

THE ART AND SCIENCE OF COUNSELLING PATIENTS ON MINOR AILMENTS/OTC MEDICINES

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ABSTRACT

Pharmacists interact with patients seeking help for minor ailments on a daily basis. Textbooks and various mnemonics provide guidance on how to proceed during such encounters. In this commentary, the authors build on that work to present a new seven-step process.

INTRODUCTION

Interacting with people with minor ailments is a critical component of pharmacy practice. Most community pharmacists can attest to fielding dozens of questions a week on such matters. Early practice research certainly provides ample evidence that this has been the case for some time¹⁻⁴.

This article discusses the interactive process between patients and pharmacists relative to minor ailments and over-the-counter (OTC) medicines. It describes the general guidance outlined in pharmacy textbooks, suggests where some improvements and re-organization of the process might be possible, then presents a seven-step system for pharmacists and students to consider during minor ailment consults.

OVERVIEW OF TEXTBOOK APPROACHES

Academics and practitioners who teach minor ailment consultations to pharmacy students may refer to standard textbooks on the matter. They may also draw from personal and clinical

experience. Regarding the former, we present the basic types of guidance outlined in them for dealing with typical patient encounters.

The Handbook of Nonprescription Drugs (American Pharmaceutical Association) calls for a uniform patient care process to ‘achieve optimal health and medication-related outcomes’. Relative to OTC-based situations, the authors outline the following steps to achieve that end⁵:

Step 1: Collect

Step 2: Assess

Step 3: Plan

Step 4: Implement

Step 5: Follow-up: Monitor and Evaluate

Step 1 includes collecting information on the chief complaint (current signs and symptoms), a medication history, the patient’s background characteristics, and a host of other aspects such as a physical examination. It is up to the pharmacist to determine which factors are pertinent in each situation, and the authors acknowledge that the extent to which these are undertaken may be less than that seen in other patient care services.

Assessment in **Step 2** leads to a prioritization of problems. In considering the cause of the problem(s), the patient’s medical history is scrutinized in order to determine if, for example, congestive heart failure could be a reason for someone seeking help for a cough. A person with dyspepsia would be assessed to determine if symptoms could be medication-related, and so on. The authors of the chapter acknowledge again that a self-care encounter may be more focused (briefer) than a comprehensive medication review.

In **Step 3**, activities of the first two steps culminate in one of three general recommendations: 1) recommend some form of therapy, 2) refer to another practitioner, and 3) recommend self-care until another health care provider can be consulted. **Step 4** implements the recommendation, while **Step 5** will involve monitoring and evaluating it.

To assist in navigating through all five components described, the QuEST-SCHOLAR (MAC) tool is presented as a way of highlighting key areas (most relevant to self-care) within these five steps. This suggests the five steps are the over-arching concepts to utilize, while QuEST-SCHOLAR (MAC) is the operational in-the-aisle format. As far as how this method unfolds in a community pharmacy, it is pointed out that the SCHOLAR (MAC) component is enacted during the ‘Qu’ stage of QuEST (Figures 1 and 2).

Figure 1: SCHOLAR process of patient interaction

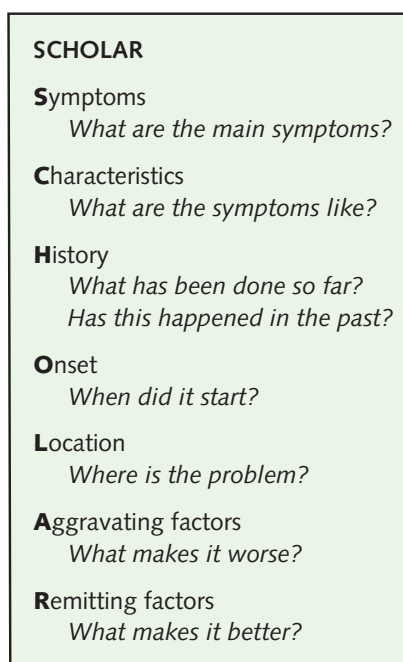
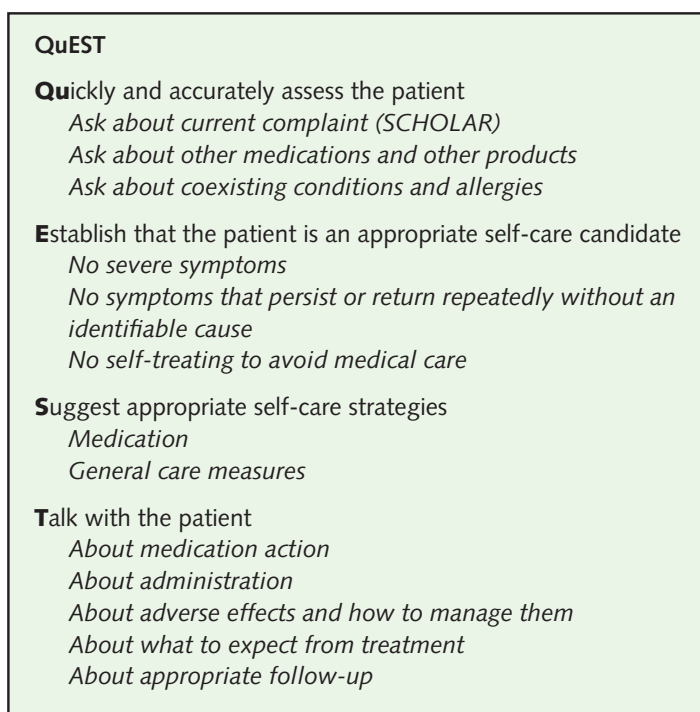


