

Motivating customers to develop and maintain a  
relationship with pharmacist: an application of a Stages of  
Change Model

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Submitted to the  
Faculty of Communication Sciences  
University of Lugano

for the degree of  
Ph.D. in Communication Sciences

May 2007

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## **Abstract**

A consistent branch of research in health communication has been focused on the study of the pharmacist - patient relationship. In past decades, the pharmacist and his role in the health care setting has shifted from a product oriented approach, where the primary focus was the production and compound of medicines, to a more patient oriented approach, with main focus becoming the understanding and caring for clients and the problems they bring to their health care providers. As a consequence, research in the health communication field, with a focus on community pharmacy settings needs to examine strategies to get the pharmacist closer to the clients, developing a long – term relationship, and adopting a more patient- oriented information approach to move closer to the needs of the client.

The main purpose of my doctoral thesis is to examine the pharmacist - client relationship focusing in particular on the attempt to integrate the Stages of Change Model (Prochaska and DiClemente, 1983), with two models currently in use to describe relationship development in the pharmacy context, in order to identify strategies that can support the pharmacists in building a relationship of loyalty with their clients in the future.

I hypothesized that targeting health information according to the level of the relationship clients are in could produce the necessary loyalty to commit to the pharmacist and to enhance the long run acceptance and effectiveness of the health message. In particular, the empirical section is devoted to understanding how to produce the necessary loyalty that can lead to better future response for the therapeutic and health needs of the client. The hypothesis was tested in the context of Tessin pharmacist – client relationship by means of a three phase study: an explorative study, a descriptive study, and finally an intervention study.

Using the data collected in the descriptive study, two models of relationship development were tested: one static and one dynamic. The static model treats the perceived relational benefits, relationship selling behaviours, perceived expertise and stages of change constructs as antecedents of trust. The dynamic model adds the Stages of Change moderating effect on perceived benefits, perceived expertise, perceived relationship selling behaviours, as antecedents of trust. In the dynamic model, trust is directly influenced by the perceived expertise of the pharmacist, relationship selling behaviours, and perceived relational benefits. The Stages of Change Model moderated the relationship between perceived relational benefits and trust, and approached significance in moderating the relationship between perceived expertise and trust.

The moderated relationship influences the way to structure an intervention to increase client intention to frequent the pharmacy in the future: in particular, it suggests tailoring the message depending on the stage of the relationship. The analysis of the data shows that targeting health messages according to the level of client relationship (developmental stage/maintenance stage) and building the messages focusing on the variables most influential to the particular relationship stage should bring to a more “loyal client” in the future. Furthermore, results in the intervention study show that for people in the developmental stage, a targeted message, that is a message focused on relational benefits, was more effective than either no message, or a stage mismatched message.

To my husband Fabrizio, and to my parents





## **Acknowledgements**

I wish to thank Professor David Brinberg, the supervisor of my doctoral thesis, who from the very beginning supported me in conducting my research..

I owe a huge debt of thanks to Professor Peter Schulz for the possibility he has given me to work with his team at the University of Lugano and for his constant support and advice, all of which have helped me to complete this project in more ways than he can imagine.

Special thanks also go to Professor Kent Nakamoto who has inspired crucial reflections on the contents of my work.

Thanks also to the Ordine dei Farmacisti del Canton Ticino for their involvement in the project, and to the Swiss National Science Foundation that has financed my visit to Virginia Tech (USA), where I have refined and deepened my analysis.

I would like to thank all the friends and colleagues of the Institute of Communication and Health of the University of Lugano. In particular, I wish to acknowledge the support of Sara Rubinelli who has been my first point of reference during the difficult moments of my research, as well as the support of Maria, Benedetta, Maria Regina and Benedetta.

Most of all I thank my husband Fabrizio for his patient, support and for constant love which has made each day of this doctorate special.

A huge thanks goes to my parents, Giorgio and Marilena, for the education they have given me, and for the sacrifices made to support my studying in Lugano.

Last but not least, I thank all my friends who have shared the agonies and joys of this experience, in particular my flatmates Isabella and Chiara, and Maddalena, Alessandro, Sara, Cristina and Marco.



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## **Executive Summary**

In the field of Health Communication, the provider – patient relationship has been extensively studied in the last 30 years. The relationship between a health care provider and a client/patient is considered fundamental for a successful exchange of information that can lead to a satisfied patient/client, and a more patient oriented health care provider.

Obviously, different types of provider - patient interactions exist: doctor – patient, nurse – patient, pharmacist - client, health care institution – patient, etc. All of those interactions occur in a particular context (hospital setting, community pharmacy setting, health departments and public offices, etc.), and may vary as the interests, the tasks, and the motivations of the subjects involved change, since their role and the context where they take place also change.

A consistent branch of research in the health communication field has been focused on the study of the pharmacist - patient relationship. In past last decades, the pharmacist and his role in the health care setting has shifted from a product oriented approach, where the primary focus was the production and compound of medicines, to a more patient oriented approach, with main focus becoming the understanding and caring for clients and the problems they bring to their health care providers. The re-professionalization to a more patient-oriented approach has forced pharmacists to identify areas where they could intervene to enhance the quality of patient care and to perform their services with a particular focus on the needs of their clients. At the same time, the client needs to learn how to use this new source of information. Given the rising complexity and costs of health care, the role of pharmacists as primary health care providers will become more essential. As a consequence, research in the health communication field with a focus on community pharmacy settings needs to examine strategies to get the pharmacist closer to the clients, developing a long-term relationship, and adopting a more patient-oriented information approach to move closer to the needs of the clients.

Trust is considered a key component in relationship development and maintenance of pharmacist – patient interactions. A long-term relationship is a prerequisite in the pharmacy context to provide the pharmacist with proper responses and feedback to the individual health needs of the clients. Numerous difficulties and numerous barriers exist for the pharmacist to approach the client and to interact with him in an ideal way (space, time, education, economical return).

A long-term relationship is required because even if the pharmacist is an expert in the provision of health care services and advises the client in the proper way, the advice will be ineffective if the client is not ready and willing to accept and to interact with the pharmacist.

The literature in the field, underline the importance of trust for the development of a long term relationship. Trusting the health care provider and being loyal to him, could enhance the provision of health care information and services, the exchange of information and the acceptance of the messages by the patient/client.

The first part of my thesis is devoted to the analysis of the literature about pharmacist – patient relationship, with two particular foci: first, I try to understand the relevant issues related to that interaction. Second, I examine and present relevant literature in the field that proposes factors contributing to the development of that relationship considering that it lies at the boundaries between that of a physician and his patient, and a business service provider and a consumer. Thus, I will carefully review the literature that examines service provider – client relationship, considering what has been done in the pharmacy context.

Examining models currently used in this field, and that have already been adapted from the context of relationship marketing, I will try to understand how to better study pharmacist - client interactions and the determinants of intention to visit the pharmacy in the future.

The literature both in the pharmacy context and in the relationship marketing field does not provide recommendations or indications of strategies which might help the pharmacist develop and maintain a relationship with his clients, particularly given that the pharmacist – client relationship is likely to be in different stages.

The main purpose of my doctoral thesis is to examine the pharmacist – client relationship focusing in particular on the attempt to integrate the Stages of Change Model (Prochaska and DiClemente, 1983), with models currently in use to describe relationship development, in order to identify strategies that can support the pharmacists in building a relationship of loyalty with their clients in the future.

I hypothesized that targeting health information according to the level of the relationship clients are in could produce the necessary loyalty to commit to the pharmacist and to enhance the long run acceptance and effectiveness of the health message. In particular, the empirical section is devoted to understanding how to produce the necessary loyalty that can lead to better future response for the therapeutic and health needs of the client. The hypothesis was tested in the context of Tessin pharmacist – client relationship by means of a three phase study: an explorative study, a descriptive study, and finally an intervention study.

