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Situational communication self-confidence among community pharmacists: A descriptive analysis

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1. Introduction

Pharmacists are recognized as one of the most accessible and most trusted health professionals in the United States (US).[1] Of 295,000 licensed pharmacists in the US, approximately 130,000 are employed in community pharmacy settings, or 41 community pharmacists per 100,000 US citizens.[2,3] Community pharmacists are well positioned to not only counsel their patients about medications but also to engage patients and communities in public health-related prevention efforts. Over the last few decades, pharmacists in the US have transitioned from being discouraged from discussing medications with patients to being required to do so by law.[4,5] The role of pharmacist-patient communication in improving medication adherence and optimizing patient outcomes is supported in the literature.[6,7] Likewise, barriers to engaging in said communication has also been reported.[8–10]

Interpersonal communication is inherent in a majority of community pharmacists' efforts to educate and counsel patients, and to collaborate with other health care providers. Although a majority of communication scenarios occurring between pharmacists and patients or providers could be considered benign (e.g., describing how to take an oral antibiotic for the treatment of a respiratory tract infection), certain communication topics have the potential to place pharmacists in perceivably contentious situations. Prescription drug abuse and addiction (PDAA)-related communication is such a context. For the purposes of this study, prescription drug abuse was defined as nonmedical use, or use of a medication without a prescription, in a way other than as prescribed, or for the experience or feelings elicited.[11] Addiction was defined as compulsive drug seeking and use despite sometimes devastating consequences.[11]

Prescription drug abuse and the ramifications thereof have increased substantially in the US over the last two decades, prompting the Centers for Disease Control and Prevention (CDC) to deem it epidemic in nature.[12] National-level strategies have been developed and implemented to combat prescription drug abuse from both supply (e.g., decreased prescribing/dispensing) and demand (e.g., increased screening for, referral to, and access to treatment) perspectives.[13,14] Whereas the role of community pharmacists in PDAA prevention efforts has yet to be fully conceptualized, dispensing pharmacists do have a corresponding responsibility, along with prescribers, to ensure medications are dispensed for legitimate reasons and are required to evaluate drug therapy regimens for misuse or abuse.[4,15] Given the interpersonal communication inherent in these activities, exploration of pharmacists' perceptions of their communicative skills and abilities is warranted.

Interpersonal communication competence has been conceptualized and defined in multiple ways over the last 25 years.[16–19] McCroskey and McCroskey[17] defined communication competence as "adequate ability to pass along or give information; the ability to make known by talking or writing." Rubin et al.[18] defined communication competence as "a person's ability to interact flexibly with others in a dyadic setting so that the communication is seen as appropriate and effective for the context", thus placing additional emphasis on the setting and the information receiver's perceptions. Whereas self-perceived communication competence (SPCC) research has largely been atheoretical, the construct has been conceptualized as communicative self-efficacy.[18,20] Competence tends to be ability or skill based and is assessed via validated metrics. For example, health professionals must pass board examinations with set minimum competencies for licensure. However, as a self-perception, competence could be interpreted as an ability judgment, or self-confidence. Therefore, when self-perceived, competence and confidence judgments in the context of communication skills could be difficult to demarcate. Importantly, SPCC

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may or may not reflect actual communicative ability and may or may not align with objective competency assessments. Considering self-efficacy theory, perceptions of one's ability to complete a task influences engagement in the task.[18,21,22] For example, if a community pharmacist feels she is not capable of communicating in a situation (irrespective of actual ability), or perceives she does not possess the skills to do so (irrespective of the skill set possessed), she is less likely to engage in the communication task. Previous research has identified a positive correlation between one's context-specific SPCC and willingness to communicate.[17,23]

SPCC instruments with both trait (i.e., general disposition) and state (i.e., situational) foci have been developed and employed in communication competence research. McCroskey and McCroskey[17] developed and validated the 12-item, trait-level Self-Perceived Communication Competence scale that assessed SPCC across receiver type (stranger, acquaintance, friend) and context (dyad, group, meeting, public). Rubin and Martin[24] developed and validated the trait-level, 30-item Interpersonal Communication Competence Scale that assessed 10 dimensions of interpersonal communication competence. Importantly, research has indicated state SPCC does not correlate heavily with trait SPCC.[25] Therefore, trait-level assessments of SPCC may not be valid indicators of state-level SPCC. For example, an individual who scores highly on a trait-level SPCC assessment may still experience low SPCC in specific situations, such as when communicating about PDAA-related topics. State-level communication competence instruments have been developed and used in medicine[26,27] and dentistry,[28] and have noted that health care professionals lack confidence in uncomfortable communication contexts. Our preliminary research assessing community pharmacists' communication self-efficacy beliefs specific to PDAA supports these findings.[10]