Figure 2: QuEST process of patient interaction



In this method, as with all models that follow here, significant detail and sub-components are further described within each step. Brevity prevents going into greater depth in this article.

A Canadian text follows a similar path⁶:

Step 1: Collect information

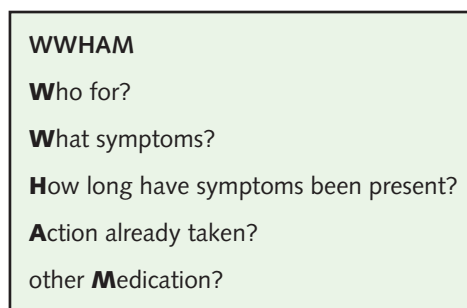
Step 2: Perform Assessment and Triage

Step 3: Create, Implement, and Counsel on a Care Plan

Step 4: Evaluate Results of Care Plan

Many of the activities parallel what is laid out in the American reference textbook. Two mnemonics are described within this chapter – WWHAM (Figure 3) and QuEST-SCHOLAR (MAC), described as being able to assist with the gathering of information.

Figure 3: WWHAM process of patient interaction



Also in Canada, the counselling reference ‘Pharmacists Talking with Patients’ outlines three main steps: 1) Gather Information / Identify Needs, 2) Develop a Care Plan / Resolve Problems, and finally 3) Provide Information / Educate⁷. In ‘Nonprescription Product Therapeutics’, Pray (USA) again suggests three main components: 1) Acquiring Information from Patients, 2) Analyzing Product-Related and Patient-Related Information, and 3) Counseling Patients: Triage⁸. An author in Japan follows five similar steps⁹.

In the UK, ‘Minor Illness or Major Disease?’ starts the process quite specifically by having the pharmacist ask ‘Who is the patient?’¹⁰ (as is done with WWHAM). The patient then explains their illness in their own words. To acquire more detail, the mnemonic SIT DOWN SIR can be used (Figure 4). Patients should also be asked about current and recent medicines they use. Somewhat later in the process, relevant past history is ascertained.

The above guidelines are very helpful and yield a lot of important information. They outline a process to elicit an array of required clinical detail. Building on that expertise, the practice experience of one author (Taylor) as an OTC advisor has led to a system with similarities, but also some differences. Those differences are felt to be enough to justify a re-configured approach. The

main difference concerns when to ask about a patient's medical and medication history. Current approaches have that occurring early in the process, whereas a delay is suggested here.

Figure 4: SIT DOWN SIR process of patient interaction

SIT DOWN SIR
S ite/location
I ntensity/severity
T ype/nature
D uration
O nset
W ith (ie does it occur with other symptoms?)
a nnoyed or aggravated by
S pread or radiates to
I ncidence/frequency pattern
R elieved by

A NEW SYSTEM FOR PATIENT INTERACTION

The majority of consumers who enter pharmacies to purchase OTCs do not ask for assistance¹¹⁻¹³. In one Canadian city, consumers starting a search for an OTC product in pharmacies were tracked. Of 5153 consumers doing so, 2762 limited their question to simply asking where a product was shelved¹⁴. One reason consumers may not ask for help is that they claim to have little difficulty in selecting a product¹⁵. Indeed, many will be able to self-diagnose their situation and select an appropriate and safe product, tenets that allow a medicine to be available without a prescription in the first place.

For those that do receive advice, an encounter typically begins with either a pharmacist offering assistance, or more likely, a patient asking for help¹⁴. This usually involves garnering a pharmacist's attention at the dispensing counter and posing a question. That question is generally configured in one of three general ways: 1) the patient asks whether the pharmacy stocks a specific OTC product ('Do you have []?'), 2) the patient asks a specific OTC drug-related question ('Does this cause drowsiness?'), or 3) the patient describes their symptoms and asks for relief.