Using the data collected in the descriptive study, two models of relationship development were tested: one static and one dynamic. The static model treats the perceived relational benefits, relationship selling behaviours, perceived expertise and stages of change constructs as antecedents of trust. The dynamic model adds the Stages of Change moderating effect on

perceived benefits, perceived expertise, perceived relationship selling behaviours, as antecedents of trust. In the dynamic model, trust is directly influenced by the perceived expertise of the pharmacist, relationship selling behaviours, and perceived relational benefits. The Stages of Change Model moderated the relationship between perceived relational benefits and trust, and approached significance in moderating the relationship between perceived expertise and trust.

This moderated relationship influences the way to structure an intervention to increase client intention to frequent the pharmacy in the future: specifically, it suggests tailoring the message depending on the stage of the relationship. I expected that targeting health messages according to the level of client relationship (developmental stage/maintenance stage) and building the messages focusing on the variables more influential to the particular relationship stage should bring to a more “loyal client” in the future.

Results in the intervention study show that for people in the developmental stage, a targeted message, that is, one focused on relational benefits, was more effective than either no message, or a stage mismatched message.

Those results tell us that if the pharmacist tailors health messages to the relationship level he has with the client, this will help him in approaching the client and in creating a basis for more loyalty in the future. The intention to remain loyal to a pharmacy is a prerequisite for the growth of the relationship and an important component for responsible provision of health care services by the pharmacist. This is also important information for acceptance by the client, especially those who are in the developmental stage, because clients in the maintenance stage are already committed and loyal to the pharmacist.

# **Chapter 1: Literature review and theoretical framework**

## **Introduction**

The main purpose of my doctoral thesis is to examine the pharmacist – client relationship by focusing, in particular, on the attempt to integrate the Stages of Change Model, a subset of Prochaska and Di Clemente (1983), with the models currently in use to describe relationship development in the pharmacy context, in order to identify strategies that can support the pharmacists in building a relationship of loyalty with their clients in the future.

Such a topic implies a multidisciplinary approach. A deeper understanding of the pharmacist – client relationship builds upon the study of social sciences (such as communication studies, psychology, etc.) and the application of principles from many professional fields (such as health care, education, management, marketing, and relationship marketing).

In the first chapter, I will explain the theoretical foundation behind my dissertation. I will explain the different steps that lead to the definition of the research questions, and that help me to focus my attention on a particular issue.

The first section of the chapter contains a brief background of work in the pharmacy practice context throughout the past few years. This description clarifies the origins of the need for investigating the pharmacist – client relationship and makes explicit the issues surrounding this topic.

Numerous studies, as it will be argued, underline the importance of focusing on the understanding of how the pharmacist –client relationship develops. In particular, one issue seems to be unresolved; that is, how this relationship grows, considering that the development depends on the different level of loyalty felt by the clients, and as a consequence, on the different stages of the relationship in which the client is. To answer to that question, I will then introduce some insights offered by different disciplines that are useful in better understanding the implications of the study of the pharmacist – client relationship.

Communication and relationship quality seem to be the most important factors in strengthening the pharmacist's relationship with the clients. I will identify some studies in the fields of community pharmacy to relationship marketing that contribute significantly to the study of pharmacist – client relationship.

A lack of understanding exists in explaining how a relationship develops given the fact that it grows in a dynamic way, and considering that the growth also depends on the relationship stage of the client and pharmacist.

It will be hypothesized that the integration of the Stages of Change Model with the models currently in use to describe the pharmacist – client relationship allows for the definition of strategies for pharmacist to tailor health information according to the relational level with the clients, enhancing the process of relationship development.

### **1.1 Provider – patient interaction**

Research in the field of health communication considers provider – patient interaction as one of the most relevant areas of investigation. Indeed, research into different aspects of this relationship has been examined in the last 30 years and, although the emphasis has changed over the years, provider – patient interaction should be considered a key area of study in the context of health communication (Cegala, and Lenzmeier Broz, 2003).

Provider – patient interaction can be contextualized in various manners, depending on the subjects that are involved in the relationship: the doctor – patient relationship, for example, is the one most extensively studied. It can be defined as therapeutic alliance that, if managed well, may lead to relevant outcomes. These may include: satisfaction, adherence, compliance, and recall of information by the patient (Belle Brown, Stewart and Ryan, 2003). Though most of the literature has mainly been devoted to the study of the doctor – patient relationship, other types of provider – patient relationship exist. They may vary as the interests, the tasks, motivations of the subjects involved, role, and the contexts change. The nurses – patient relationship, pharmacist – clients relationship, and other types of health professionals – client relationship have been studied.

Each of the former interactions has peculiar characteristics, though the final objective for every type of provider – patient interactions should be the well-being of the patient/client, a desirable improvement on health status, and an improvement in client quality of life.

Looking at the most extensively studied relationship, that of the doctor – patient, numerous authors agree that doctor – patient communication may lead to a good interpersonal relationship. A good interpersonal relationship may be defined as a relationship where mutual trust exists between the doctor and the patient and where a patient-centered method is applied. Also, the interactions must be characterized by mutuality, which requires that a dialogue is established between the doctor and the patient as a vehicle through which the patient values are explicitly articulated and explored by the physician who can be considered a counsellor. Doctor – patient communication may help the exchange of information between the physician and the

patient, and can enable doctor and patient in the process of making sound decisions about treatment (Ong *et al.*, 1995).

Numerous methodologies have been adopted to examine doctor – patient interactions. Considering the fact that the focus of these studies is the enhancement of communication between the physician and the patient, quantitative and qualitative methods have been adopted to capture the most relevant features of the dialogues between the two participating groups

Quantitative methods focus on the analysis of the “cure system,” which means being sensitive to the instrumental (task focused) behavior of the doctor; an example of this is the Bale’s Interaction Process Analysis. Other quantitative methods focus on the “care system” and measure the affective (socio- emotional) behaviors of the physician; an example of this is the Patient-Centered Method. An example of a quantitative interaction analysis system that tries to capture both the types of behaviors is the Roter Interaction Analysis system.

Qualitative methods used to assess the dialogue between physician and patient are: discourse analysis, conversation analysis, and narrative analysis. The qualitative methods lack theoretical models and conceptual framing with which to organize results (Roter and McNeilis, 2003).

My research interest surrounds the pharmacist – patient interaction and the understanding of which factors allow this relationship to grow in the future. As I am interested in obtaining the most generalizable results, I decide not to use the approach of dialogue analysis in my research.

Qualitative methods were adopted only in a preliminary phase of the research, where the intention was to better understand the Tessin context where pharmacists of my investigation operate.

Research in the area of health communication also reflects the peculiar communication concerning the doctor – patient relationship. Examples of communication behaviors are: instrumental vs affective behaviors, verbal vs non verbal behaviors, privacy behaviors, high vs low controlling behaviors, and medical vs everyday language vocabularies. Research in the field has also tried to study the influence that those communicative behaviors may have on some relevant patient outcomes, such as patient satisfaction, patient compliance and adherence, patient recall of information, and patient health outcomes (Ong *et al.*, 1995).

Doctor – patient communication has been defined as a therapeutic relationship (Roter and McNeilis, 2003) where the primary focus is the enhancement of patient outcomes. Previous research documents the importance of measuring the ways the patient perceives and engages in the relationship, as well as the ways physicians engage and validate patient participation in decision making.

The doctor –patient relationship can be considered an interaction where the therapeutic aims are most relevant in assessing quality and success of the interaction. The pharmacist – client relationship that is at the core of my research interest lies at the boundary between therapeutic issues and business matters.

Certainly, trust and communication skills of pharmacist remain a key component of successful relationship. The communication skills essential to the development of a good relationship are, for example, demonstrating friendliness and warmth, using the patient’s name, expressing genuine interest and concern for patients and their needs, discussing shared interests, demonstrating appropriate sympathy and empathy, referring to previous encounters, being readily available, offering reassurance, and asking open ended questions (Morrow and Hargie, 2001; Tindall et al., 1994) These communication skills have already been the object of study in the pharmacy context, but they are not enough to start an interaction with a client.

