do both aspects of the job (patient 1/6).

While stakeholders concentrated on the changing role of pharmacists in relation to changes in workspace arrangement, they also discussed the environment of the pharmacy and the need to acquire better people skills, through early career training. Pharmacy staff thought training was adequate and of a professional level, but stakeholders were sceptical that trainees, particularly pharmacists, had the basic social skills necessary to ever present a patient-centred professionalism approach. Rather, they saw trainees as having good qualifications and a firm grounding in science, but clinical orientation to the exclusion of all else. In addition, they described the professional 'type' entering pharmacy as not the type to be comfortable with consultation. Pharmacists put lack of people skills down to the training programme itself, which they saw as: "woefully inadequate" (pharmacy 2/4). Pharmacists agreed with stakeholders that the curriculum was science-based

rather than person-based, denying students the basic courses in helping others, like First Aid, with breadth rather than depth of understanding. Whether training or character, this may go some way to explaining why, despite the new remit, consultation skills like consultation rooms are not being fully utilised.

### **Box3. Consulting in the community pharmacy**

Pharmacists are not using the consulting rooms (stakeholder 1/4).

You are taught communication and not consultation (stakeholder 1/3).

Consulting rooms are put in wherever there is a space. No thought has been put into it. Patients may not want to go into the consulting room (stakeholder 1/2).

We could use space differently if we had time to use the consulting space. You can't give your full concentration to both jobs (pharmacist 1/4).

Some pharmacists are not good at communication or people skills. They have no eye contact and are miserable (stakeholder 1/5).

The pharmacy degree [course] attracts 'nerds'. High qualifications are needed. It does not attract people with good communication skills (stakeholder 1/4).

There's a conflict of interests. GPs have a very professional style of consultation. Pharmacists you can ask anything. They are trying to balance business with the professional side (stakeholder 1/3).

### ***Patient-centred professionalism – Different roles and expectations***

Pharmacist as 'shopkeepers' rather than as 'patient-centred health professional' was the response participants gave to the bio-photographic data, in stark contrast to their impressions of GPs and their workspace. Pharmacists defended this position to an extent, by emphasising that GPs could design their own spaces, whilst concentrating on patient need through timely, well-organised appointments. Pharmacists were unable to relax from checking prescriptions or conducting MURs. They were pressurised by patients' unrealistic demands to consult at any time of the day, normally without having a fixed appointment:

Time factors impact the time you can allow each patient. GPs have appointments. Their day is structured. Pharmacists have

to see who walks through the door on any day. Pharmacists can't really plan... If we had more of a structured day we could focus more on the patient. (Pharmacist 2/1)

As a result, pharmacists could not relax or explore the full extent of patient issues, leaving them frustrated and alienated, wanting to escape to the dispensary or consultation room when it was not in use for 'time out', and rid themselves of more insistent clients. Though they recognised the importance of getting to know patients better, through both informal and formal consultation, the consultation room as a 'refuge' for the pharmacist rather than as a 'consultation space' for the patient was for many the preferred option.

#### **Box 4. Differences in GP and community pharmacy roles**

GPs have appointments. The[ir] day is structured (pharmacist 2/1).

We are very restricted by the companies we work for (pharmacist 1/3).

Doctors don't work for companies (pharmacist 1/4).

Doctors have their own space and can organise it how they like. Pharmacists can organise to a degree, but are restricted by company rules and regulations. Some things are imposed. For example, I have to order things by their generic name. I am not always able to work in the way I want. As a pharmacist I couldn't have plants and personal items unless I have approval. What I can do is guided by the company (pharmacist 1/2).

Patients can choose to go elsewhere to another pharmacist so we could lose the business. This is not so for GPs (pharmacist 1/3).

Patients emphasised differences between GPs and community pharmacists in terms of their different approaches to practice. GPs took medical histories and built up relationships with patients over time, taking the initiative with diagnosis and prescribing, and making recommendations for long-term care. Pharmacists were more restricted in all these aspects. In some cases they had no knowledge of the person entering the pharmacy, were limited in the time they could spend with clients and the extent to which they could prescribe medicine. In addition, whilst GPs were driven by what they prescribed, pharmacists were driven by the sales of what GPs prescribed; a subtle yet essential difference that affected their professional standing to the core.

## Conclusions

This in-depth, qualitative, consultation study has begun the process of clarifying 'patient-centred professionalism' in modern-day, UK community pharmacy. This is in line with current interests in this subject worldwide (for example: Hill, 2000; Droege, 2003; Williams, 2007; PPRT, 2009), and in how pharmacy education can play a part in enhancing patient-centredness (Boyle et al., 2006; PPRT, 2009).

Our research investigated what the concept meant to professionals and the public and which elements of professionalism were particularly valued. Whilst our ongoing study will embellish these findings, we can already see not one but many definitions emerging through nuanced, complex, relational sets of ideas. These are dependent on personal positioning (professional or public), individual expectation, and different patient experiences of community pharmacy, as well as shared, group knowledge. Definitions change according to whose positions are being upheld at any given time, and which elements of practice, setting or interaction are being described: the pharmacist's day, the public's experience, the pharmacy environment, the direction the pharmacy profession is moving, etcetera. Thus the concept cannot be defined in any singular or stationary sense, but rather should be seen as a 'moving feast', best understood through the everyday examples of practice and interaction, in terms of whose experience is being expressed, and whose needs are being considered. The phrase is being mobilized by a whole series of interests and stakeholders to reshape practice, the effect of which remains both uncertain and contested.