The first two scenarios are, on the surface, rather straightforward. The third pathway (those presenting with symptoms) is discussed here. A patient will ask something like 'What is best for a bad cough?' or 'Can you help me decide on something for a red eye?' While not always possible to leave the dispensary, we feel that getting out to the applicable products as soon as possible allows them to be used as 'props' during an encounter (see later). Doing so also removes a significant barrier to communication, the dispensary divider.

We envision seven steps to guide what happens next (Figure 5).

Figure 5: Seven-step process of patient interaction

<p>Step 1: Who is the patient?</p> <p>Step 2: Has a prescriber been seen for this situation?</p> <p>Step 3: Assess the patient's situation</p> <p>Step 4: Contemplate a tentative course of action</p> <p>Step 5: Inquire into the patient's health status</p> <p>Step 6: State a recommendation</p> <p>Step 7: Provide information on proper medicine use (if applicable)</p>

Step 1: Who is the Patient?

We recommend the first question a pharmacist asks is 'Is this for you or someone else?' Since the person asking for help may be a parent or caregiver, this step addresses this issue right away. Even a seemingly straightforward question posed as 'I need something for a bad cough' could be a request on behalf of a child or aging parent. Conversely, asking this question will not be needed for an opening such as 'I have hemorrhoids. What will help?'

This question as a first step can save time. On hearing that the patient with the bad cough is an infant, for example, this information might lead a pharmacist to refer to medical care before proceeding much further into the consult.

For the sake of comparison, the first step in WWHAM is similarly 'Who for?', while QuEST-SCHOLAR appears to open with 'What are the main symptoms?'

Step 2: Has a prescriber been seen for the situation?

Consider the person who asks 'What is good for heartburn?'. Step 1 will let us know who has the problem. Step 2 has us ask whether the patient has consulted with a prescriber for that heartburn.

Often the answer to this is simply a yes or no.

On hearing yes, probing will be needed to determine how long ago that consultation took place and what was said or recommended.

At times, without pharmacist prompting or probing, some insight might be subtly given in a response. 'No, it's not that bad' speaks to the self-perceived seriousness of the problem, leading the patient to seek pharmacy rather than medical care. But since they are now in a pharmacy asking for help, they still felt the situation warranted at least some professional input. 'I don't like bothering my doctor for little stuff' also speaks to perceived severity and a sense of how they use health care providers. Wyke *et al* provides an excellent review of how people respond to symptoms¹⁶.

Conversely, a response such as ‘No. I tried to, but could not get in today’ means the current pharmacy visit is actually a default plan for the patient. Medical care was warranted in their estimation (speaks to symptom severity), but in lieu of that, assistance from a pharmacist might suffice.

Some patients will have seen a doctor for their current problem, perhaps very recently, with directions to simply go to a pharmacy to acquire some form of OTC drug therapy. If a pharmacist chose not to utilize our Step 2, a consult could get quite deep into the process, only to find out that the pending encounter was one of product location/availability rather than a call for clinical assistance. As such, this step can save time.

We do acknowledge this question may seem somewhat awkward and/or premature to ask at this juncture. Raising the issue of doctor contact so quickly into the process could add an unwarranted tone of seriousness to each and every event. However, one’s modulation of vocal tone can reduce that concern. By asking this, we may also inadvertently socialize our patients to consider medical care as the *de facto* standard of care. Further, a person who indicates ‘I have the sniffles’, does not summon the need for medical attention in most people’s minds. While all that is true, this step is presented as a quick option to identify patients that might simply be looking for a product suggested by a doctor. Alternatively, it may make more sense for pharmacists to ask about medical guidance in Step 3, with phrasing such as ‘Is your situation bad enough to see an MD?’ Further rationalisation for perhaps waiting to ask this question is that if a patient had been told by a doctor to get product X in a pharmacy, a good portion of patients will likely indicate that initially, probably right when the pharmacist asks ‘Can I help you?’.

Step 3: Assess the Patient’s Situation

The objective of the next step is to assess the nature of the problem. This requires inquiring about symptoms, severity, duration etc. As noted earlier, this step is described in great depth - and occurs earlier - in the references mentioned above.

Does a pharmacist have to explain why s/he is asking such questions or get permission to do so? Our opinion is no, this should not be required. By the patient’s act of asking for help, one can assume that a ‘mental contract’ has been forged that gives the pharmacist tacit permission to ask questions. If aspects of sexual history are required, however, it could be appropriate to explain that sensitive questions will be asked. While consent is generally implied at this juncture, it may still be prudent to preface this section by explaining that you have a few questions to ask in order to best assist them. This also primes the patient for subsequent information gathering.