Considering the outcomes relevant in assessing the success of this interaction, and considering the peculiar duties of the pharmacist, the pharmacist who works in a competitive market and is not only a provider but also a seller needs to establish a trusting and long-term relationship with the client. The first relevant outcome that must be achieved in his context is loyalty. The doctor has a peculiar relationship with the patient where the permanence of the patient is not in doubt.

The focus in the pharmacy context is in developing the relationship between the pharmacist and his clients. In the next sections the reasons of that focus become clear, and also the factors that characterize this peculiar relationship.

## **1.2 The focus on the relationship**

The relationship between the pharmacist and client is the focus of my research. It lies at the boundary between the therapeutic relationship of a physician and his patient, and that of a business service provider with the consumer. The context of the pharmacy, because of its many commercial activities, is much closer to a business service rather than a therapeutic health setting. Thus, I will review more carefully the literature that examines the pharmacist as a service provider in the context of a business relationship rather than as in physician – patient relationships.

Pharmacy is one of the oldest health professions. It is associated with medicine because “*it delivers services of fundamental value to society and [is] complementary to services offered by other health care professionals*” (Mrtek and Catizone, 1989: 29). Pharmacists are considered a

good source to educate and counsel their patients about health care topics (Angorn and Thomison, 1989).

In recent years, research in the context of the pharmacy practice documented the emerging issue of factors enabling the pharmacist to develop and maintain a relationship between himself and his clients.

As Lawrence *et al.* affirm:

*«Understanding the nature of the pharmacist-patient relationship and the variables that determine its depth, are important for the future development of the pharmacy profession»* (1995: 23).

A series of changes in the pharmacy profession, in pharmacists' activities, in health care systems, and in individuals have raised the interest in, and relevance of, this topic.

### **1.2.1 The pharmacist: from a product-centered approach to a patient-centered vision**

The primary motivation to examine the dynamics of the pharmacist - client relationship can be traced to an evolution of the pharmacist profession and some changes in the surrounding environment.

During the 20<sup>th</sup> century, pharmacists assumed different social roles, and the changes in these roles reflected the changes that occurred in society. As a consequence, these changes in the profession had repercussions in terms of significant shifts in the structure, organization, and nature of the profession (Penna, 1987). Hepler and Strand (1990) distinguish three major periods in which we can see different conceptions of the pharmacist's functions and obligations.

#### ***The traditional stage (1900-1940)***

The ancient roots of the pharmacy profession were the knowledge of and the skills needed to compound a drug-product (Mrtek and Catizone, 1989). This is defined by Hepler and Strand (1990) as the traditional stage in pharmacists' professional development.

The main functions of the pharmacist were to procure, prepare, and evaluate drug products. Primary obligations ranged from ensuring that products sold were "pure, unadulterated, and prepared *secundum artem*," to providing advice to clients because of his expertise in the field. During this period of time, the pharmacist was the drug expert and the only supply source. The need for change first occurred with the rising of pharmaceutical manufacturing that eliminated the primary function of the pharmacist: the ability to compound drug products. As a

consequence, the mechanized processes of industry more efficiently replaced “*the back room compounding laboratories of most corner drugstores*” (Mrtek and Catizone, 1989: 30).

One consequence of the technological development in the pharmacy industry was the forcing of pharmacists to abandon historically used practices for new ones.

The pharmacists were aware of the dangers of drug usage and the importance of proper use. They shifted their focus to “*the quality assurance aspects of drug use*” (Mrtek and Catizone, 1989: 30). The function was to ensure that drugs provided to clients and to physicians were safely and accurately dispensed.

Even this function disappeared as the choice of therapeutic agent began to focus on physicians (Hepler and Strand, 1990) and pharmaceutical manufacturers employed sales representatives to promote the products of their company to physicians. As Mrtek and Catizone state:

*«In the span about 50 years, the profession lost no less than three of the four functions that had been the mainstay of the work of pharmacists since at least the 8<sup>th</sup> century: the old mysteries of the art of apothecary, drug procurement, storage, and compounding, had vanished»* (1989: 30).

This loss has put the identity of the entire pharmacist profession at risk. The changes have actually limited the role of the pharmacist to that of a dispenser of prefabricated medicines prescribed by others, with associated monetary transactions (Gilbert, 1998; Hepler and Strand, 1990; Mrtek and Catizone, 1989).

### ***The transitional stage (1940-1970)***

The transitional stage corresponds to a period in which “*pharmacists sought self-actualization and the full achievement of their professional potential*” (Hepler and Strand, 1990: 534).

Pharmacists began to perform new services, identify new functions, and make new contributions to the literature. As Hepler and Strand (1990) state, the scientific movement to re-legitimize the pharmacy identity can be explained both as an inevitable response to the loss of traditional functions, and as a necessary maturation of the profession relating to changing social needs.

The first attempts were toward the clinical pharmacy practice that “*placed drugs at the forefront and only mentioned the patient*” (Hepler and Strand, 1990: 534).

### ***The patient care stage (1970- today)***

Pharmacists reacted to this change, and to the growing confusion surrounding their role in health care, by considering a “re-professionalization” toward a more extended role (Birembaum, 1982; Edmunds and Calnan, 2001; Pilnick, 2003; Gilbert, 1998).

The topic has caused an active debate in the health and other fields, about the opportunities that the new role could offer and the new functions that pharmacists must cover.

The re-professionalization took different forms and spread differently by country, but it was clear that all new services offered and the new functions performed by pharmacists needed to be oriented more to clients and their diseases rather than on the production and compounding of medicines (Pronk. et al., 2001; Edmunds and Calnan, 2001).

The attention of pharmacists shifted from a product-centered focus to a patient-centered focus, the main thrust of the relationship becoming:

*«The understanding and caring for patients and the problems they bring to their interaction with health care provider, and not just patient disease and symptoms» (Worley-Louis et al., 2003: 29).*

Hence, I assert that the pharmacist profession is currently in its patient care stage that was *“both an unavoidable response to the disappearance of the apothecary role and a necessary pre-condition to professional maturation”* (Lawrence et al., 1995: 22).

The patient-centered approach, in its different forms and applications, forces pharmacists to value their relationships with their clients. This makes the relevance of an in-depth analysis of the pharmacist - client relationship clear.

Tindall et al. (1994) offer a significant contribution to this topic. They argue that in the patient care stage all professional activities between pharmacists and clients take place in the context of the relationship they establish:

*«An effective relationship forms the base which allows a pharmacist to meet professional responsibilities in patient care» (1994: 4).*

According to the authors, establishing a good relationship with clients is a pre-requisite to acting as a good pharmacist. It can lead to more effective communication and education by pharmacists, which in turn can produce improved health outcomes and lifestyles for clients.

The success seems to be related to the pharmacist's ability to develop a trusting relationship with clients that can lead to an open exchange of information and client involvement.

Various attempts have been made all over the world to extend the role of the community pharmacist. Pharmacists tried to identify areas in which they could enhance the quality of patient care in different ways and with different foci (Barber *et al.*, 1994).

### **1.2.2 The new pharmacist activities: the need to build rapport with clients**

The first step in the direction of patient care can be traced to the USA and the development of the concept of pharmaceutical care by Hepler and Strand.

It was defined as:

*«The responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life» (1990: 539).*

The outcomes were: 1) cure of disease; 2) reduction or elimination of symptoms; 3) arresting or slowing of a disease process; 4) preventing a disease or symptoms.

Pharmacists had some difficulty accepting and adopting this concept. It thus remained unknown by most clients because *“it was not being performed as a routine, and several barriers existed, which were attributable to problems in education, skills, resources, and environment”* (Berenguer *et al.*, 2004: 3931).

