Changing pharmacists' and pharmacist assistants' practice in dealing with direct requests for non-prescription analgesics

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Objectives — To design, implement and evaluate an intervention to improve pharmacists' and pharmacist assistants' practice in dealing with non-prescription analgesics.

Method — Direct request situations, rather than symptom presentation situations, were targeted. A sample of 27 pharmacies (14 intervention, 13 control) was recruited in the French speaking Canton of Neuchâtel, Switzerland. Intervention pharmacies participated in a training programme developed at the University of Sydney based on psycho-social and behavioural conceptual frameworks and communication skills. A pseudo-patient technique was used to assess the effect of training on the frequency and quality of pharmacists' and pharmacist assistants' verbal interaction with their patients. The pseudo-patient visits were followed-up by the provision of immediate feedback to the intervention group, a form of on-going training. A scoring system was developed for the consultation with the pseudo-patient and 189 interactions were audio-taped and analysed. One-way analysis of variance was used to compare the mean total scores obtained in the intervention and the control groups, at each time point (seven pseudo-patient visits in each pharmacy). The study period was two months.

Key findings — There were significant differences ($P<0.05$) between the scores obtained in the intervention and control groups. Pharmacists' and pharmacist assistants' practice changed pre- and post-intervention. Interactions involving C-list (pharmacy only) medicines showed a greater change than those involving D-list (not restricted to pharmacies) medicines.

Conclusion— The results indicate that the training programme and the pseudo-patient methodology facilitated a more comprehensive questioning process and increased the provision of personalised advice to individual patients.

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Int J Pharm Pract 2002:10:23-9

WITH the current trend in deregulation of drugs and the steady increase in access to information on health and medicines via the media, the advisory role of the community pharmacist and pharmacy staff is becoming more prominent.[1,2] As the pharmacy profession moves its focus from the products to the patients, communication and interaction with patients will acquire a pivotal function, having an impact on drug information, patient compliance and appropriate use of medications.[3-5] The challenge is for pharmacists to be prepared to abandon traditional pharmacist-patient approaches and to develop new skills in proactively advising their patients in the appropriate choice and safe use of non-prescription medicines.[6,7]

Communication and behavioural sciences are not yet commonly included in the pharmaceutical sciences curriculum in Switzerland, but it has been pointed out that it is now important to supplement scientific training with skills relevant to a wider pharmacist role. Additionally, in the non-prescription area, pharmacist assistants have a key interacting role.[8] Therefore it is essential to involve both pharmacists and pharmacist assistants in specific training to promote optimal practice in dealing with direct requests for non-prescription drugs.[9-13]

Conceptual frameworks have been developed to address the broad range of issues inherent in the drug-use process and care provider-patient interactions.[14,15] Those behaviour models that have been adapted to the health care setting often incorporate the activities associated with the use of medications.

Two health models were used in this study as a basis for the development of a specific framework that could be used within community pharmacy. These were the stages of change model and the health belief model. The stages of change

model[16] integrates multiple perspectives in order to describe and explain behaviour change. It can be used to assess patients' needs and their willingness to change, and pharmacy staff can tailor their approach and deliver a specific intervention. Over the past decade this model has served as the framework for a broad range of interventions. In the context of appropriate or inappropriate use of non-prescription medicines, de Almeida Neto designed a short intervention based on the stages of change model to help pharmacists in their interactions with patients misusing non-prescription analgesics.[17] De Almeida Neto's model helps to describe how pharmacy staff could use specific strategies to interact with their patients.[18] To deliver this approach, pharmacists must familiarise themselves with behaviour change concepts and learn to gauge what stage of change patients are at before deciding how to intervene.

The health belief model is also relevant in a theoretical framework that aims to support a collaborative approach with pharmacy non-prescription medicines customers.[19,20] Without being predictive, the model explains some human health behaviour, taking into account the patient's socio-economic background as well as his or her perception/belief of a disease or a drug. This model could help pharmacists and pharmacist assistants to take their patients' abilities, beliefs and needs into account, even in a brief interaction involving a direct request for a specific medicine.

A direct request situation is defined as one where the customer asks for a specific product, mentioning its name without any other comments (named product request).[21-23] Oprandi[22] showed in an observational study in pharmacies in Switzerland that direct sale (sale without any discussion except the mention of the price of the product) was common practice for non-prescription medicines. Thus, the current study concentrated on direct product requests in Swiss pharmacies with the intention of changing practice.