It is recommended to start broad with open-ended questions (‘Can you describe your back pain’), then progressively move to closed-ended questions to extract more detail (‘You mentioned it hurts to bend. Is it a stabbing or throbbing pain or both?’). Sign-posting may also be a good technique during the process – ‘I just have a few more questions, to help assess your situation’.

As the situation is spelled out by the patient, it is useful to roughly gauge that person’s level of

healthcare literacy, based on the words and phrases they use. The sophistication of the pharmacist's language must then be adapted to that patient's level of understanding, using more basic, or more complex terms, as needed. One should also watch for non-verbal behaviour; puzzled looks subsequent to professional jargon can be addressed. Non-verbal behaviour can also determine if one actually over-estimated a person's willingness to listen to any advice. Are they soon squirming to get away from a 'very helpful' pharmacist? Given that the duration of OTC consults is generally quite short¹⁷⁻²¹, and that most encounters are initiated by patients, we feel this is unlikely to be a problem.

A critical component of this step is to determine what products - if any - the patient has tried to date. This helps decide whether a move to a more potent agent, or even medical referral, is the next course of action. Importantly, feedback such as 'I have tried acetaminophen for headaches', 'I don't feel any better when I use Pepcid', or 'Last night I put in a few drops of Visine for eye allergies' should not be left as is. This information has to be dissected to determine why that course of action was not helpful. For one, was it used or taken correctly (dose, duration)? Just as important, were the patient's expectations for relief reasonable? Patients expecting complete relief from an oral antihistamine, for example, will likely face disappointment. When in pharmacies, we find it useful (to help jog memories) to have patients point to actual products they have used.

The final discussion point for this step is the specific symptom-based questions to be asked. This is the fundamental crux of the entire consultation process, and undoubtedly poses the most problems for practitioners and students alike. Knowing what specifically to ask across a full spectrum of minor ailments can be daunting. For something like a headache, pharmacists will be concerned about something more troublesome than a simple tension or migraine headache. Enough of the right questions are needed to rule out medical referral. Students charged with trying to learn this or any other system, plus which questions are relevant to a vast array of conditions, will face some frustration during their training.

As a result, an assortment of mnemonics has arisen to guide minor ailment consults. Some examples already presented above are SIT DOWN SIR^{10,22,23} and QuEST-SCHOLAR²⁴, with three other examples (STARZ²⁵, ENCORE²⁶, SHAPED²⁷) outlined here (Figures 6-8).

Figure 6: STARZ process of patient interaction

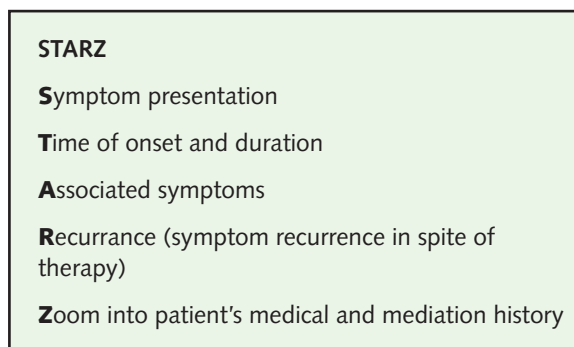


Figure 7: ENCORE process of patient interaction

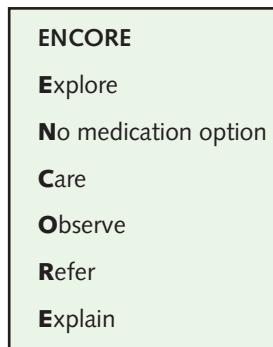
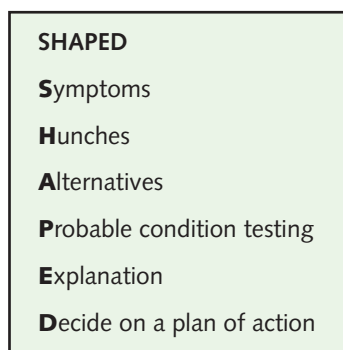


Figure 8: SHAPED process of patient interaction



A reader is welcome to adopt any mnemonic s/he feels meets their needs. Either way, it is important to note how these tools will mesh with the proposed process presented here. Our stepped plan guides a typical encounter from start to finish. Any of the symptom assessment tools above, if used, would be slotted into our Step 3. After that, its application is fulfilled and it can be put away. However, it must be noted that specific to the QuEST-SCHOLAR model, it would only be the SCHOLAR component that would be used.

We would note that IF one is used, given their complexity it may be most efficient to have the mnemonic spelled out onto a graphic within an iPad or smart phone for the consult. When a patient asks for help, the pharmacist simply calls it up for use during Step 3. For that matter, it would also make sense to outline the entire seven-step process onto a device for the same reason.