These problems limited the pharmacists' success in establishing, developing, and maintaining relationships with clients.

The responsible provision of drug therapy, for the purpose of achieving definite outcomes, requires the involvement of clients in the decision-making process regarding treatment and the establishment of therapeutic goals that need to be approved both by the pharmacist and by the client (Tindall *et al.*, 1994).

Hepler and Strand coined the concept of “pharmaceutical care” and described a “covenant relationship” that pharmacists need to establish with clients to reach the therapeutic goals of pharmaceutical care (compliance, adherence, and concordance).

A covenant relationship is defined as:

*«A mutually beneficial exchange in which a patient promises to grant authority to the provider, and the provider promises competence and commitment to the patients. The covenant relationship requires fidelity in both promises and truth telling; proficiency of skill to provide care, control by the patient of his person and environment, freedom from fear, pain and abandonment, and encouragement of realistic hope for improvement or cure» (Hepler and Strand, 1990: 539; Lawrence *et al.*, 1995)*

The issue of understanding the nature of a pharmacist - client relationship and the factors that allow the pharmacist to grow closer to the client is of primary importance in the context of pharmaceutical care.

The route to developing this relationship remains uncertain because there are no specific professional strategies that the pharmacist can apply to build a covenant relationship with clients. This is because pharmaceutical care is based primarily on client needs, and not only on the functions, activities, or services of the pharmacist (Strand *et al.*, 1991). The implications of the dynamics of this relationship also explain why pharmaceutical care is more developed and has had more success in hospital and institutional settings than in community pharmacy settings.

As Gilbert asserts:

*«The shift in favor of more active involvement with patient care was less successful in community pharmacy setting, the main reason being the pharmacist's lack of access to the patient's health status record»* (1998: 153).

Pharmacists in community settings can do very little without having the information necessary to make accurate clinical judgments about clients, which are central to drug therapy decisions (Mrtek and Catizone, 1989).

This covenant relationship approach allows pharmacists in a community setting to place an emphasis on health and not just medicine, including services of prevention, education, health promotion, counseling, and advice about minor illness. All those services could be considered part of the offerings of primary health care in the modern health care system (Cipolle *et al.*, 1998).

These types of initiatives seem to be easier to practice in a context like community pharmacy settings, where the role of the pharmacist is less technical and more client -oriented.

Re-professionalization has developed in many countries. The first attempts occurred in the Netherlands, Malta, South Africa, Canada, USA, and England (Lloyd-Williams, 2003; Campbell, 2002). There are many examples of the pharmacist's efforts to achieve a client -oriented approach and to establish valued relationships with them. In the UK, for example, pharmacists advise clients on minor ailments, diagnostic testing, health education and promotion of primary care, and record keeping (Gilbert, 1998).

Advice on minor ailments covers many topics such as: headache, cough, sore throats and colds, eye disorders, constipation, diarrhea, abdominal disorders, perianal and perivulval pruritus, ear

disorders, musculoskeletal disorders, face and scalp skin disorders, trunk and limbs skin disorders, childhood ailments, foot disorders, oral and dental disorders, etc. (Nathan, 1989).

**The components of pharmacists' health promotion activities**

- Using the pharmacy premises effectively to promote health through the display of posters and leaflets on health topics.
- Providing an advice or counseling area.
- Using written information to supplement verbal advice (e.g., using a leaflet on healthy eating, as well as selling a bulk laxative as part of the response to a customer asking for advice on constipation).
- Offering one to one advice about individual behaviors (e.g., smoking cessation), this might be linked with the sale of nicotine replacement therapy.
- Offering clinics (perhaps in conjunction with local medical practices) on specific topics such as menopause.
- Targeting individuals known to be at risk (e.g., those receiving prescription medicines for angina, osteoporosis) and discussing management if appropriate and considering with the individual the effect of the treatment on their quality of life and offering further information if required.
- Networking with other health professionals and health agencies to participate in activities and campaigns that address the local community's health needs.

Figure 1: Health promotion activities by pharmacists (Blenkinsoop et al., 2001: 160)

There is a need to better understand the dynamics of the pharmacist - client relationship when giving advice. As Anderson *et al.* (2004) state, some difficulties exist in health promotion if there is no relationship established between the pharmacist and the client. If a customer is open to the idea of a pharmacist providing health advice, they do not need the initiative to approach the pharmacist to ask for help.

Another area where pharmacists may re-invent their profession is that of health education, concerning such diseases as diabetes, asthma, and hypertension. The pharmacist can give the support necessary to improve client adherence to advice, compliance, education, monitoring, and prevention (Holdford *et al.*, 1998).

As Campbell states:

*«Primary care physicians are more effective in managing acute conditions than in providing care for chronic ones because chronic disease requires clinicians to spend considerable time with patients»* (2002: S18).

This role of the primary health care provider is now shifting to the pharmacist as he starts specializing more on health prevention education and support for chronic diseases.

Numerous initiatives and interventions have been created. It seems to be important that the pharmacist builds a strong relationship with the clients to achieve these interventions. All the initiatives appear well technically defined, but there are no recommendations about how the pharmacist might build a strong relationship with a client so as to involve him in these kinds of activities. Thus, there is a need to discover ways to move the client closer to the pharmacist. This will assist in establishing a long-term relationship that improves initiatives associated with health outcomes, client health knowledge, and better use of health care services not only in community pharmacy settings but also in institutional and hospital settings.

<b>Extended role of community pharmacists</b>	
1. Delivery services to household patients	13. Patient referrals to general practitioners and other health professionals
2. Services for groups with special needs	14. Development of local formularies
3. Services for residential home	15. Provision of professional advice
4. Out of hours services	16. Advice on palliative care
5. Domiciliary visits	17. Supply of disability aids
6. Hospital discharge and admission procedures	18. Reporting adverse drug reactions
7. Health promotion activities	19. Provision of quiet area of confidential conversations
8. Needle and syringe exchange schemes	20. Supply of complementary medicines
9. Distribution of welfare food	21. Advice on over the counter medicines
10. Disposal of unwanted medicines	22. Training of other health professionals
11. Sale prepayment certificates	
12. Health screening	

Figure 2: Extended role of pharmacists (Barber, Smith & Anderson, 1994)

### **1.2.3 Changes in the imperatives of the health care systems**

The growing interest concerning the pharmacist - client relationship can also be attributed to attempts to reduce public health care expenditures, inviting citizens to become more interested and responsible for their own health (Indritz and Artz, 1999).

Health policy and implementation seem increasingly centered on promoting health, inviting citizens to appropriately use medical and health care services, and in promoting a new form of competition between health care providers based on value and quality of care (Deering, 1998).

At the same time, it is evident that unnecessary and inappropriate health care utilization that often causes increased health care expenditures can be reduced through innovative programs to prevent health problems and to promote sound medical choices (Fries, 1994; Fries *et al.*, 1993; Vickery, 1995. Cit. in Deering, 1998). This is one reason why governments and institutions stress the importance of concepts like self care, defined as: “*the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness and restoring health*” (WHO, 1983. Cit in Bernardini *et al.*, 2003).

In 1998 the World Health Organization defined the same concept similarly;

*«Self care is what people do for themselves to establish and maintain health, prevent and deal with illness. It is a broad concept concerning: hygiene (general and personal), nutrition (type and quality of food), lifestyle (sporting activities and leisure), environmental factors (living condition, social habits), socio-economic factors (income level, cultural benefits), self medication»* (WHO, 1998).

The existing experiences of pharmacists in this new role support the notion that they can significantly enhance the interest of citizens in the promotion of their health, including a better use of health care services due to pharmacist provision of health information and client counseling.

Various health care systems have tried to familiarize people with concepts like self-care and self medication. These preventive actions can lead to an enhancement of citizens' health and a better use of the services offered by other components of health care system networks. The focus is shifting, making the client more responsible for his health status.