In Switzerland, pharmacist assistants undergo three years of training, alternating course-work and practical days. The programme includes basic sciences and pharmacy courses. Communication and psychology are not included. Since pharmacist assistants are involved in non-prescription medicine sales, the study involved them as well as pharmacists.

Aim The aim of this project was to design, implement and evaluate an intervention to improve pharmacists' and pharmacist assistants' practice in dealing with direct requests to purchase non-prescription products.

The research had two main objectives. The first was to determine current practice in a direct request, rather than a symptom, presentation. Secondly, the research aimed to assess the extent to which a specific training programme could increase pharmacists' and pharmacist assistants' frequency of interventions in direct requests and improve the quality of verbal interaction with their patients.

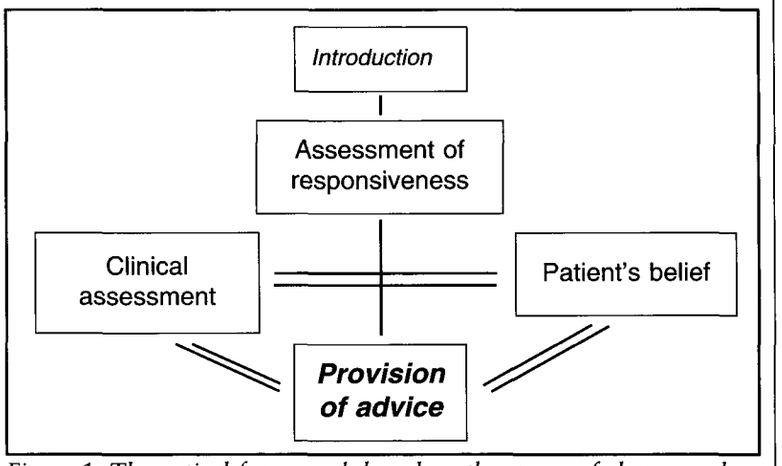

Figure 1: Theoretical framework based on the stages of change and health belief models

Method

Study design A controlled trial was conducted with a sample of community pharmacists. Pharmacists and pharmacist assistants in the intervention group took part in a workshop to develop their communication skills and to introduce the use of a practice protocol for direct requests for non-prescription medicines.

The research design involved each pharmacy receiving seven pseudo-patient visits, at which requests were made for non-prescription medicines. Visit 1 and 2 were for collection of baseline data. In the intervention group, training was given after visit 2 and direct feedback to the pharmacy staff was given after visits 3, 4, 5, 6 and 7. Control pharmacies had no training and no feedback.

Each consultation was scored by the pseudo-patient researcher using a pre-determined framework. Consultations were audiotaped for scoring.

Theoretical framework To address the specific issue of changing pharmacists' and pharmacist assistants' practice in dealing with direct product requests, a novel theoretical framework was designed, based on the two health models described. The models were chosen for their adaptability to the community pharmacy setting.

The theoretical framework (Figure 1) consisted of three connected elements and was used as a tool to assess patient responsiveness and to take patients' perceptions and knowledge into account in a skilful interview. Its aim was to help pharmacists and pharmacist assistants tailor their interactions to identified individual needs.

From the theoretical framework, a practical

Table 1: Drugs requested at each pseudo-patient visit			
Visit	Product name	Ingredients	Legal category
Visit 1	Saridon	Paracetamol 250mg, propyphenazone 150mg, caffeine 50mg	D list
Visit 2	Aspegic	Aspirin 500mg	D list
Visit 3	Dafalgan	Paracetamol 500mg	D list
Visit 4	Algifor	Ibuprofen 200mg	C list
Visit 5	Spasmo-Cibalgine	Propyphenazone 220mg, drofenine 20mg	C list
Visit 6	Tonopan	Dihydroergotamine 0.5mg, propyphenazone 125mg, caffeine 40mg	C list
Visit 7	Aspegic	Aspirin 500mg	D list

protocol was then developed. The "personalised advice protocol" was designed to be a flexible protocol that helped staff to use open-ended questions to assess their patients' responsiveness as well as to guide them through the patient questioning. The desired outcome was the provision of individualised advice.

In the practical protocol (Figure 2) the question "how are you doing with that drug" was used to start the interaction with the patient, giving them the opportunity to describe their situation.