Patients clearly prioritise a quick and efficient dispensing service, provided by approachable and knowledgeable pharmacists expecting pharmacists to be available as and when necessary. Irrespective of pharmacy environment, if dispensing is timely and advice-giving appropriate, patients feel supported and well-served. Pharmacists are well-matched with this with respect to dispensing being the defining aspect of their work, and see effective dispensing as evidence of patient-centred professionalism. However, whilst taking particular pride in their technical skills, they are unhappy about patients' expectations of immediate accessibility. Indeed, pharmacists rail against an increasingly demanding public and overtly formalised consultation that takes them away from dispensing. Interestingly, this runs counter to the findings of Edmunds and Calnan (2001), whose 2001 study (reprofessionalisation of community pharmacy) indicated that pharmacists were keen to extend their roles into: "the domains that have traditionally been perceived as belonging to the medical domain" (p. 949). Edmunds and Calnan commented that despite a tendency to attribute ultimate authority to doctors, pharmacists wanted to become more patient-oriented. Our study has identified a reversal of views since 2001, and in light of the current emphasis on patient-centred values in pharmacy this may be of concern (RPSGB, 2008). However, the turn-around may be better understood if we take into account workload pressures and their inability to reconfigure the traditional role of dispensing whilst at the same time increasing the patient-centredness of their role. For pharmacists,

expectations that they be more patient-focused appear to compromise their sense of personal integrity and professional self-identity.

Changes in patient expectation regarding the immediacy of service provision, alongside stringent company regulations have increased pharmacists' anxiety, leaving many of them overwhelmed and demoralised. They feel a loss of pride in professionalism and turn away from patients to escape to the dispensary or consultation room. They reflect nostalgically on the time before manifold, external demands, when they could function according to their vision of professionalism within the sanctuary of the dispensary, perfecting technical skills and ensuring an orderly medication through-put. With additional managerial tasks and company requirements to boost retail sales and change health-service delivery, this is a professional group with a diminished sense of self-respect. These findings are in line with Williams' (2007, 'professionalism in South African pharmacy'), who indicated that over-regulation of product pricing, and product-for-profit corporate approaches has negatively impacted on professionals' sense of autonomy.

The professionals' descriptions of the disempowering effects of environment on practice, indicate that neither open-plan space nor old-fashioned, cluttered, ramshackle space (the absent-minded shopkeeper), is entirely welcome. Here is a professional group clearly unhappy with both extremes of design, seeing them as preventing rather than enabling patient-centred professionalism. Moreover, the mixture of retail and dispensing highlights fundamental problems in the smooth running of the pharmacy. Whilst patients insist it is down to the people running the spaces rather than spaces themselves, pharmacists argue that they cannot provide the services patients require because they are victims, not leaders, of stylistic and process-driven change. Pharmacists and stakeholders see change as enforced by out-of-touch, output-orientated company managers, with unreasonable goals in the name of financial gain, leaving professionals torn between the familiarity of dispensing and informal advice-giving, and the unfamiliarity of formal advice-giving, within nondescript, corporate workspaces. They seek alternative professional roles to break free of the shackles of managerial responsibility.

Ramalho de Oliveira and Shoemaker (2006) presented a six-step approach to encouraging patient-centredness in pharmacy practice, including reflective listening, questioning, and recognition of behaviour and expectation. They argued that a current shift in focus from pharmacist to patient heralds an urgent need to change both the pharmacists' mindset and their practice. Whilst we agree that we should reconsider patient-centred professionalism within current practice, this study highlights the more urgent need to consider how change has led to a sense of despondency and disillusionment amongst professionals, and how to counter that. If there is such a number of divides between patient, corporate and professional need, how do we bridge that gap and bring about closer alignment? We would also suggest that whilst considering the different group positions in relation to this multi-faceted, complex notion, the stepped and regimented approach of Ramalho de Oliveira and Shoemaker may be too linear to account for the nuanced disclosure of the concept this study revealed. Rather, we propose each facet could be

considered in its fullness: environmental, relational, practical, spatial, personal, institutional, etcetera, and that in relation to each, the positive and challenging aspects of practice that have been aired are highlighted, so that professionals can know for themselves how workspace and practice could support or hinder their experience. Like Droege (2003) we recommend the introduction of the topic at an early career stage, and we agree that this should include personal reflection, problem-based learning and collaborative teamwork. We would recommend teaching that, in line with the more humanistic problem-based learning approaches (Barrows & Tamblyn, 1980), is supported by a set of schemas or templates with problem scenarios built in that we will identify through ongoing investigation, emphasising exemplars of best and challenging situated practices. This could be reinforced through Continuing Professional Development throughout the pharmacist's career to ensure enhanced people skills that are sustainable. Schemas should cover issues spanning the range of definitions of patient-centred practice that this study has begun to identify, matching them to the trainee or registered pharmacist's knowledge-base.

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## Appendix 11.

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### **Obtaining consensus regarding patient-centred professionalism in community pharmacy: nominal group work activity with professionals and members of the public**

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Key words: patient-centred professionalism, UK community pharmacy, consensus methods, professionals, public, Nominal Group Work technique.

**Abstract**

**Objectives:** The aim of this study was to develop a ranked thematic list encompassing the positive and negative exemplars of patient-centred professionalism in community pharmacy.

**Method:** An adapted Nominal Group Work (NGW) method was used in six individual consultation workshops (2 with established pharmacists, 1 with newly qualified pharmacists, 1 with pharmacy staff, 1 with stakeholders and 1 with members of the public) followed by a mixed group Forum event.

**Findings:** Each of the six workshops resulted in the production of approximately ten positive and ten negative exemplars of patient-centred professionalism. The thematisation of these exemplars allowed the development of eleven broad themes. The mixed-group Forum event then provided a mechanism for ranking the importance of these themes. Safety, professional characteristics and relationships with patients were ranked as the most important themes by our study participants.