It should also be noted that in spite of pharmacists' best intentions during this stage, some patients may not always share pertinent information²⁸. Watson and colleagues found a low rate of information disclosure about health matters to pharmacy staff during a recent pharmacy visit²⁹.

Do pharmacists diagnose during Step 3? This may have relevance to many jurisdictions around the world, but is an especially contentious issue for Canada as pharmacists enter the realm of prescribing for minor ailments³⁰. Physicians in this part of the world contend that pharmacists can neither diagnose nor prescribe.

Diagnosis is dictionary-defined as the art or act of identifying a disease from its signs and symptoms³¹. Taking that further, physicians 'enumerate the diagnostic possibilities and estimate their

relative likelihood’ during the first step. In the second step, ‘physicians incorporate new information to change the relative probabilities, ruling out some of those possibilities, and ultimately choosing the most likely diagnosis’³². Whether this should be done, or can be done, by pharmacists has been discussed both within the confines of the profession³³⁻³⁶ and beyond³⁷⁻⁴⁰. Attempts at helping pharmacists with the diagnostic process date back to at least 1995 in the UK⁴¹.

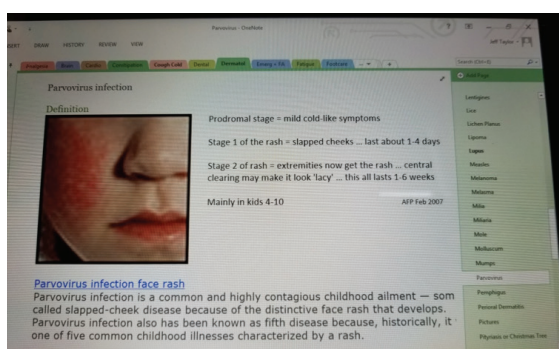
While we understand the power and symbolic importance of diagnosis to physicians, it seems self-evident to us that pharmacists have been ‘diagnosing’ minor ailments in all but name for decades. There is almost 100% certainty that all community pharmacists have listened to situations involving respiratory symptoms and concluded that the person has a chest or head cold. We would add that patients can self-diagnose in many situations as well.

More training on this front is undoubtedly needed³⁶, and pharmacists have to do a better job at symptom-pattern recognition and ruling in *versus* ruling out potential causes of symptoms. For dermatologic conditions, by way of example, pharmacists must be able to envision a workable array of common possibilities subsequent to a patient complaining of a rash. Perhaps Eczema, Urticaria, Contact dermatitis, Seborrhea, and Tinea immediately come to mind. Then, questions are posed to help narrow down a possible cause. Pharmacists must be aware of the value of any question before it is even asked. On inquiring as to whether the rash is itchy, for instance, one must know which conditions actually present with itch. Otherwise, the answer would not help rule in or rule out any of the possibilities from the original list of conditions.

That said, it could also be argued that pharmacists may not need to know the actual diagnostic value of ALL questions they pose. In certain circumstances, many can still be relevant, even though the answer may not help point towards a particular diagnosis. Asking about itch (as above) might at least garner some perspective on how bothersome a symptom is for a patient. Similarly, on hearing a patient describe the rash as long-standing and/or severe, that information alone clearly exceeds pharmaceutical comfort levels and necessitates referral to medical care.

For the future of OTC consults, we feel that more visual dynamics should be utilized. A good starting place would be in dermatology, where patients may not be able to expose or present a rash or lesion in the pharmacy. But a pharmacist can ask ‘Does it look like this?’ (see Figure 9).

Figure 9: Screen Capture of Dermatological Conditions on a Tablet



Step 4: Contemplate a Tentative Course of Action

This step is deemed tentative (or interim) because it is not verbalized to the patient at this time. Instead, it is a triggering mechanism to help direct Step 5. The following example could be a pharmacist's thoughts at Step 4 in a given consult:

Okay, from what I have heard so far, I think this person needs standard headache therapy, likely with ibuprofen, as she has not tried it yet. Now, what do I have to find out about her medical background to support this agent OR in fact change my recommendation? I also have to ask about factors that could contribute to possible side effects and contraindications specific to ibuprofen.

Based on the symptoms and information accrued in Step 3, a pharmacist should now have a good idea of what s/he is likely to recommend. Whether that agent (or another course of action) is recommended will depend on the following step – the patient's health status. For now, though, that choice is placed on hold.

Step 5: Inquire into Patient's Health Status

The patient is asked about their health and medical status, past and current medication use (outside the context of the minor ailment under discussion), relevant family or social history, vaccination record, allergy or intolerance history for the proposed drug, etc. The information garnered will help refute OR support the tentative recommendation conceived above. In other words, has anything now surfaced that precludes use of the agent(s) in Step 4?