Provision of immediate feedback following a pseudo-patient visit makes it possible to provide a form of non-threatening on-going training. Feedback promotes reflection upon what took place during the interaction and allows the researcher to clarify what happened and to establish reasons why. Previous studies have shown that use of this technique is more effective than simple education.[9,24,25] In this research, the pseudo-patient had a dual role of collecting data through observation and interaction, and educating pharmacy staff through immediate and constructive feedback.

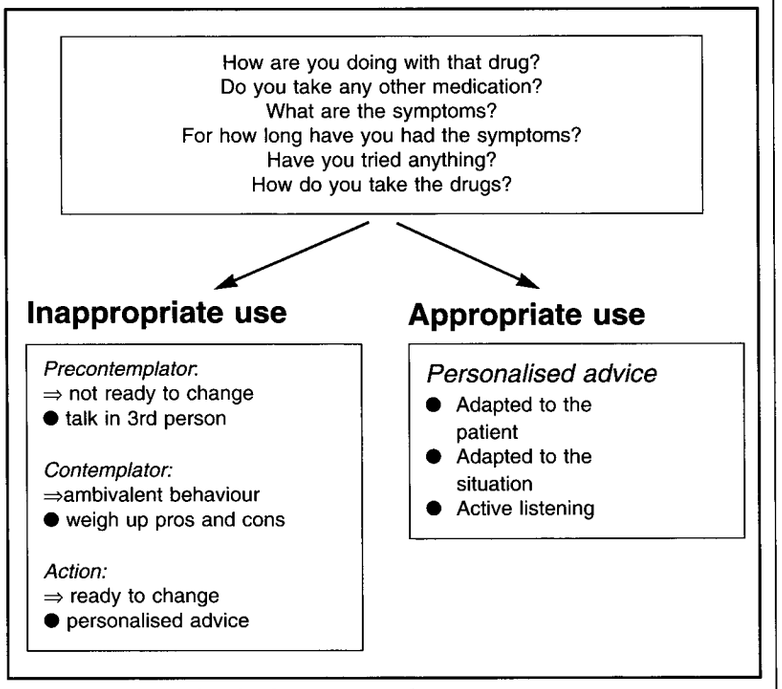

Figure 2: Personalised advice protocol

Sample size The sample size and the number of visits needed were determined using the POWER program, a statistical package for sample size calculations. Looking for a difference of 5 points on the pharmacy score, it was found that 13 pharmacies were required for each study group (two sided significance at the 0.05 level, power of 70 per cent). The pharmacies were randomly selected after a proportional stratification by country and city (1:3 ratio) from 51 pharmacies of the French speaking canton of Neuchâtel, one of the 26 cantons of Switzerland.

Recruitment Thirty-three pharmacists were telephoned to explain the research project and 27 agreed to participate. The researcher visited each pharmacy to give further explanation to the staff and to distribute the ethics information and consent forms. Recruitment followed a standard approach which provided information about the research as well as about data confidentiality (Appendix 1). All pharmacies were made aware of the possible visits of pseudo-patients in the next two months and informed that these consultations would be audio-taped for analysis. After recruitment, the pharmacies were randomly allocated to intervention or control groups. The study duration was two months.

Workshop Pharmacists and pharmacist assistants in intervention pharmacies participated in a training workshop. Three evening (five hour) workshops were held, one for the pharmacists and two for the pharmacist assistants. In total, 20 pharmacists and 65 pharmacist assistants attended the workshops. These incorporated role-plays, an explanation and demonstration of the theoretical models and discussion of the practical protocol and the pseudo-patient methodology.

The protocol and the framework were distributed on a small laminated card to all members of the intervention group.

Pseudo-patients Pseudo-patient techniques were used to assess the effect of the training on the frequency and quality of the pharmacists' and pharmacist assistants' verbal interaction with patients making direct requests for medicines. The pseudo-patients were trained to present seven direct request scenarios. They were not known to pharmacy staff and did not know whether the pharmacy was in the control or the intervention group. A pseudo-patient visited each pharmacy and initiated a direct request scenario. After each visit, they completed a standard form recording

their impressions of the interaction. A description of the staff member that dealt with the request was noted so that the researcher would be able to recognise the person to whom feedback should be given. The pseudo-patient also carried a concealed tape recorder to produce a record of the conversation.

Direct request scenarios The therapeutic class chosen was non-prescription analgesics. In Switzerland, as in many other countries, these are the most common name-requested over-the-counter medicines (OTCs), after cough and cold products. Seven different scenarios involving different OTCs were developed.