Pharmacists have the opportunity to become a vital component of an integrated patient-centered system of health care (Berenguer *et al.*, 2004). Relative to other health care providers, the most important advantages of having pharmacists assume this role are easy accessibility and availability, as they are well distributed throughout countries. Pharmacies are open all day and are visited by healthy people as well as those who are ill. Pharmacists are often considered the first point of contact and are the only contact with a health care provider for some people. They have relatively frequent contact with the public and often they are the only health care professional to have personal contact with the client over an extended period of time (Lloyd-

Williams, 2003; Indritz and Artz, 1999; Anderson S., 2002; Anderson C., 2000; Schulz and Brushwood, 1991; Berenguer *et al.*, 2004). Taylor and Harding affirm:

*«Pharmacists are able and willing to advise patients on minor health complaints as well as on health education, (...) advise patients on “over the counter” medications, treat their minor illness, and when it is appropriate to do so, refer them to general practitioners. This allows a much more efficient use of the general practitioner’s time, while ensuring that minor illness are seen and treated by a suitably qualified individual»* (1989: 210).

O’Loughlin *et al.* seem to have the same opinion when they assert:

*«Community pharmacy thanks to their qualities could provide an important channel for the delivery of the activities of prevention, education and counseling concerning health topics».* (1999: 324).

In summary, the advantages of the pharmacist acting as a primary health care provider are cost containment, provision of services, and quality of health care (Indritz and Artz, 1999). Pharmacists have been encouraged by other stakeholders of the health care system, governments and health institutions, to be more patient-oriented and to get closer to the clients in order to educate and counsel them. Understanding ways to establish a long-term relationship with clients is an important component of the pharmacist’s future activities.

#### **1.2.4 A change in individuals**

An additional factor that has led to an increased interest in the pharmacist - client relationship is the role of the individual in reducing health care expenditures, inappropriate or unnecessary use of medical services, and improving health outcomes. At the same time, consumers have become more proactive *“in seeking, even demanding such involvement”* (Deering, 1998: 127). Improved educational levels and greater access to health information by clients, combined with an increased individual interest in personal health, are resulting in growing demand for direct participation in health care decisions (WHO, 1998).

Therefore the client is more willing to participate in the decision-making process concerning minor illness and receive information about his health from health care providers. This is defined as “patient empowerment,” where the emphasis is placed on strengthening the therapeutic alliance with patients by increasing the level of patient participation in the relationship (Tindall *et al.*, 1994).

In recent years, this concept has received more attention and it encompasses:

*« (...) informed choices about health care plans and providers, patient-centered care, share decision making, or even self care»* (Deering, 1998: 127).

Nevertheless, the concept of empowerment does not imply patient autonomy, as Bernardini *et al.* (2003) note, and it does not reduce the role of health care providers. More than ever, patient guidance is necessary because of the vast amount of health information presented to consumers and the need to sift through it to make the right decisions about their health care.

In order for the pharmacist to contribute to reaching this objective, that of acting as a guide and being a health care provider, it is fundamental that he approaches clients and establish a long-term relationship with them (Worley-Louis *et al.*, 2003).

Another factor that is related to the empowerment of individuals is health literacy. A common definition of health literacy is offered by Selden *et al.* (2000: v):

*«The capacity of individuals to obtain, process, and understand the basic health information and services needed to make appropriate health decisions».*

According to Selden *et al.* (2000), health literacy and health education are strongly linked, and poor health education results in poor health literacy. As individuals are asked to become more responsible for their health and to make better use of the complex modern health care system, they need to reach a higher level of health literacy. Health literacy includes the ability of the customer to distinguish useful information from useless or inappropriate information and knowing to whom to turn to in order to obtain pertinent information about health.

The question arises concerning the extent to which pharmacists can be considered as major providers of health literacy. This requires an approach where health literacy is more than simple reading and arithmetic skills. The Skills Attainment Model proposed by Schulz and Nakamoto (2005:4) goes beyond this basic skill level, integrating procedural knowledge with judgment in health literacy (Schulz and Nakamoto, 2005).

Pharmacists play an important role because they are primary health care providers and can recognize that a client has an inadequate health literacy level (Youmans and Shillinger, 2003). The pharmacist can then tailor health information according to the health literacy and health knowledge of the client. Also, the pharmacy can become a first point of contact to educate and inform clients in order to increase their health literacy level.

In both cases, the pharmacist needs to establish a relationship with clients to understand their knowledge and their level of health literacy. Consequently, it becomes easier to adapt and tailor health information to the health literacy level of the client. Establishing a relationship also aids in response to the health needs of clients and in increasing their use of the pharmacy as a primary source of health care education and disease prevention.

In conclusion, there is a growing interest concerning how relationships are formed and maintained between pharmacists and clients in the health care context; the research in this field can be useful in understanding how to structure these relationships to improve patient care and health outcomes (Worley and Schommer, 1999).

### **1.3 The pharmacist and the client: how to shorten the distance?**

#### **1.3.1 A communicational approach: the importance of communication skills**

The pharmacist has begun to adopt a consumer-centric approach. Achieving this new objective necessitates that the pharmacist develops and establishes a long-term relationship with his customers. One important issue remains unresolved: which factors can enable the pharmacist to develop this relationship with his customers?

Numerous authors seem to agree with the idea that communication is essential to the successful development of the pharmacist - client relationship (Tindall *et al.*, 1994; Anderson, 2000; Sleath, 1996; McCallian and Cheigh, 2002; Cipolle *et al.*, 1998; Krips *et al.*, 1998; Hargie *et al.*, 2000; Morrow and Hargie, 2001).

There is a strong case for this idea that only effective communication can lead to a better informed and satisfied patient. Furthermore, good communication leads the pharmacist to better educate the client, allowing him to become more responsible for his health and his quality of life. McCallian and Chiegh (2002) offer significant insight on this point. They assert that good communication skills are essential for effective patient assessment and self care counseling. The pharmacist can tell the client “*all the right things, but if the patient does not understand the information or is resistant to the message, he or she is unlikely to follow the pharmacist’s advice*” (2002: S40). To achieve the goals of being more patient-oriented and developing close relationships with clients, pharmacists need to update their technical and professional expertise and re-orient themselves toward the client. (Moroow and Hargie, 2001).

In the context of health communication and particularly that of pharmacist - client communication, research proposes a list of communication skills as a means to aid in forming a trusting relationship. Consequently, the development of a long-term relationship can provide the exchange of information that is necessary to assess the client’s health conditions, information needs, and evaluate the effects of treatment on a client’s quality of life (Tindall *et al.*, 1994).

Hargie *et al.* (2000) highlight the importance of the relationship elements of practice, or what they called “building rapport.” Research is still needed to better understand the criteria a

pharmacist might use to provide health services and information that best fit a client's health needs and expectations. To the best of my knowledge, there are no guidelines about how to practice effective communication or how the pharmacist might approach a client to create a long-term relationship.

In the literature on pharmacist - client relationships, a gap exists between the patient care activities that the pharmacist proposes, the communication skills of the pharmacists, and the successful development of a relationship with clients.

*«Current and future health communication research will increasingly focus on the effective dissemination of relevant health information to promote public health. Modern health promotion efforts will recognize the multidimensional nature of health communication, identify communication strategies, that incorporate multiple levels and channels of human communication, and implement a wide range of different prevention messages and campaign strategies targeted at relevant and specific (well-segmented) audiences» ( Kreps et al., 1998: 14).*

Typically, the pharmacists' initiatives presented in the literature lack an in-depth reflection on the strategies that the pharmacist can use to grow closer to the client (Berardo *et al.*, 1989; Blenkinsop *et al.*, 2001). Only after knowing the client better is it sensible to build targeted health initiatives, individualized health prevention tactics, and education plans for customers.