**Conclusions:** The adapted NGW was a useful method to allow the development of a ranked thematic list that illustrated the important positive and negative exemplars of patient-centred professionalism in community pharmacy.

## Introduction

There is a dearth of literature within the pharmacy field related to patient-centred professionalism in spite of the fact that a number of recent related studies have examined what professionalism means within the pharmacy context<sup>1</sup> and the role of professionalism in education and practice<sup>2-4</sup>. In addition, whilst the UK's Code of Ethics for Pharmacists and Pharmacy Technicians lays down detailed and clear principles regarding what is expected of these professionals<sup>5</sup> and has been used as a basis for the production of a series of professional standards and guidance documents that expand upon the principles for specific areas of practice or professional activities this has not been undertaken in relation to patient-centredness<sup>6</sup>.

A report by the Picker Institute explored the concept of patient-centred professionalism within the wider healthcare arena and concluded that "for doctors, 'patient-centredness' might mean one of four things: that they work in the patients' interest, that they practise in accordance with patients' preferences or wishes, that they are in partnership with, or involve, patients or that they take a person- 'centred' approach"<sup>7</sup>, but a similar definition has not been stated for pharmacy practitioners and up until this point there has been no UK-based research that has specifically explored what patient-centred professionalism means within the pharmacy arena.

Consensus methods provide a means of synthesising information, and where published information is inadequate or non-existent, they provide a means of gaining insights on views or approaches from appropriate experts and stakeholders<sup>8 9</sup>. Consensus methods aim to establish the extent of agreement on a particular issue. They also aim to overcome some of the problems associated with group decision-making processes, where dominant views may lead the process and crowd out other perspectives<sup>8</sup>.

One of the commonly used consensus methods within healthcare settings is the Nominal Group Work (NGW) technique. NGW was first developed by Delbecq et al in the 1970s as an organisational planning technique<sup>10 11</sup>. The process of NGW normally involves four main phases. Phase one is the nominal or silent phase, during which individuals consider their personal responses to a defined question and write them down without discussion. Phase two is the item generation phase, during which individual participants take turns to share their responses (related to the pre-specified research question) with the wider group. Items generated are recorded as succinct phrases on a flip chart but again are not discussed within the group. Phase three involves a discussion and clarification phase, in which group members are allowed to ask questions in order to clarify items on the list and discuss their merits and demerits. During this process, items with similar meanings may be combined and duplicate items removed. The final phase is the voting phase where each individual is asked to prioritise the listed items by assigning ranks to them. NGW encourages individual contributions and the inhibitory factors of group conformity are avoided with even the more reticent group members facilitated to participate in all phases<sup>12</sup>.

NGW has been widely used within pharmacy to explore such concepts as the appropriateness of long-term prescribing in general practice<sup>13</sup>, addressing recruitment issues in hospital pharmacy<sup>14</sup> and advice-giving in community pharmacy<sup>15</sup>.

The purpose of this study was to employ a modified NGW technique to determine what constitutes patient-centred professionalism and to quantify the relative importance of these issues within a mixed group of pharmacy professionals and members of the public. This paper focuses specifically on the quantitative analysis of the NGW activities and given the complexity of the methodological approach a detailed description of adapted NGW technique is also provided. Given the recent 'paradigm-shift'<sup>16-18</sup> within pharmacy to a more patient-centred rather than commercial approach, as well as extended pharmacy roles<sup>19</sup> this study is pertinent in clarifying what patient-centred professionalism means to these groups. The generation of prioritised themes in this study was carried out within the context of a wider study that examined the issue of "Contextualising patient-centred professionalism in pharmacy practice: consulting with patients, professionals and stakeholders" (results of which have been published elsewhere)<sup>20 21</sup>.

## **Methods**

An adapted NGW technique<sup>8 12</sup> was used to undertake a consultation exercise that would help determine the most important themes related to patient-centred professionalism. The study took place in Swansea, UK. The study was presented to the Chair of the South West Wales Research Ethics Committee and was deemed not to require formal ethical approval due to being classified as a service evaluation and its situation within Community Pharmacy.

### *Participants*

Recruitment was purposively designed to include members of the public and professional groups in order to include a wide range of views and professional experience and knowledge. Experienced pharmacists (greater than 2 years post registration), newly qualified pharmacists (up to 2 years post registration) and pharmacy staff were recruited from all types of community pharmacy and included locums and single-handed manager owners as well as representatives of small and large pharmacy chains and Multiples (supermarket chains). Members of the public were purposively recruited to include people with different needs and expectations: frequent and infrequent users, the old and the young, a parent of young children, a carer and someone with a long-term illness. This also ensured that the workshop would involve the range of members of the public who use pharmacies. Stakeholders were recruited to include lecturers and education providers, policy developers and policy implementers.

Participants were contacted by letter by the study Research Assistant (SW). Each potential participant was sent an information pack and consent form. Signed consent indicated willingness to participate. Participants were assured that all information would be anonymised and information would be treated according to the ethical principles of confidentiality. Following consent, all

participants were contacted to arrange the consultation workshops and were sent data for use in the first part of the consultation workshop two weeks ahead of their workshop. All consenting participants agreed to be tape-recorded during the consultation workshops.

### *Data collection*

#### Consultation workshops

NGW consensus exercises were carried out in each of a series of 6 half-day consultation workshops (2 pharmacists, 1 newly qualified pharmacist, 1 stakeholder, 1 member of the public and 1 pharmacy staff). We aimed to recruit six study participants for each workshop in keeping with the literature on optimal numbers for group consultation events <sup>22</sup>.