The Swiss medicines scheduling system consists of five lists constituting two main classes (Compendium Suisse des Médicaments 1998). The first class is prescription drugs, including A-list, non-repeatable prescription drugs, and B-list, repeatable prescription drugs (possible refill on the same prescription). The second class is non-prescription drugs, which is also divided in two groups. Medicines on the C list (pharmacy only) are sold only in pharmacies but do not require the direct supervision of a pharmacist. The D list consists of drugs that can be sold in pharmacies and druggist shops. Druggist shops are distinct from pharmacies and individuals operating them do not require a pharmacy degree but instead attend a specific professional school. The scenarios involved three C-list and four D-list medicines (Table 1).

Scoring system A scoring system was developed to analyse the audio-taped interactions between the pseudo-patients and the pharmacy staff. The score comprised 15 different attributes that addressed the various facets of non-prescription services. The assessment of each interaction was divided into five sections: welcoming, patient, clinical, communication and advice. Each of these sections was then subdivided into specific questions, defining the interaction by listing a number of simple behavioural acts or communication elements. A score between one and four was allocated for each component (Appendix 2). A total score was calculated for each visit.

Data and statistics All data were entered into an SPSS database by the researcher. An independent researcher scored 30 randomly chosen audio-taped interactions to validate the analysis process. The two researchers obtained the same scores for 29 recorded interactions and for the remaining one their scores differed by only one point in the welcoming section.

Scores were compared pre- and post-training using a time series analysis, for both the intervention and control groups. One-way analysis of variance (ANOVA) was used to compare the mean total scores obtained in the intervention and in the control group, at each time point (seven pseudo-patient visits in each pharmacy, over the two-month period). The Scheffe post hoc test and independent t-test allowed the determination of different factors influencing the scores (drug schedule, pharmacy location). As the total scores in each group were not normally distributed, the non-parametric Kruskal-Wallis test was also used to test whether the differences among the samples signified genuine population differences or whether they merely represented the variability that might be expected among random samples from the same population.

Table 2: One-way analysis of variance (ANOVA) assessing the differences in scores between the intervention group and the control group

	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6	Visit 7
F Probability	0.603	0.359	0.013	0.001	0.006	0.001	0.001

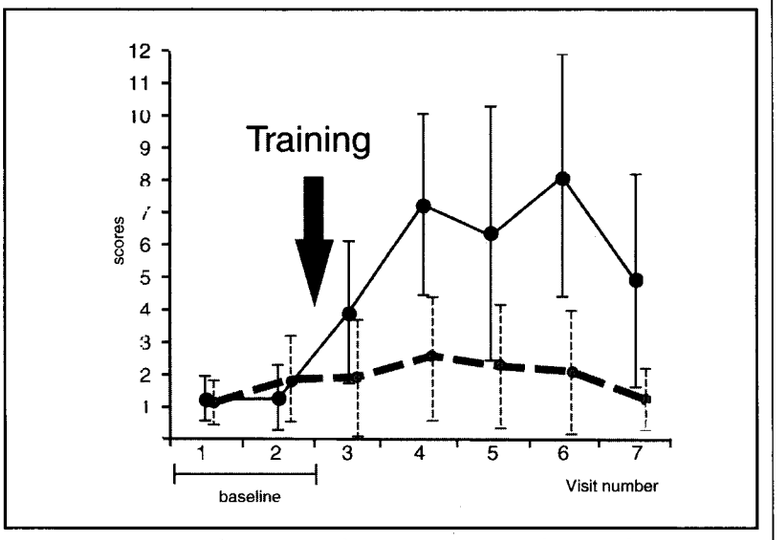

Figure 3: Mean total scores in the intervention and control groups — solid line = intervention pharmacies (98 interactions); broken line = control pharmacies (91 interactions)

Results

In total, 189 audio-taped interactions were analysed. The one-way analysis of variance comparing the total scores of both groups showed that there was a significant difference between the mean total scores obtained at each visit time point post-training (visits 3 to 7). The pharmacies in the intervention group obtained significantly higher scores than those in the control group, indicating a shift from principally direct sales to greater interaction with the patient. Similar significant results were obtained from the Kruskal-Wallis test (Figure 3 and Table 2).

Figure 3 shows that the intervention group's mean scores started to increase immediately after the training, ie, after visit 2. It should also be noted that there is a drop in the mean scores at visit 7.