Anderson (1998), in a study of the consumers' view about pharmacists as health promoters, asserts that very little research has been done evaluating the effectiveness of health promotion leaflets and even less has been done concerning consumers' responses to leaflets. She conducted interviews in some UK pharmacies and found that even if the pharmacist had been well trained and was highly motivated, very few consumers actually read the leaflets.

Blenkinsop *et al.* (2001), in an attempt to describe health promotion implications for the pharmacist, views the key issue as the need for development of a new working style that "embraces the notion of negotiation and partnership with the public" (Blenkinsop *et al.*, 1998: 162). As Worley-Louis *et al.* (2003) observe, pharmacy practitioners could use the information they gain in the encounters with clients to deliver better care and engage in a more professional relationship. As already aforementioned, pharmacists should develop "practice strategies and counseling techniques in which they actively participate in patient care activities" (Worley-Louis *et al.*, 2003: 235).

A review conducted by Anderson *et al.* (2004) assessed the contribution of community pharmacy in improving the public's health all over the world by analyzing different projects and interventions in the field. They concluded that pharmacists need to assume a "proactive"

role in health interventions instead of taking a reactive role. They found little published research into users' views of services and about clients' perspective in general.

### **1.3.2 Effective communication in community pharmacy: the lack of a relational dimension**

In past decades, the pharmacist and his role in the health care setting has shifted from a product-oriented approach, where the primary focus was the production and compound of medicines, to a more patient-oriented approach. The new focus has become understanding and caring for clients and the problems they bring to their health care providers. This shift, as I have shown in the first section of this chapter, can be traced to changes in the surrounding environment as well as an evolution of the pharmacist profession itself.

The re-professionalization of the industry to a more patient-oriented approach has forced pharmacists to identify areas where they could intervene to enhance the quality of patient care and to perform their services with a particular focus on the needs of their clients. To be patient-oriented, as it has been described in the literature, the pharmacist needs to become a source and channel of information regarding prevention, education, and counseling, focusing on the client and his need. At the same time, the client needs to learn how to use this new source of information.

Given the rising complexity and costs of health care, the role of the pharmacist as a primary health care provider will become more essential. As a consequence, research needs to examine strategies to make the communication between the pharmacist and his clients more effective. The main need is for effective communication between the pharmacist and his clients in order to make the information more patient-oriented.

A patient-oriented approach will lead to the tailoring of health-oriented messages (Kreps *et al.*, 1998). The exchange of information in a community pharmacy context occurs in a complex system where the pharmacist must pay attention to many factors. At the core of tailoring health information is the attempt to answer to the question, "How can the information be customized, or tailored, to meet the unique needs, interests, and concerns of a specific individual?" When health care professionals tailor health information to a patient, they try to combine information and behavior change strategies based on characteristics that are unique to that person, related to the outcome of interest, and derived from an individual assessment (Kreuter *et al.*, 2000).

Research on the topic of tailoring health messages focuses on the factors that are most likely to influence a person's motivation or ability to make whatever changes in health or behavior necessary to accomplish the health goal. The factors identified are the basis in building a tailored message. Thus, it is necessary to use different models in framing the needs of individuals and in understanding the unique characteristics of a person (Kreuter *et al.*, 2000).

In the social sciences, there are many well-established and empirically supported theories and models that explain health related behavior change: Transtheoretical Model, Health Belief Model, Social Cognitive Theory, Theory of Reasoned Action, etc. They are all intuitive and clear, with well defined constructs. They point out ways in which a person's thoughts, beliefs, motives, expectations, present habits, and past experiences can influence his decisions and actions. They also explain how social environmental factors can affect health (Brinberg and Hampton, 2002). However, there are some limitations in definitions and considerations of these constructs such as, in tailoring health information, researchers do not generally consider the characteristics of the individual in creating a message.

In the Yale Model, Hovland and his colleagues (Hovland, Janis, and Kelley, 1953) formally conceptualized the factors that characterize an exchange of information between two actors. It asserts that persuasion strength is dependent upon “**who says what to whom.**” The message persuasiveness is a function of the “**who**” – the characteristics of the source (e.g., credibility), the “**what**” – the nature of the message (e.g., quality of argument), and the “**whom**” – the characteristics of the audience (e.g., intelligence).

Along these lines, the effectiveness of communication between the pharmacist and his clients can be conceptualized as a product of the message (the nature of the information being communicated and how the pharmacist communicates the information), the pharmacist (the knowledge, characteristics, and beliefs that affect his perception and communication of the information), and the client (the knowledge characteristics and beliefs that influence the reception of the message).

As one can see, this definition centers attention not only on the characteristics of the message and of the receiver, but also stresses the importance of the sender, the source from which the message comes. This conceptualization is meaningful because the sender is not a neutral entity; the sender has some characteristics that can influence the exchange of information and can determine the success or not of communication. The same message incorporating unique client needs can be received in different ways, depending on who is giving the message. This view is consistent with what literature details about the communication skills of the pharmacist.

The Yale Model brings at least one novel element to the understanding of how to produce effective health communication. In building a message, one must first pay attention to the source that gives the information, the message content, the structure of the message, and certain characteristics of the receiver. From my perspective, however, an essential component in the development of a persuasive message is the **relationship** between the sender and the target, not simply a compendium of characteristics. A central issue of my research is to expand the traditional view of communication, as a passive flow of information from a source to a target, to include the nature of the relationship between the target and source. The relationship

between the pharmacist and his client will indeed influence the impact of the health information provided by the source (pharmacist) to the target (client). The Yale Model suggests the basis for increasing the level of persuasiveness of a message, but it misses one important factor: the consideration of the relationship between the source and the receiver.

In my view, the Yale Model lacks dynamism. In reality, the three elements that characterize a persuasive communication are combined and play a unique role in the interactions between the pharmacist and the client. The exchange of information occurs in a complex context where the relationship developed between the two actors of the exchange plays a role, in addition to the source, the message, and the receiver.

As discussed previously, the pharmacist needs to improve his ability to develop a trusting relationship that can produce an open exchange of information and can lead to increased involvement, responsibility, and participation of the client in the. The result can be called a “covenant and therapeutic relationship” (Berger, 1993; Lawrence *et al.*, 1995).

The fundamental argument of my dissertation and that will be developed throughout my work is synthesized as follows: message tailoring must first be conducted on the relationship level, so that one might build a message based on the specific characteristics of the relationship. This means that the pharmacists might take into account, for example, the level of trust, health knowledge, and so on, elements that characterize the relationship with the client. Then, the pharmacist would create different messages depending on the level (depth) of the relationship. Only after having examined the relationship and its stage of development it is possible to build tailored health messages.

A general hypothesis is formulated as follows:

*Depending on the stage of the relationship between the pharmacist and a client, messages tailored to the stage of the relationship are likely to be more effective than a general message.*

In the next chapter, I will focus on two fundamental issues:

1. Understanding the factors that enable the development of the pharmacist - client relationship
2. How those factors influence the progression through the different stages of a relationship.

These issues are central in identifying new strategies that the pharmacist may use to develop a trusting and loyal relationship with clients, including primary health care services, and supporting clients in gaining responsibility for their health.



## **Chapter 2: The bridge between effective communication and the relationship**

According to the existing literature explored, effective communication by the pharmacist, and acceptance and use of the information by clients depends on the pharmacist's professionalism, communication skills, and knowledge, on the characteristics of the clients, and on the quality and level of the relationship established between the pharmacist and clients (Ross *et al.*, 1994; Kreps *et al.*, 2003).

According to my hypothesis, tailoring health messages in the community pharmacy context is possible only after gaining a better understanding of the different needs of the clients in the different stages of the relationship. Hence, what is needed is a framework to understand the pharmacist - client relationship.