The workshops were organised in three parts: the first part involved discussion relating to a series of biophotographic examples from general practice and community pharmacy <sup>21</sup>. The second part encouraged participants to enter into extensive discussion, using personal examples of what patient-centred professionalism meant to them. The examples were organised under a series of broad headings (building trust, patients and professional needs and expectations, relationships in practice, changing role of pharmacists, interaction and communication, healthcare practice and notions of professionalism, organisation and management of space and changing healthcare spaces). The final part of the workshop involved the NGW work exercise in which participants were asked to address the following question: “what are the positive and negative exemplars of patient-centred professionalism?”. The aim of the NGW exercise was to refine and condense issues raised in the first two parts of the workshop into a list of approximately 10 positive and 10 negative exemplars and subsequently rank these in order of significance (Steps 1-7, leading to Output 1, Figure 1).

The generation of the exemplar lists using NGW followed the approach outlined in previous literature on the methodology <sup>8 12</sup>. The NGW exercise began by inviting participants to identify what they regarded as *positive* exemplars of patient-centred professionalism and to write their ideas down on paper. Each individual was then asked to volunteer an exemplar, each of which was written down on a flip chart. Participants were invited to divulge the exemplars on their list in turn, to ensure that everyone participant had an opportunity to contribute fully to the process of exemplar generation. This continued everyone’s exemplars were disclosed. The next phase involved group discussion and clarification of the resulting list of exemplars. The list was then refined by removing duplicates and amalgamating similar exemplars until the required number approximated 10 exemplars. Each participant was then asked to copy the list onto a specially prepared proforma, and then rank the exemplars: with ‘1’ representing the exemplar they regarded as being most important and subsequent ranks signifying that the exemplars were of diminishing importance (Steps 1-7 resulting in Output 1, Figure 1). Participants were advised that they should only rank those exemplars that they regarded as being important to them and not to rank any that they regarded as unimportant. They were also told not to assign the same rank to more than one exemplar in a desire that they should discriminate between all

of the exemplars. There was also space on the proforma to allow participants should they so wish to append a qualitative statement or comment alongside each of the ranks. This entire NGW process was then repeated for the *negative* exemplars of patient-centred professionalism.

The data generated from the ranking exercises (Output 1, Figure 1) were assimilated for each workshop. Median ranks with interquartile ranges (IQR) were calculated for each of the exemplars on the positive and negative lists and a consensus ranked list was produced based on these final median ranks.

### Generation of themes

The NGW exercise was modified and extended to include an additional multi-group ranking round (Steps 10-12, Figure 1). Following the completion of the six individual workshops rather than compiling a complete list of positive and negative exemplars for further ranking, the final positive and negative exemplar lists from each of the workshops were organised into a series of common themes (Step 8, Output 2, Figure 1). The development of themes was done to ensure that all participants had an equal voice and that issues regarded as important by one group were not diluted by the greater participation of another group. Independently of each other, two of the study team (FR and HH) reviewed the complete set of exemplars (n= 64 positive exemplars and n= 66 negative exemplars) and sought to identify themes that were thought to encompass both the positive and the negative exemplars of patient-centred professionalism. The thematisation involved reducing the number of items in the full set of exemplars. Exemplars that were duplicated across lists were amalgamated into a single exemplar. A third member of the study team (SW) then generated a final set of common themes based on the thematisations by FR and HH. Further condensing of the positive and negative exemplars encompassed within each theme was undertaken by amalgamating similar exemplars and producing a new overarching statement for that exemplar if necessary.

### Forum event

Participants that had attended the original workshops were invited by letter to participate in a half-day Forum event with the expectation of recruiting at least 20 of them. All the study team were asked to attend the Forum.

Two weeks prior to the Forum event all participants (including those that could not attend) were sent a pack of A5-sized cards, each of which outlined a broad theme as a header under which were listed the associated set of positive (on the left) and negative (on the right) exemplars that were encompassed under that theme. Participants were asked to rank the *themes* in order of importance: with '1' representing the theme they regarded as being most important and subsequent ranks signifying the themes that were of diminishing importance. They were advised that they should only rank those themes that they regarded as important. Space was made available to provide qualitative information on the rank order if desired (Step 9, Figure 1). Participants were asked to return the ranked cards prior to their attendance.

The data from the returned cards were collated. Median ranks and interquartile ranges (IQR) were calculated for each of the themes, and a consensus ranked thematic list was produced based on these final median ranks. This list was presented at the Forum event for discussion.

The attendees were split into three groups. The groups were organised to ensure a mix of pharmacists, newly qualified pharmacists, pharmacy staff, members of the public and stakeholders in each group. In addition, each group was facilitated by one of the research team who in turn was supported by at least one other member of the study team.

The purpose of the Forum event was to produce a final consensus list of themes that encompassed positive and negative exemplars of patient-centred professionalism and to qualify what these themes and exemplars meant to Forum participants. Following a summary of the information collected and details regarding how it was assimilated, participants were presented with the consensus list produced as a result of the pre-Forum thematic ranking exercise (Step 10, Figure 1). They were advised that there would be discussion regarding the generated lists and asked whether they felt that the ranking was an accurate reflection of the relative importance of each theme (Steps 10 and 11, Figure 1).

Following group discussion of the pre-Forum generated consensus list, the Forum participants were each asked to privately re-rank the themes on the list. Based on these, a final consensus list was thereby generated (Step 12 leading to Output 3, Figure 1).