That tentative step creates a very important dynamic – it sets the stage for more focused questioning within Step 5. This narrowing of focus is mentioned in the American reference several times⁵. By way of example, if you had a non-steroidal anti-inflammatory drug (NSAID) in mind at Step 4, directed questioning can now come into play on such matters as gastrointestinal and cardiovascular health, NSAID-induced asthma, other red flags, etc. At the same time, other aspects that were potential inquiries can now be deemed as irrelevant.

If this aspect is dealt with earlier, such as in the first steps of many textbook processes, containment can become a problem; where does one stop? In dealing with an elderly man with cough/cold symptoms, a pharmacist might broadly want to ask (as described in typical Step 1s) about heartburn (ibuprofen), asthma (antitussives), blood pressure (decongestants), constipation (1st generation antihistamines), prostate issues (decongestants), antidepressant use (decongestants) and so on. If, on the other hand, our tentative step has a pharmacist leaning solely to a cough suppressant, the level of inquiry can be curtailed. This approach recognizes that OTC consults are not long in duration. It also prevents question fatigue that can occur with patients, leading to a more focussed interaction.

In one author's institution (Taylor), students are trained to ask about medication allergies, medical histories, and drug usage at the start of all OSCE encounters, regardless of the eventual nature of the case. How that unfolds is that students enter the OSCE station, then asks 'Can I help you?' The

patient actor follows with 'I need help for constipation'. Students will confirm they can indeed help, but before doing that, they explain that some background is needed. An example of this process took place in an actual community pharmacy involving a recent graduate a few years back:

Patient: *Excuse me, do these look like bedbug bites?* (shows pharmacist)

Pharmacist: *Okay, I can help, but before we start, do you have any allergies?*

Patient: *Hmm, no.*

Pharmacist: *Any medical conditions I should know about?*

Patient: *No, none.*

Pharmacist: *Are you taking an Rx, OTC, or herbal medicines?*

Patient: *No.*

In witnessing this actual encounter, it was quite plain to see the patient was becoming frustrated with the line of questioning. She wanted help with her problem and appeared to feel things had been side-tracked from her chief complaint.

To be clear, this information is critical to know. The issue is not whether to cover it, but WHEN to cover it. Our premise is that it should take place in Step 5 rather than at the start.

Regarding possible nuances within this step, a pharmacist might choose to query overall health before delving into specific medical conditions. Or, for situations that appear to be very minor, choose to do this in lieu of mentioning medical conditions at all. If this is the approach, the level of detail can be age-based; someone 20 years of age can be approached differently than someone 60 years old. 'Are you generally in good health?' will often suffice for the young adult, and hearing a YES can probably be taken at face value. Conversely, for the 60 year old patient, the same question is posed, but it would not be wise to stop at a YES. This has to be followed with probing – 'No diabetes? High blood pressure? Other conditions?' The reason is that patients might feel they are still in overall good health, in spite of a battery of health issues that may be well controlled. On hearing NOs to these latter questions, a pharmacist can then probably feel that due diligence has taken place. This is provided that each question is posed with suitable inflection, and a few seconds of space are given afterwards (allowing a pregnant pause for the answer). A tone of importance is hopefully created, the pause engendering an expectation for the listener to respond, and a hope that the patient realizes diabetes and blood pressure are mentioned simply as example conversational cues. The two conditions are very common in seniors, but arthritis could just as easily be inserted for either. Either way, we feel it is likely impractical to go down a fuller list of disease states.

Step 6: State Your Recommendation

Step 5 confirms what you plan to do. Step 6 now has you articulate that plan to the patient. This can take the form of: 1) wait-and-see / do nothing / re-assurance, 2) non-drug measure, 3) an OTC medicine, or 4) referral. Conversational examples of these are as follows:

Re-assurance

'Okay, I think I have enough information now. From what I hear you say, I don't think there is anything to be overly concerned about, at least for the moment. What you seem to be experiencing is []. I think we can wait a few more days, to see if things change, then re-assess. Why I say this is [].'

Non-drug measure

'I would not recommend the product you have chosen, but rather that you go home and try [non-medical modality]. Why I say this is because [] will be just as effective and it means you can get by NOT taking a medicine. We can even save you some money. Do you have any [] at home?'

OTC medicine

'From what you have told me, what I would do is recommend that you take []. We have some here if you do not have any at home. It will reduce your discomfort and let you sleep at night. I don't think your situation requires a visit to a doctor.'

Referral

'It sounds like what you are experiencing may be something more than simple []. We do have a few products that might help in the short term, but they could also worsen your situation or delay medical care. So, just to be safe, I would suggest that you check with your physician on this. Does that seem reasonable? Do you have a regular doctor?'