SPCC specific to PDAA-related communication is generally unexplored, yet possession or development of confidence in abilities undergirds current national training efforts to prevent and treat PDAA.[13,14] The purpose of this study was to explore community pharmacists' self-perceived situational communication confidence (SSCC) by adapting McCroskey and McCroskey's Self-Perceived Communication Competence instrument to contexts that present for this cohort.[17] In particular, we sought to compare pharmacists' self-confidence specific to dyadic PDAA communicative tasks to self-confidence across other contexts. We hypothesized that pharmacists would rate their PDAA self-confidence significantly lower than their self-confidence in non-PDAA situations.

2. Methods

2.1. Design and pharmacist recruitment

The items analyzed in this study were part of a cross-sectional study of licensed Tennessee pharmacists conducted in October and November, 2012. Institutional Review Board approval was granted by East Tennessee State University prior to study initiation.

Pharmacist recruitment methodology has been described in a previous publication and was conducted in a manner that sought to maximize the number of actively licensed, practicing community pharmacist respondents.[10] The researchers obtained a directory of pharmacists (N = 2975) who had previously been or were currently affiliated with either the Tennessee Society of Independent Pharmacists or the Tennessee Society of Chain Pharmacists; two community pharmacist societies within the Tennessee Pharmacists Association (TPA). The directory did not represent a census of all currently licensed community pharmacists in the state. The Tennessee Board of Pharmacy does maintain a directory of pharmacists, including practice setting information provided by pharmacists when biennially renewing their licenses. However, a large percentage of practice setting information is missing in the Board directory; therefore, the TPA directory was employed to initially target community pharmacists. We thereafter cross-referenced the TPA directory with the publicly available Board directory of all licensed pharmacists (N = 9681) within the State of Tennessee.[29] Potential respondents listed in the TPA directory were excluded from the sampling frame if their license status was listed as anything other than active (e.g., retired) in the Board directory or if they had out-of-state addresses. The Board directory was then cleaned by the researchers and thereafter sorted by county of residence for each pharmacist. If the Board directory indicated less than 30 actively licensed pharmacists reside in a county (N = 47 counties), all pharmacist residents (N = 549) of those counties were included in the sample, regardless if those names were included in the TPA directory. We then randomly selected 1451 pharmacists from the TPA directory to obtain a total study sample of 2000 actively licensed pharmacists.

2.2. Survey administration and response rate

Survey administration followed a modified Dillman's Tailored Design Method and consisted of four paper-based mailings.[30] No incentive was offered to potential respondents. A pre-notification postcard was mailed to the study sample, followed one week thereafter by a packet that contained a personalized cover letter, an individually numbered survey instrument, and a self-addressed, stamped return envelope. The number on the survey instrument was used solely to remove respondents from subsequent mailing waves. Seven days later, a reminder/thank-you postcard was sent to all respondents for whom surveys had not been returned. To conclude participant recruitment, a second identical survey instrument packet was sent to all non-responders 10 days thereafter. The survey instrument was not numbered in the second packet.

Using the American Association of Public Opinion Research's Response Rate #2 calculation, a usable response rate of 749/1865 = 40.2% was obtained.[31] Given the focus on community pharmacists in this manuscript, only the 636 respondents who indicated they practice in a community pharmacy setting for a minimum of 8 h per month were included in the analyses.

2.3. Measures

2.3.1. Self-Perceived Situational Communication Confidence instrument

Within a larger 55-item survey instrument assessing attitudes, beliefs, and behaviors regarding prescription drug abuse, an 18-item Self-Perceived Situational Communication Confidence (SSCC) instrument was adapted from McCroskey and McCroskey's[17] Self-Perceived Communication Competence scale with emphasis placed on self-efficacy beliefs (i.e., self-confidence) as compared to self-competence. Whereas the same 0 to 100 response scale was employed, the scale description was changed to reflect the situational self-efficacy focus (0 = completely unconfident; 100 = completely confident) of the instrument. Response anchors in the original instrument were 0 = completely incompetent; 100 = completely competent.

Respondents were asked to estimate their confidence in their ability to communicate in each of the situations. Eleven of the items were developed with particular emphasis on PDAA communication with varying audiences, receivers, and contexts. Seven items were included to assess self-confidence specific to common US community pharmacist conversations. For example, respondents were asked to estimate their confidence in their ability to counsel an established patient about a new diabetes medication and their ability to counsel a new patient about a cholesterol medication.

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