## **Results**

### *Recruitment to workshops*

There was both an under and an over-achievement of the required sample across the set of workshops, with the overall figure being 38 across the six workshops. Recruitment to the public group was achieved (n=6). We experienced underachievement in one of the pharmacy groups (n=5), the stakeholder group (n=5) and the pharmacy staff group (n=4). Underachievement was due to difficulties in accessing professionals, getting professionals to agree to attend daytime workshops, and an inability for some potential participants to commit four hours in consultation with team members (pharmacists indicated that financial incentives would not be enough to cover a locum). In addition, there were a number of non-attendees on the day who had agreed to participate. We experienced over-achievement for the other pharmacy group (n=9) and for the newly qualified pharmacy group (n=9). Over-achievement was due to running two evening workshops and the great interest expressed in the study topic and support for study team members by participants. Demographic details of each of the workshops is given in Table 1.

### *Recruitment to the Forum event*

Twenty-two participants took part in the Forum event with two non-attendees on the day. Details of those attending the Forum are presented in Table 1. In addition to the participants and seven members of the study team, a member

representing the funding body, the Pharmacy Practice Research Trust attended the workshop.

#### *Consultation workshops*

Positive and negative exemplar lists were successfully produced for each of the workshop groups. Details of the ranked ordered exemplar lists for each of the workshop groups are illustrated in Table 2.

#### *Generation of themes*

Both the team members involved in assimilation of the exemplars produced similar lists of common broad themes. The final refinement of these lists resulted in the production of 11 themes (Output 2, Figure 1). Details of the final thematic list and the positive and negative exemplars contained within them are given in Table 3.

#### *Forum event*

Of the original 38 participants that were sent the 11 themed cards to rank, 24 responded. Of those received, 21 were appropriately ranked and they formed the basis of the ranked list presented at the Forum event. Three participants ranked the individuals exemplars within each theme and were therefore excluded from the analysis. Details of the pre-Forum ranked list are given in Table 4. The themes that were regarded as most important were professional characteristics and patient safety with little separating the two. These were followed by relationships with patients. The themes that were in the 'middle ground' were those of services, confidentiality and privacy, training environment and accessibility. There was little to separate the themes ranked 8-11, which were patient characteristics, professional pressures and changing professional roles.

The ranked thematic list that was derived following the Forum event was based on responses from the 22 attending participants (Table 5). The list differed from the pre-Forum ranked list. The theme that was clearly ranked as the most important was that of patient safety, with that of professional characteristics being second. Little separated the third and fourth themes: relationships with patients and confidentiality and privacy. Following the Forum event the themes in the middle ground were accessibility, training, professional pressures and services. The themes that were regarded as the least important were environment, changing professional roles and patient characteristics.

### **Discussion**

This study attempted to identify the important themes of patient-centred professionalism in community pharmacy with a mixed group of pharmacy professionals, stakeholders and members of the public. Using a modified NGW technique<sup>8 12</sup> we were able to develop and rank a thematic list that encompassed the important positive and negative exemplars of patient-centred professionalism. One of the main advantages of employing a consensus technique was that the more reserved participants of the workshops all had the opportunity to contribute their ideas<sup>12</sup> with the modified process of thematisation allowing the views of all the participant groups to be

represented and considered. In addition, the final consultation workshop which was attended by representatives from all of the original study workshops, facilitated the engagement and further contemplation of different participant views.

There was a surprisingly diverse range of generated exemplars across the workshops, even within the same professional groups (Output 1, Figure 1). This suggests that patient-centred professionalism within community pharmacy is a multi-faceted concept that touches on many aspects of practice, and that its meaning and significance have yet to be settled. The final outcome (Output 3, Figure 1) of the NGW process was a ranked list of eleven themes. The three themes at the top of the list both before and after the Forum were safety (correct prescriptions, good hygiene, adherence to codes of conduct, compromised safety due to increased workloads and mistakes in delivery of medicines), professional characteristics (highly knowledgeable, well qualified, good collaborative links, strong sense of personal ethics, accountable, image management, pharmacists' expectations differing from public and professional bodies and professional isolation) and relationships with patients (personable, attentive, caring, loyal, trusting, self-caring patients, pressure from patient demands, lack of patient history, changing patient mindset and public perception of the pharmacist). The order of these themes changed slightly before and following the Forum. This may have been due to different participants with different views responding pre-Forum to those ranking the list post-Forum; or the post-Forum ranking being influenced by the facilitated discussion of the mixed groups at the Forum. The broad themes that were developed through the NGW process complement many of the principles highlighted in the Royal Pharmaceutical Society Code of Ethics document<sup>5</sup>. Six of the eleven broad themes (safety, professional characteristics, relationship with patients, confidentiality and privacy, training and patient characteristics) are issues that were clearly covered by the seven principles of the Code of Ethics document. It may have been that the pharmacy professionals and stakeholders were influenced by the content of this document when they ranked the thematic list before and after the Forum. Given that the representation of the pharmacy professionals and stakeholders was much greater than members of the public, the order of the themes was likely to be more representative of these groups.

Many of the themes generated by the NGW highlight the 'caring' nature of the pharmacy professionals and that their general outlook is to operate in the best interests of the patient. This accords with the first definition of patient-centredness outlined in the Picker publication that examined patient-centredness in doctors<sup>7</sup>. There does however appear to be some conflict between some of the themes with issues such as changing professional roles and professional pressures impacting on this outlook.