Possible factors influencing the scores might have included the schedule of drugs involved in

Table 3: The drugs' schedule effect						
Group		N	Mean scores	Mean difference	t	Significance (2-tailed)
Intervention	C-list drugs	42	7.1190	2.6548	3.093	0.003
	D-list drugs	28	4.4643			
Control	C-list drugs	39	2.3077	0.8077	2.115	0.039
	D-list drugs	52	1.5000			

the interactions (Table 1), the location of the pharmacy and whether it was a pharmacist or a pharmacist assistant involved in the interaction. In a further analysis using a post hoc analysis of variance (Scheffe test), the scores obtained from the intervention group were compared in order to examine any significant differences between the scores obtained in each pseudo-patient visit. In the intervention group, the results showed that the scores obtained in post-training visits 3 and 7 were not statistically different from the scores obtained in the baseline visits (before training). This test is more conservative than one-way ANOVA and it revealed a non-significant difference that was not visible in the analysis of variance.

Apart from the differences between the drug requested (Table 1) and the pseudo-patient individuality, there was one notable difference between these two visits (3 and 7) and the three others post-training (4, 5 and 6): they involved non-prescription medications of two different schedules. Visits 3 and 7 involved drugs of the D list (drugs sold in druggists and pharmacies) and visits 4, 5 and 6 involved drugs of the C list (drugs sold in pharmacies only).

The plot of the scores obtained at each visit in both intervention and control groups by the drug schedule (Figure 4) indicates that the schedule may explain the trend in scores.

To test whether this was the case, the scores obtained were grouped depending on the schedule of medications involved and compared using an independent t-test (Table 3). In the intervention group, the scores were statistically different according to the drugs' schedule, confirming the suggested trend found in the Scheffe post hoc test.

In the control group, although the Scheffe post hoc test had not shown any significant differences among the scores, the drugs schedule t-test did show significant differences. In the controls, all the visits could be grouped and compared since the pharmacy staff did not receive any training. Therefore, visits 1, 2, 3 and 7 involving D-list drugs were compared with visits 4, 5 and 6 involving C-list drugs. It was only when the scores were grouped in this way that the difference became statistically significant.

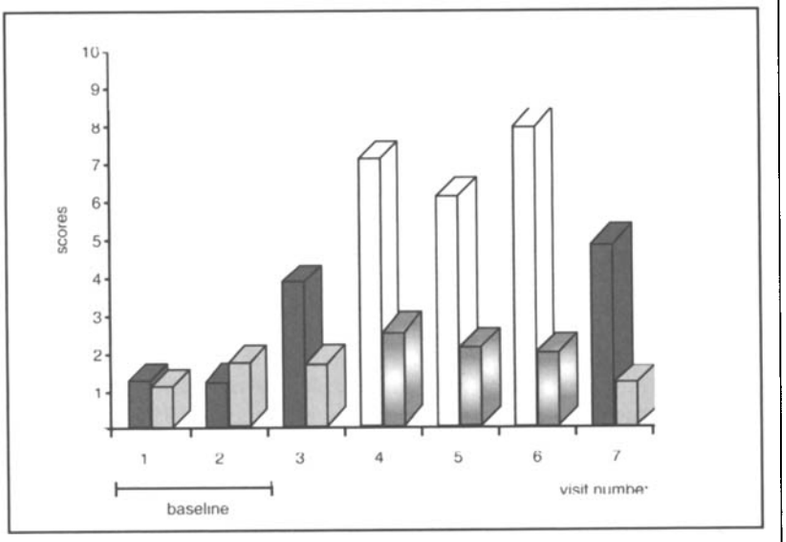

Figure 4: Comparisons of the mean scores for intervention and control groups by legal schedule of drug. Black bars = D list intervention; grey bars = D list control; white bars = C list intervention; dappled bars = C list control

Discussion

This study showed that the implementation of a "personalised advice protocol" with pseudo-patients' feedback changed the way in which pharmacy staff dealt with direct requests for C-list medicines. The intervention had no significant effect on the handling of direct requests for D-list medicines.

A patient-oriented style of questioning was targeted in the training programme for the intervention group. Pharmacists and pharmacist assistants were trained to "prompt" a dialogue with the patient, while minimising any feelings of "being interrogated". This way of interacting with patients significantly increased after training and feedback. The significant differences between the scores obtained in the intervention and the control groups at each visit time point (except baseline) allow the conclusion that pharmacists' and pharmacist assistants' practice changed pre- and post-intervention.