The research literature that examines relationships is extensive and is examined in a wide range of disciplines, including marketing, communication, conversational analysis, social psychological analysis of small groups, counselling psychology, and dyadic decision making. Each of these areas has developed models that attempt to capture the context and theoretical constructs that underlie interactions in relationships and their different outcomes. For example, relationship marketing has focused on the quality of a relationship between a service provider and the consumer, with a focus on customer loyalty. Conversational analysis has often examined the role of power and influence that emerges in the analysis of a discourse with a focus on the ways in which one party can influence another. In the counselling literature, particularly marital counselling, the focus is on patterns of interaction that lead to the success of marriages.

Although most of these areas study relationships, their focus and context make it inappropriate for them to be applied in the context of my research, where the outcome focuses on developing trust (and subsequently loyalty). Pharmacist – client relationship as in this chapter will be argue, needs to be considered a business relationship before being treated as a therapeutic one. Trust and loyalty need to be obtained in a context where the rules are economic in nature. The aspect of counselling, and the focus on improvement on the communication side are relevant, but only after loyalty and trust have been achieved. For that reason I will focus on relationship

marketing models, with special emphasis on those relationship marketing models that have been developed and applied in the pharmacy context<sup>1</sup>.

The following chapter will provide insights from different domains to build a new framework that helps to explain pharmacist - client relationship development. I will first present a discussion of the pharmacist - client relationship, as it has been described in the pharmacy context. I will then introduce some constructs and models from marketing to the study of the relationship between the pharmacist and his clients.

Based on the limitations of these models, I will propose the integration of the Stages of Change Model (Prochaska and DiClemente, 1983) as a useful approach to produce a change in the relationship between the pharmacist and his client. The application of the Stages of Change Model will clarify, according to my hypothesis, the strategies necessary to develop and maintain a long-term relationship between the pharmacist and his customers, including more primary health care services and communication.

At the end of the chapter I will present a theoretical framework that will guide my research.

## **2.1 The nature of the pharmacist - client relationship**

Numerous studies define the nature of the pharmacist profession as hybrid (Lawrence *et al.* 1995). In the community pharmacy setting, the pharmacist is a seller of prescription medicines, over-the-counter medicines, and other non medical, but often health and well-being related merchandise (Anderson, 2000; Badger *et al.*, 2002, Lloyd-Williams, 2003). The pharmacist can also be considered a primary health care provider and is thus an important element of the health care system, as he must understand the significance of the client's disease in order to provide health advice and medicines.

The pharmacist in the community pharmacy serves two functions. The first centers on the traditional function of simply selling products (Anderson and Narus, 1991). The second is more relationally oriented and involves the development and presentation of health information that is intended for a specific client. Thus, the relationship between the pharmacist and the clients can be understood as a continuum ranging from solely transactional (i.e., the selling of a product) or more relational (i.e., focused on the needs of the specific client).

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<sup>1</sup> In the chapter I will also pinpoint which are the most important similarities and contributions that relationship marketing offer to the field of pharmacist – client relationship, in particular considering the aim of developing trust and loyalty for obtain a long term relationship.

My interest is the transition of the pharmacist-client relationship from being transactionally-oriented to relationally-oriented; that is, the pharmacy should not be seen as simply a place where people go to buy the medicine they need. The relationship between the pharmacist and the client is important because the pharmacist can provide counsel or information in addition to offering advice and solutions related to the products he sells.

In this case, the pharmacist is offering a complex service where the participation of the client and of the health care provider is more significant. Customers should then be more willing to share information and to develop closer personal contacts that are likely to result in higher quality service because the provider is consequently more knowledgeable about the needs and expectation of his clients. The more the two parties participate in the relationship, the greater the impact on the perceived quality of the services provider and improve customer retention (Ennew & Binks, 1999).

As described in chapter 1, a pharmacist and his clients may develop a covenant relationship built on trust and joint participation to develop a long-term relationship. When the relationship between the pharmacist in the role of a seller and the client is strengthened, the ability of the pharmacist to function as primary health care provider is facilitated.

In the long run, then, intention to go to the pharmacist will be related to the expectation that the pharmacist will act as a trusted source for personalized health information in addition to his function as a provider of medical products. Hargie *et al.* (2000) found that paying attention to relationships can help demonstrate that the pharmacist cares for the client, preserves the client's trust, and helps ensure the success of the goals of pharmacist - client communication.

Finally, the ability of the pharmacist to meet the client's needs and to facilitate his role as primary health care provider is heavily dependent on the ability and willingness of customers to provide relevant information (Ennew and Binks, 1999). This is possible only in the context of a long-term relationship.

The current duties and responsibilities of the pharmacists' profession are evolving and the pharmacist - client interaction is not just characterized by supplying medications; it is becoming more client-oriented. The pharmacist is building and maintaining relationships with customers in order to manage medications, overall client health outcomes, and well-being (Worley and Schommer, 1999).

## 2.2 Factors influencing long-term pharmacist - client relationships

There is strong agreement in the health care literature that pharmacists need to move away from a discrete, product-oriented exchange toward a long-term, client-oriented relationship in order to enhance the pharmacist's role as a health care provider, (Worley and Schommer, 1999; Hepler and Strand, 1990; Berger, 1993).

Research seems to agree that quality long-term relationships between health care providers and their patients/customers can lead to improved patient compliance and health outcomes (Viinamaki *et al.*, 1993). Worley and Schommer (1999) argue that the development of the pharmacist - client relationship highlights the necessity to take a client perspective of the relationship. This is due to the focus on the patient in the new era of pharmacy practice, and the emerging individually-oriented nature of the health care system. According to these authors, the identification of the factors that lead to the development of long-term quality and committed relationships between the pharmacists and the clients by using the client's perspective:

*«can provide pharmacists with information to develop strategies to transform their relationship with their patients into the types of relationships that are needed to accomplish the duties and responsibilities of pharmacists' evolving role in pharmacy practice»* (Worley and Schommer, 1999: 159).

This approach is significant in the context of the pharmacist - client relationship, making clear that providing effective informational services requires pharmacists to enhance their relationships with clients (Hardy and Conway, 1988: 63-72). Pharmacists must move their role from merely providing prescriptions to that of a competent counsel about health care .

Some research has examined the importance of pharmacist development and maintenance of such a relationship with a client. Lawrence *et al.* (1995), for example, suggest that a committed relationship between the pharmacist and the clients may lead to improve clients' health outcomes. Worley and Shommer (1999), who in their empirical work adapted the Relationship Quality Model of Crosby *et al.* (1987; 1990) and applied it to the pharmacist - client relationship, found that relationship quality (defined to include clients' trust of and satisfaction with their pharmacists) was a key construct in the prediction of long-term relationship.

Berger (1993) similarly asserts that in building a covenant relationship with the clients, the pharmacist should not simply dispense information, but must feel a "commitment... to the well being of the patient" (p.2403). Beyond that, he characterizes a covenant relationship as "the observable ability of the pharmacist and the client working together in a realistic, collaborative relationship based on mutual respect, liking and commitment toward well-being and good health outcomes for the patient" (Berger, 1993: 2400, readapted). He also affirms that a

precondition to a therapeutic change is a mutual commitment, the elements of which are a mix of pharmacist competence, trustworthiness, and caring.

As Worley and Schommer (1999) state:

*«Although the patient may view his/her pharmacist as an expert and may frequently interact with his/her pharmacist, a level of relationship quality must be developed in the pharmacist-patient relationship before a committed relationship can be formed» (1999: 168).*

Although the literature supports the importance of long-term relationships and the relevance of trust, there are no useful models to explain how the relationship is formed and maintained. I will discuss in subsequent sections a theoretical perspective that will allow one to influence the transition from a transactional interaction to one which is more relational and long-term.

### **2.3 In search of a new domain**

The literature we presented clearly shows that a long-term relationship between the pharmacist and his clients produces benefits that enable the pharmacist to assume to role as primary health care provider. The next question that arises concerns how to manage these relationships. The literature in the health care field provides a basis for understanding the formation of long-term relationships, which can be useful to pharmacists in their new role as primary health care providers.