Interestingly some of the themes that were developed through the NGW process do not relate to the Code of Ethics document: specifically those of accessibility, professional pressures, services, environment and changing professional roles. The Code of Ethics document does however seem to focus on the practise of pharmacists and pharmacy technicians rather than

'environmental' issues. In addition, this document is a generic one and relates to pharmacy in its entirety. Our study was situated in community pharmacy and thus may reflect themes that would not necessarily have purchase in hospital pharmacy for example. Some of the themes obtained from the NGW may be more related to the current climate within community pharmacy, for example issues related to professional pressures and changing professional roles. More detailed discussion of these matters has been made elsewhere<sup>20</sup><sup>21</sup> but they may reflect the issues of commercialism and extended roles within pharmacy<sup>16-19</sup>.

In day-to-day practice the importance of these themes is likely to vary according to the context and the specific relationship between pharmacist and service user. In this study the modified NGW process was a mechanism for distilling the important components of patient-centred professionalism in this mixed group of individuals. The process of qualitative elaboration of these themes and what they mean to the pharmacy professionals, stakeholders and public members will provide a more comprehensive picture which could then be used to make recommendations to improve the practice of community pharmacy. This work could then be incorporated into teaching and professional education materials.

Although patient-centred professionalism has been examined in other fields such as general practice, no specific work has been carried out within pharmacy. The study is novel in that it uses an adapted NGW consensus approach with a mixed group of pharmacy professionals, stakeholders and members of the public. It therefore allowed the views of all the participating groups to be considered. This study however was carried out within one geographical location in South Wales, UK and specifically focused on patient-centred professionalism within community pharmacy. Further work is therefore needed to examine whether these views are representative of the wider geographical and pharmacy communities.

## **Conclusions**

Using an adapted NGW method we were able to develop a list of eleven broad themes that encompassed positive and negative exemplars of patient-centred professionalism. A series of individual workshop events with pharmacists, pharmacy technicians, stakeholders and members of the public was followed by a combined Forum event that facilitated the development of these themes and acted as a mechanism for drawing out the views of this mixed group to produce a final ranked thematic list. The themes that were regarded as the most important were safety, professional characteristics and relationships with patients. More than half of the developed themes were issues that were covered in the Code of Ethics for Pharmacists and Pharmacy Technicians document produced by the Royal Pharmaceutical Society of Great Britain. Some of the ranked themes developed were not covered by this document and may specifically relate to community pharmacy. Further work is needed to determine how the ranked themes relate to in-depth qualitative findings and whether the findings are mirrored in other geographical locations and within other aspects of pharmacy. The ranked

thematic lists may be a useful resource that could be considered for the development of teaching materials for pharmacists and pharmacy technicians.

Word count = 4009

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### **Conflicts of Interest**

None

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Figure 1. Flow diagram steps (1-12) involved in the NGW exercise of the study