The demonstration of the two health models during the training may have helped pharmacists and pharmacist assistants to alter their perception of patient knowledge and abilities. It seemed that they became more confident to question their patients and to continue the interaction once they assessed the patient's responsiveness. After training they conducted more comprehensive questioning and provided their patients with personalised advice. Pseudo-patient visits may have helped pharmacy staff to change their perception of assumed patient knowledge and to limit misinformed product use.

It was hoped that choosing a common non-prescription product would increase the oppor-

tunities for the pharmacy staff to use the "personalised advice protocol" and therefore to try to change daily practice. However, although an increase in scores was evident over the two months of the study, the results cannot predict whether the changes will be sustained over time. The decreasing scores in the intervention group at visit 7 suggest that pharmacy staff might have benefited from a second training session at this point. However, as visit 7 involved a D-list medicine, it is possible that the lower scores reflect a different approach to such medicines.

This hypothesis is reinforced by the finding in the study that pharmacists and their staff may interact differently with their patients depending on whether the request is for a D-list analgesic or a C-list analgesic. It is possible that pharmacist assistants and pharmacists may be less concerned about the D-list medications, thinking that if the products are available in non-pharmacy outlets they have a lower requirement for pharmacy advice. The perceived complexity of the C-list medications, on the other hand, may explain why visits involving those drugs obtained higher scores. Indeed, the complex combination products requested in visit 5 and visit 6 may have raised pharmacy staff awareness of potential contraindications, hence contributing to the increase in scores in those visits. However, these questions will require further research and cannot be answered from the current study.

Conclusion

A combination of training and feedback on individualised consultations has the potential to change the practice of pharmacy staff in dealing with direct requests for non-prescription medicines. The changes and improvements in practice achieved following the workshop encourage the future development and testing of similar education programmes. The innovative concepts used in this study are expected to be expanded to other therapeutic classes, and to be introduced into Swiss pharmacists' and pharmacist assistants' training programmes.

References

1. Bond CM, Bradley C. Over the counter drugs. The interface between the community pharmacist and patients. BMJ 1996;312:758-60.
2. Kennedy J. Over the counter drugs: Changing the roles of doctors and pharmacists. BMJ 1996;312:593-4.
3. Landis NT. Lessons from medicine and nursing for pharmacist-patient communication. Am J Health-System Pharm 1996;54:1306-14.
4. Kessler DA. Communicating with patients about their medications. New Engl J Med 1991;325:1650-2.
5. Evans S, John D, Bloor M, Luscombe D. Use of non-prescription advice offered to the public by community pharmacists. Int J Pharm Pract 1997;5:16-25.
6. Sclar DA, Robison LM, Skaer TL. Pharmacy consultation and over the counter medication purchasing outcomes. J Clin Pharm Ther 1996;21:177-84.
7. Schommer J. Effect of interrole congruence on pharmacist-patient communication. Health Comm 1994;6:297-309.
8. Ward PR, Bissel P, Noyce PR. Medicines counter assistants: roles and responsibilities in the sale of deregulated medicines. Int J Pharm Pract 1998;6:207-15.
9. Anderson-Harper HM, Berger BA. Pharmacists' predisposition to communicate, desire to counsel and job satisfaction. Am J Pharm Educ 1992;56:252-4.
10. De Young MH. Research on the effects of pharmacist-patient communication in institutions and ambulatory care sites, 1969-1994. Am J Health-System Pharm 1996;53:1277-91.
11. Morrow D. Improving consultations between health-care professionals and older clients: Implication for pharmacists. Int J Aging Human Develop 1997;44:47-72.
12. Anderson C, Alexander A. Response to dysmenorrhoea: An assessment of pharmacists' knowledge and its application in practice. Int J Pharm Pract 1993;2:180-3.
13. Krska J. An audit of responding to symptoms in community pharmacy. Int J Pharm Pract 1996;4:129-35.
14. De Young MH. Reflections on guidelines and theories for pharmacist-patient interactions. J Pharm Teach 1996;5:59-77.
15. Hudmon K, Berger B. Pharmacy application of the transtheoretical model in smoking cessation. Am J Health-System Pharm 1995;52:282-7.
16. Protchaska JO, Di Clemente CC. Toward a comprehensive model of change. In: Miller WR, Heather N, editors. Treating addictive behaviors. New York: Plenum; 1986. p3-27.
17. De Almeida Neto AC, Benrimoj SI, Gomel M, Fois R. Inappropriate self-medication practices: A pharmacy-based intervention. J Soc Admin Pharm 1996;13:131-8.
18. De Almeida Neto AC, Benrimoj SI, Boakes RA. A pharmacy based protocol and training program for non-prescription analgesics. J Soc Admin Pharm 2000;17:183-92.
19. Stretcher VJ, Champion VL, Rosenstock IM. The health belief model and health behavior. In: Gochman DS, editor. Handbook of health behavior research (I): Personal and social determinants. New York: Plenum; 1997.
20. Sleath B. Pharmacist-patient relationships: Authoritarian, participatory, or default? Pat Educ Counsel 1996;28:253-63.
21. Bissel P, Ward P, Noyce P. Variation within community pharmacy 1: Responding to