Step 7: Provide Information on Proper Use

For the sake of discussion, we will assume an OTC product is recommended in Step 6.

Even though complete instructions for effective and safe product use are required on packaging and within inserts, some attention on this front would always be helpful and strongly encouraged. Unfortunately, probably every pharmacist has said at least once 'The directions are on the package' to a patient when short on time. The pharmacist will know this is not optimal, but the package does provide the necessary details, and the attention paid to product selection may be perceived as more justified. In this case, encouraging a patient to call if they have questions would be helpful.

The specific amount of detail to mention here probably creates minimal anxiety for most pharmacists; it is relatively straightforward. How much to apply, how many to take, used for how long, what to expect (improvement and side effect-wise), and what to do if treatment fails would all seem reasonable aspects to address. Practically speaking, the information eventually conveyed is likely a function of how much time a pharmacist has, rather than what items to actually include. This is reflected in the mnemonics described above, where few go into detail on using an agent.

This highlights a key difference between counseling on prescribed medicines compared to OTC medicines. For the former, a physician selects the agent to use, while the pharmacist counsels on how to effectively and safely use it. For OTC medicines, it is the pharmacist that selects the

appropriate agent and accordingly, that aspect may garner more time and attention versus providing instructions on proper use (given the limited time one has during an encounter). Another difference is that, if using the Indian Health Services model⁴² for prescription counseling, a prime question will be – ‘Were you told what the medicine is for?’ This would not be needed during OTC consults because the patient literally tells the pharmacist what they want a medicine for.

A practice reality of importance to minor ailment consults is that OTC customers are often ‘allowed’ to cut ahead of the cue. Imagine a busy community pharmacy opening the doors at 9:00 am. The pharmacist has soon laid out 6 refill requests that were left on the answering machine overnight. He also has had four patients personally drop off another six upon opening the door. For the last person doing so, the pharmacist says the wait will be about an hour. At this moment, a woman asks for help for her 7 year old child with a cough. In the realm of OTC consults, it will be the rarest of patients who, upon hearing a pharmacist say – ‘Yes I can help pick something, but I have 12 prescriptions to fill first. If you can wait an hour, I would gladly help you then’ – to respond by saying ‘they would be glad to wait’. As pharmacists, we feel obliged to attempt to help, but likely compensate by going faster than usual and/or cutting back on how to use the product, given that other tasks await behind the counter.

By no means are we suggesting that the provision of drug information should be curtailed. If time is not an issue, we strongly support all the attention that can be afforded. But, in the dynamics of most situations within busy pharmacists, choices have to be made. This is unfortunate given the difficulties consumers can have with OTC-related information⁴³⁻⁴⁹. We do recommend that if having to resort to this, it is important to at least alert the purchaser to the package insert for in-depth information before use and to contact the pharmacist if they have any questions.

Regarding side effects, it is our contention that mentioning two (for argument’s sake) common ones, with information on how to manage them, is better than mentioning five without that perspective. Pharmacists may focus on ones that are a balance of common and/or worrisome. Some information exists on how to address side effects specific to OTC medicines, and how risk is framed for patients can be important. A person can be told that a certain drug comes with a 30% chance of something negative (a side effect) happening or a 70% chance that it won’t happen. Even though exactly the same level of risk is communicated, patients can react to each version differently. Berry and colleagues noted that people considering an OTC analgesic over-estimate the side effect risk of the agent⁵⁰. For a fictitious headache medicine, another study showed a higher likelihood of taking it when the numerical side effect data was phrased positively (90% won’t get it versus 10% will get it)⁵¹. The inclusion of numerical data to depict side effect occurrence (eg 10% chance) did not strongly influence OTC medicine decision-making⁵².

As an internal safety net within our seven-step process, the side effects of an agent addressed here can be used to query precautions and contraindications that may have been missed during Step 5. For example, for an NSAID – ‘This agent might be hard on your stomach. Do you have a history of ulcers or heartburn?’.

On this front, we note the risk-averse nature of pharmacists and thus offer some caution not to over-emphasize side effects relative to the potential benefit of a medicine. OTC NSAIDs indeed have justifiable concerns for gastrointestinal safety⁵³; opting not to use such agents will obviously circumvent that issue. But, if other options have already been tried, it also can now mean a patient has a 100% chance of experiencing pain if one is not initiated.

We feel strongly that what to expect from therapy is an under-utilized component of encounters. Patients in the laxative section of a pharmacy will see a lot of products, perhaps assuming they all do the same thing, at the same speed. The dose and side effects will be spelled out on packaging, but what to expect is an aspect where pharmacists can add important perspective. This is especially important given some misplaced expectations that patients harbour about medicines and conditions, such as 14.2% of responders feeling acetaminophen is completely harmless to use⁵⁴, or patients with GERD feeling they did not have a serious condition nor any long-term consequences⁵⁵.