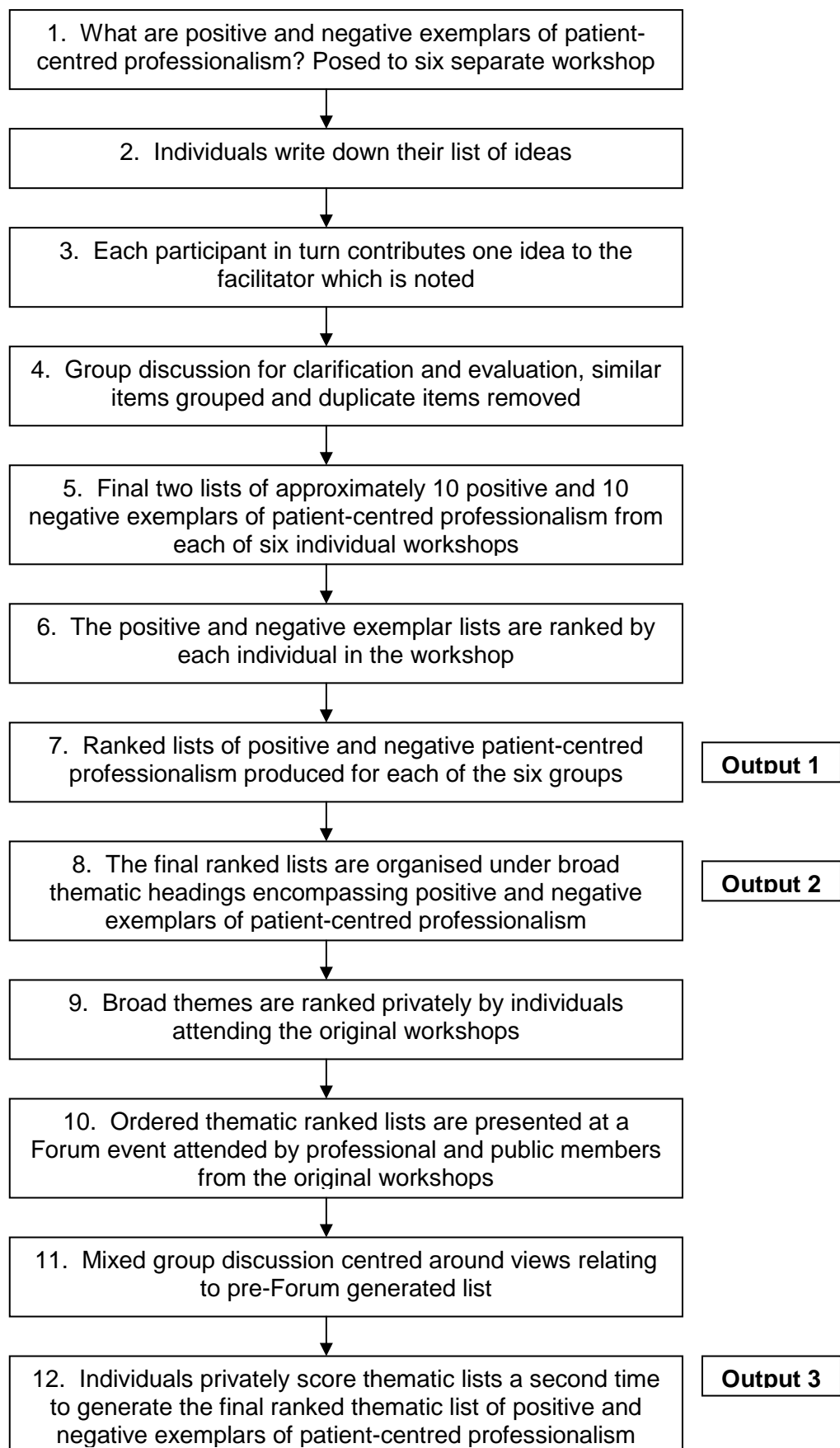


Table 1. Summary of workshop and Forum participant samples

<b>Group name</b>	<b>No. of participants at workshop</b>	<b>Pharmacy type or Role, function, characteristic</b>	<b>No. of participants at Forum</b>	<b>Pharmacy type or Role, function, characteristic</b>
Members of public	6 (2 males, 4 females)	1 x occasional user 1 x carer 1 x older person 1 x parent 1 x long-term condition 1 x teenager	6 (2 males, 4 females)	1 x occasional user 1 x carer 1 x older person 1 x parent 1 x long-term condition 1 x teenager
Stakeholders	5 (1 male, 4 females)	2 x pharmacy teachers 2 x policy developers 1 x policy implementer	4 (1 male, 3 females)	1 x pharmacy teachers 2 x policy developers 1 x policy implementer
Pharmacy staff	4 (all females)	2 x small chains 2 x large chains	3 (all female)	1 x small chain 2 x large chain
Pharmacist 1	5 (3 males, 2 females)	1 x locum 2 x small chains 1 x large chains	3 (2 males, 1 female)	1 x locum 2 x small chains
Pharmacist 2	9 (3 males, 6 females)	2 x locum 1 x single-handed manager owner 1 x large chain 5 x small chains	3 (1 male, 2 females)	3 x small chains
Newly qualified pharmacist 1	9 (2 males, 7 females)	1 x locum 6 x small chains 1 x single-handed manager owner 1 x large chain	3 (3 females)	2 x small chain 1 x large chain
<b>TOTAL ATTENDANCE</b>	<b>38</b>		<b>22</b>	

Table 2. Positive and negative exemplars lists generated by each workshop

<b>Group</b>	<b>Positive Exemplars (n=64)</b>	<b>Negative Exemplars (n=66)</b>
<b>Pharmacy Staff</b>	1. Accessibility issues	1. Insufficient staff and time
	2. Welcoming	2. Unappreciated by management
	3. Knowledgeable, trained staff	3. Insufficient pharmacists
	4. Availability of goods and services	4. Management pressure to perform, unrealistic targets
	5. Rapport	5. Insufficient Accuracy Checking Technicians
	6. Helpful and attentive	6. Customer pressure, especially waiting
	7. Working to a script	7. Low morale/ being demotivated
	8. Comfortable, friendly environment	8. Unavailability of stock
	9. Confidentiality	9. Lack of company support
	10. To leave happy	10. Medicine Use Reviews (MURs) shouldn't be separated out from work
	11. Burden of bureaucracy, burden of paperwork	
<b>Pharmacists (group 1)</b>	1. Demonstrate care/concern/interest to individual	1. Inappropriate levels of support staff
	2. Training to communicate	2. Unmanageable work responsibility linked to stress levels
	3. Education of patients	3. Role unsuitability
	4. CPD	4. Company expectations too high
	5. Professional image of workspace	5. Inadequate training both pharmacists and staff
	6. Convey a personal professional image	6. Different levels of service
	7. Access to privacy/confidentiality	7. Inadequate workspace facilities
	8. More time to consult	8. Commercialism versus professionalism
	9. Separation of healthcare and management roles	9. Lack of privacy
	10. Good relations with other healthcare professionals	10. Image management of profession by professional bodies
<b>Pharmacists (group 2)</b>	1. Patient safety	1. Compromised quality and safety
	2. Knowledgeable	2. Time constraints and stress
	3. Accessibility	3. Insufficient staff
	4. Service and time	4. Disidentification / inappropriate attitudes
	5. Training of support staff	5. Competing demands on professionalism
	6. Personable (yourself and staff)	6. Lack of appropriate training
	7. A range of services	7. Depending on others
	8. A community pharmacist	8. Negative environment
	9. Integrated with other healthcare professionals	9. Locums, continuity problems
	10. Environment	10. Isolation
	11. Self caring responsible patients	11. Negative accessibility
	12. Disalienated	12. Legal restrictions
		13. Demanding patients