requests for over-the-counter medicines. J Soc Admin Pharm 1997;14:1-15.
22. Oprandi P. Haufigkeit von Aktivitäten im Kunden/Patientenkontakt. University of Basel, 1998.
23. Morris C, Cantrill J. "One simple question should be enough": consumers' perceptions of pharmacy protocols. Int J Pharm Pract 1997;5:64-71.
24. De Almeida Neto AC, Benrimoj S, Kavanagh DJ, Boakes RA. Novel educational training program for community pharmacists. Am J Pharm Educ 2000;64:302-7.
25. De Almeida Neto A, Kelly F, Benrimoj S. Shaping practice behaviour: novel training methodology. Int J Pharm Pract 2001;9:203-10.

Appendix 1: Pharmacist information

Re: Changing Swiss pharmacists' practice in dealing with non-prescription analgesics

Self-medication is increasing due to choice of OTC products, more and more products are available without prescription, and to greater availibility of information via technology or the media. This new situation allows pharmacists and staff to enhance their professional role in self care. They have the opportunity to demonstrate their clinical expertise by assisting patients in the selection of therapeutically appropriate and cost-efficient OTC medication.

This research aims to determine current practice and to assess need for further support in the form of education to ensure improved consumer health outcomes through provision of optimal training.

Participation of your pharmacy and staff in this research would be very simple with minimum inconvenience caused. Measurement of current practice will look at the products purchased, the personnel involved and their actions, ie, questions asked or advice given. This will involve sporadic purchases of OTC products from your pharmacy over a period of five weeks. Person(s) unknown to yourself or your staff will make these purchases without identifying themselves as a researcher. As a more reliable form of observation, the researcher will audio-tape the purchase encounter. Audio-taping is a more effective form of observation and will provide more accurate information than exclusive reliance on researcher observation and interpretation. Audio-tapes will not be used to collect any personal information and they will be destroyed once the research has been completed to guarantee confidentiality.

The project has been approved by the University of Sydney Human Ethics Committee and steps have been taken to ensure that all participants remain anonymous. Data collected through the study will provide valuable information on the current needs of pharmacy assistants in respect to further training in non-prescription medicines.

Prior to commencement of the research you will be required to sign a consent form to ensure that I have your permission to use the data obtained in the pharmacy for the purposes of the study. This also provides assurance that all data collected will be treated with strict confidentiality and not used to identify any pharmacy or pharmacy staff member. A report may be submitted for publication in the future but individual participants will not be identifiable in any way.

An anticipated outcome of this project is the further development of the professional image of pharmacy and your participation is greatly appreciated. Any inconvenience to your pharmacy, staff or customers will be restricted to a minimum.

Participation in this project is entirely voluntary and you are able to withdraw at any time.

(Contact details for the researcher [TS] were given in case pharmacists required further information.)

Appendix 2: Scoring system

For each component, a yes/no answer was recorded

Component	*Score*
Welcoming	
1. Dialogue?	1
2. Is the pharmacist or the assistant listening to the pseudo-patient?	1
Patient	
3. How are you doing with that drug?	4
4. Who is it for? or Is it for you?	1
5. Do you know that drug? or Have you taken it before?	1
6. Are you happy with that drug? or Does it suit you?	2
Clinical	
7. What are the symptoms?	1
8. For how long/since when?	1
9. Have you tried anything else?	1
10. Do you take any other medication?	1
11. Do you have any other health conditions?	1
Advice	
12. Provision of advice?	1
13. Adapted? Personalised?	1
14. Side effects, contraindication?	1
Communication	
15. Type of questions (open-ended)?	1

Date article received 5.4.01; returned to author for revision 3.7.01; accepted for publication 7.1.02