During this step, the tendency of every student in our practice lab setting is to hold the box/product while counseling on an agent. This is not the best approach. Yes, a student will need some time to confirm the ingredients, but once that is done, it is far better to quickly put the product into the hands of the patient. This takes the pressure off. Now the patient focuses on it rather than having to fixate on the speaker (and perhaps straining to see the product). The student can point to the product, using it like a prop to point out aspects that s/he wants to convey. We recommend this within actual pharmacies as well.

Another approach we take in practice lab settings is to encourage students to pick two products to discuss (again, quickly passing both on to the patient), rather than just one. Even though one should clearly be preferred (via Step 4 and 5), presenting both loperamide and attapulgite (for example) to a patient allows comparisons such as – ‘This one is stronger’, ‘This one has fewer side effects’, ‘This one costs more’, ‘You may not like the taste of this one’, thus adding an important degree of patient choice.

Someone reading here might ask whether the second product must be a viable option? Most often, it should be. But a second product that is NOT suitable can still be used, with the conversation proceeding along the lines of – ‘The other product here is far more commonly used, but it is not the best choice for you because []’. At that point, the pharmacist can put the product back on the shelf, having served its purpose.

DISCUSSION

Is this plan practical? Does it take too much time? Does it advance the art and science of how to interact with people seeking OTC medicines in any way? Is there really any need for a new approach? These are questions that can be pondered by each reader for their own situation.

On the practicality front, the experience of one author (Taylor) leads to a conclusion that it works

well. Regarding its validity, it follows similar guidance presented by other authors on how to approach this area, with tweaks and re-organization offered to potentially streamline the process. It must be noted that QuEST-SCHOLAR is parallel in intent and may serve well. For one, our plan does not come as a mnemonic, and does not provide a listing of helpful sub-components at each stage. Being able to recall and activate those sub-components, however, is the crux of the matter; using a device to aid in that recall would seem logical. Either way, therapeutic content should not vary for either method. That said, our system does take a different tact by adding a formal tentative step to help drive the medication/medical history. However, it does not make questioning towards a differential diagnosis any easier, and SCHOLAR (or equivalent) is likely still needed for that process.

Time will always be a factor in any approach taken, but it is argued here that this new approach would not take any longer than any other system available. As pharmacists get pressed for time, the unfortunate reality is that content is likely to be curtailed, regardless of the process used.

Being too formulaic in practice settings can be unwise, and what is proposed here is indeed a formula. However, while seven steps in length, we do feel it follows a reasonably naturalistic flow in how such consults can and do unfold. With time, as with any approach to develop clinical acumen, the process becomes more automatic and natural.

While adopting any system might help improve our general effectiveness during OTC consults, practice research tells us we still have work to do^{20,56-61}. Wisconsin researchers found that with secret shoppers (ibuprofen or emergency contraception) asking – ‘What else should I know before taking this product?’ – the question led to 1.2 new information items being discussed⁶². This would seem to suggest that the full spectrum of information (needed for safe and effective use) did not materialize under normal dynamics of encounters, requiring some level of ‘prodding’ by the patient to be revealed.

Does this new system work for every situation? We feel it has broad applicability, with perhaps simply the depth of an encounter varying across situations. For vitamin consults, symptoms are often not involved. Yet, we see relevance in still asking who it is for, moving on to why they want a supplement, and then general health aspects applicable to the eventual user. Asking about doctor input is generally not covered unless the consult enters the areas of patient fatigue (iron and vitamin B12), osteoporosis management, folate during pregnancy, age-related eye disease vitamins, and the like. For a person with a superficial cut, pharmacists may skip to how it happened and what they have done so far (Step 3), take a quick query into general health (Step 5), then move on to how to care for it (Steps 6 and 7). The general flow is still in place, with simply depth of inquiry being altered, and at times, jumping over some to resist being too formulaic.

Regarding agents located behind-the-counter in pharmacies, or pharmacist prescribing situations, the process would be the same. However, we did not address how pharmacy technicians/assistants fit into this model^{63,64}.

Readers may wonder whether such a system would be welcomed by the public? Authors have pointed out that some consumers do not feel the need to be questioned⁶⁵⁻⁶⁷. The context for the current discussion, however, is a patient presenting symptoms. They want help. We find patients to be extremely grateful for the attention they get from pharmacists regarding minor ailments. This is surely irrespective of what technique a pharmacist may or may not be using. In this practice area, simply engaging in more consults is probably far more important than how one is done. If the proposed new system here, or any other for that matter, helps a pharmacist navigate the process, it would be a welcomed development.

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