<b>Group</b>	<b>Positive Exemplars</b>	<b>Negative Exemplars</b>
<b>Stakeholders</b>	1. Patient safety	1. NHS contract/ funding
	2. Building trust	2. Time poverty
	3. Patient needs, wants and expectations	3. Specific commercial targets and budgets
	4. People skills	4. Generic commercial business
	5. Professionalism	5. Resistance from other healthcare professionals
	6. Respect	6. A need to change patient mindset
	7. Collective team working/support	7. Resistance within the profession
	8. Balance commercial vs. professional	8. Time to train oneself and staff
	9. Accountability	9. Constraints of government policy
	10. Profile of pharmacy team	10. Lack of qualified staff
	11. Spatial separation	11. Clarity and visibility to role
		12. Limited space
		13. Personal ethics and beliefs
<b>Members of Public</b>	1. Correct prescriptions	1. Mistakes in administering / delivering medicines
	2. Quick, efficient services	2. Long waits for prescriptions
	3. Accessible	3. Too busy, problems with multi-tasking
	4. Dedicated dispensary	4. Lack of confidentiality
	5. Good hygiene	5. Lack of patient history
	6. List of services on offer	6. Stress related to heavy workloads
	7. Personable	7. Indistinct environment
	8. Work with GP	8. Lack of clarity of roles and services
	9. Relationship of equals	9. Too commercial
	10. Taking on new roles	10. Captive pricing
<b>Newly Qualified Pharmacists (group 1)</b>	1. Thinking about the patient first	1. Changing roles increasing stress
	2. Good communication	2. Company targets
	3. Accessible	3. Lack of trained support staff
	4. Caring	4. Public perception
	5. Automatically professional	5. Relationship to General Practitioners (GPs)
	6. Delivery of accurate information	6. Other healthcare professionals perceptions
	7. MUR's	7. Timing
	8. First port of call for minor ailments	8. Lack of promotion
	9. Happy Customer	9. Nice to everyone
	10. Friendship with patients	
	11. Building loyalty	

The positive and negative exemplars within each workshop group list represent the ranked lists ordered by the individuals in each group. The exemplars generated are based on direct quotes from the individuals attending the workshops.

Table 3. Final themes encompassing positive and negative exemplars

<b>Theme</b>	<b>Positive exemplars</b>	<b>Negative exemplars</b>
Relationships with patients	The pharmacist is highly personable and attentive towards patients Trust, loyalty and genuine care and respect underpin the relationship Access to privacy encourages a relationship built upon trust Self-caring responsible patients	The demands from the patient intensify work pressures for the pharmacist Inadequate information on patient history impacts on how pharmacists relate to patients A need to change patient mindset Public perception of the pharmacist
Safety	Correct prescriptions for patients Good hygiene Adherence to codes of conduct and accuracy of service in the interests of patient safety and welfare	Increased workloads and pressures compromise on quality of service to patients Mistakes in administering/delivery of medicines
Professional characteristics	Highly knowledgeable and qualified professionals Patients benefit from pharmacists' collaboration with other healthcare professionals Strong sense of personal ethics and beliefs Personal accountability for their actions	Efforts to collaborate with others (GPs, other pharmacists) are resisted Patients and other healthcare professionals have inappropriate perceptions of the role of the pharmacist-image management Pharmacists' personal expectations of professionalism differ from that of the members of the public and the professional body An isolating profession can be de-motivating and lead to low morale
Confidentiality and Privacy	Pharmacist and staff treat patients with confidentiality and privacy The pharmacy offers access to privacy and confidentiality in terms of geographical space	Lack of confidentiality Lack of patient history Lack of privacy
Changing professional roles	Taking on new roles Separation of healthcare and management roles Increased time to consult Raising profile of pharmacy team	Change to role induces stress Insufficient time for new roles
Services	First port of call for minor ailments An extensive range of services for patients that is clearly defined within the remit of community pharmacy Knowledgeable and trained support staff Confidentiality is respected and trust and loyalty develops with patients Dedicated dispensary	Inefficient service is provided as a result of time constraints on staff due to heavy workloads Long waits for prescriptions Lack of staff Insufficiently trained/unsuitable support staff Lack of continuity due to use of locums Captive pricing Limited and unavailable stock

	Provision of MURs for patients by pharmacists	
Accessibility	The pharmacy is geographically and physically usable Patients have easy access to a pharmacist at any time Quicker consultation than using GP surgery for minor ailments Pharmacy embedded in the local community	Negative accessibility: limited space for patients to be seated Inadequate workspace facilities
Patient characteristics	Self caring and responsible Happy customer	Demanding Pressure especially waiting Public perception
Professional pressures		Company expectations too high Specific professional targets and budgets (NHS contracting and constraints of government funding) Commercialism versus professionalism Company expectations too high and unappreciated by management Customer pressures Lack of appreciation from management
Training	Up to date knowledge and skills through regular CPD for both pharmacists and associated staff Provisioning of time for training	Limited opportunities for training for pharmacists and staff Inadequate training Inadequate time and resources for training and professional development
Environment	Professional, hygienic and clearly defined workspace Welcoming, comfortable and friendly social environment Supportive or patient need and expectation	Inadequate and ill-defined work space for dispensing No clear distinction between dispensing and retail areas

The positive and negative exemplars encompassed within each theme are based on direct quotes from the individuals attending the workshops.

Table 4. Ranked thematic list prior to the Forum event (n=21)

Ordered rank (1-11)	Theme	Median rank (IQR)
1	Professional Characteristics	2 (3.5)
2	Safety	2 (5.25)
3	Relationship with Patients	4 (3.75)
4	Services	5 (3.5)
5	Confidentiality and Privacy	5 (3.5)
6	Training	6 (4)
7	Environment	7 (3.75)
8	Accessibility	7 (4.5)
9	Patient characteristics	9 (2.25)
10	Professional Pressures	9 (3.25)
11	Changing Professional Roles	9 (5)

Table 5. Ranked thematic list following the Forum event (n=22)

Ordered rank (1-11)	Theme	Median rank (IQR)
1	Safety	1 (0)
2	Professional Characteristics	2 (1.5)
3	Relationship with Patients	4 (3.25)
4	Confidentiality and Privacy	4 (4)
5	Accessibility	5 (5)
6	Training	6 (3)
7	Professional Pressures	6.5 (4.5)
8	Services	7 (3)
9	Environment	7.5 (3)
10	Changing Professional Roles	9 (2)
11	Patient characteristics	11 (4)