In this section I will introduce some useful ideas belonging to the discipline of relationship marketing in order to answer this question, and I present some insights about how the pharmacist may develop and maintain a relationship with clients.

#### **2.3.1 The relationship marketing approach**

In the relationship marketing literature, the relationship between a seller/service provider and a customer has been studied extensively. As will be described, relationship marketing has examined relationship formation and maintenance between a seller and a customer, especially when there is maturation from a relationship with products to a relationship with a service provider (Berry, 1995). The literature in this field is a useful domain from which to adapt some models because of the similar interest and shift in the pharmacy context (from merely a dispenser of medicines to a primary health care provider).

This approach also is relevant because the interest in forming long-term relationships is more important for high involvement services where the service provider has a strong impact and where client involvement is high, as is the case of the pharmacist as a primary health care provider.

One of the most important objectives of research in the relationship marketing field is understanding the processes of the development and maintenance of a long-term relationship because of the benefits the relationship brings to the actors involved. The relationship marketing approach can be useful in different kinds of contexts, ranging from business-to-business to business-to-consumer to service marketing.

The goal in this research area is the determination of how to select clients who are profitable for a company and develop long-term relationships with them. The development and the maintenance of a long-term relationship between a company, seller, or service provider with a client make sense only if it produces some benefits for both the parties involved. Regardless of whether the benefits are economic or not in nature, they determine whether it is valuable to maintain the relationship in the long run.

I will briefly present some basic definitions developed in the relationship marketing context and then present the leading important models in this field to develop a framework to examine the relationship between the pharmacist as a seller and his clients.

My overview will be guided by two basic research questions:

1. Does relationship marketing offer some insights in understanding of the development and maintenance of a relationship?
2. If yes, does it offer insights and propose strategies useful to the development and the expansion of the relationship over repeated interactions?

### **2.3.1.1 Some useful definition of relationship marketing**

In this section I will offer a brief overview of the more popular definitions of relationship marketing. Grönroos states that relationship marketing aims to:

*« Establish, maintain and enhance relationships with customers and other partners, at a profit, so that the objectives of the parties involved are met. This is achieved by a mutual exchange and fulfillment of promises» (1990:38).*

According to Grönroos, relationships with clients are key elements in the development of a company. Accordingly, all marketing activities should aim at building, enhancing, and developing those kinds of relationships.

Morgan and Hunt define relationship marketing as:

*«All the activities which aim to establish, develop and maintain successful relationships with clients» (1994: 22).*

Sheth and Parvatiyar (2000: 17) say that relationship marketing activities can “improve marketing productivity and enhance mutual value for the parties involved: increased effectiveness and efficiency.” In this case, one may notice that the positive return is not just economic in value. A perceptive approach along this direction can increase the effectiveness of the products or services offered.

As Claycomb and Martin argue:

*«Relationship marketing perspective provides the basis for the study of building and enhancing relationship with customers, with the recognition that stronger relationships with customers result in a number of competitive advantages» (2002: 616).*

These definitions are consistent with my perspective because they stress the importance and value of long-term relationships and the development of trust in this relationship.

Although a long-term relationship between the pharmacist and his clients can lead to some economic benefits, the primary benefits are not economic in nature, such as trust of the health care provider and the enhancement of the client health.

Sheth and Parvatiyar (1995) assert that when a product or a service is inseparable from who provides it, as is the case in considering the pharmacist - client relationship, clients must develop a relationship with the provider.

It follows that the client will also pay attention to the informational services that the pharmacist offers, which cannot be separated from its provider, and not just to the products the pharmacist sells. If the seller tries to establish a relationship that increases customer's value by use of partnering activities, this will likely create a greater seller-customer bond. In this way, the customer becomes more committed to the relationship.

In considering my topic, it firstly becomes important to understand which benefits of a long-term relationship are useful in building a therapeutic relationship with clients in the community pharmacy context.

### **2.3.1.2 Benefits in developing a long-term relationship between the pharmacist and his clients**

In the relationship marketing approach, the value of building and developing a long-term relationship must be perceived by both parties involved. At this point it becomes important to understand which benefits derived from a long-term relationship are useful in building a therapeutic relationship with clients in the community pharmacy settings.

From the pharmacist's point of view, developing a long-term relationship with clients increases his ability to serve and advise them on health care topics through the years, and consequently, to increase the quality of the service. By developing a long-term relationship with his clients, the pharmacist can also be better informed about the needs and frequent questions of his clients, be capable of offering a tailored service for each client, and more employ more effective and open communication. From the client's perspective, he can obtain value added services, better quality, and improved communication with the pharmacist as a primary health care provider.

To sum up:

*«A strong relationship between customers and service providers engenders the trust that is necessary for customers to commit to the service» (Claycomb and Martin, 2002: 617).*

Overall, understanding the relationship marketing approach is beneficial to realizing my objectives, because it concerns the similar matter of analyzing and studying ways to build long-term relationships with clients. Individual to my case, some of these benefits are non economic in nature.

This approach can help increase understanding of the client in hopes of offering him a tailored health service and more effective communication. In the case of the pharmacist - client relationship, a strong relationship can engender the trust that is necessary for the customer to embrace the pharmacist in the role of a primary health care provider.

In the next paragraphs I will try to understand how the literature in the field of relationship marketing explains relationship development, relationship maintenance, and factors that influence the process of how two parties progress through various stages of a relationship.

## **2.4 Relationship development: stages and processes**

In the area of marketing, two distinct approaches have been proposed to examine relationships. One approach focuses on the structural aspect of the relationship, observing and analyzing the different phases of the relationship over time. The second approach examines the processes that underlie the development of the relationship. During my description I will also present some integration of the processes and stages. My intent is first to understand which mechanisms, as presented in the relationship marketing literature, underlie the development of the relationship. Then, I seek strategies or ways to produce a change in the relationship.

### **2.4.1 Structural models of relationships**

Several authors have proposed models that describe the stages or phases in the development of a relationship. I will present a brief overview of three such models.

Dwyer, Schurr, and Oh (1987) propose a five stage model of relationship development: awareness, exploration, expansion, commitment, and dissolution. In the awareness phase, party A recognizes that party B is a feasible exchange partner, but there is no actual interaction. As discussed in a subsequent section, there is no formal pre-awareness stage in which the party is unaware of the need to initiate the search for a relationship. In the exploration phase, the two parties begin to consider the obligation, burdens, and benefits associated with the possibility of exchange. This second phase is conceptualized by the authors as containing five sub-processes: attraction, communication and bargaining, power and justice, norm development, and expectations development. These sub-processes are considered important aspects of the exploration phase because they enable each party to gauge and test the goal and compatibility, integrity, and performance of the other. The outcome of the second phase is an initial decision to develop a relationship, although the links between the parties are relatively weak, and either party can withdraw from the relationship with limited loss. The five sub processes occur in the third phase, but with greater range and depth than the previous phase. During the expansion phase, the costs of withdrawing from the relationship increase as does the level of trust and joint satisfaction. The third phase is characterized by a continual increase in benefits obtained by exchange partners and increasing interdependence. At the end of the third phase there is an “implicit or explicit pledge of relational continuity between exchange partners” (Dwyer, Schurr, and Oh, 1987: 18).

The authors do not provide a micro-level of analysis of the shifts in the actual processes that occur within the second or third phase (e.g., an increase in attraction and a decrease in norm development), nor do the authors describe what processes are needed to move from an exploration phase to an expansion phase.

In the fourth phase, the relationship is characterized by a greater range of resources that are considered fungible (i.e., material resources, status, emotional expression, services), durable (i.e., remains functional over a period of time and environmental uncertainty), and consistent (i.e., expectation of similar responses over time and context). Both parties invest substantial resources in the maintenance of the relationship. During the last phase, one (or both) of the parties evaluates the dissatisfaction with other party, concluding that the costs of continuation or modification outweigh benefits (see figure below).

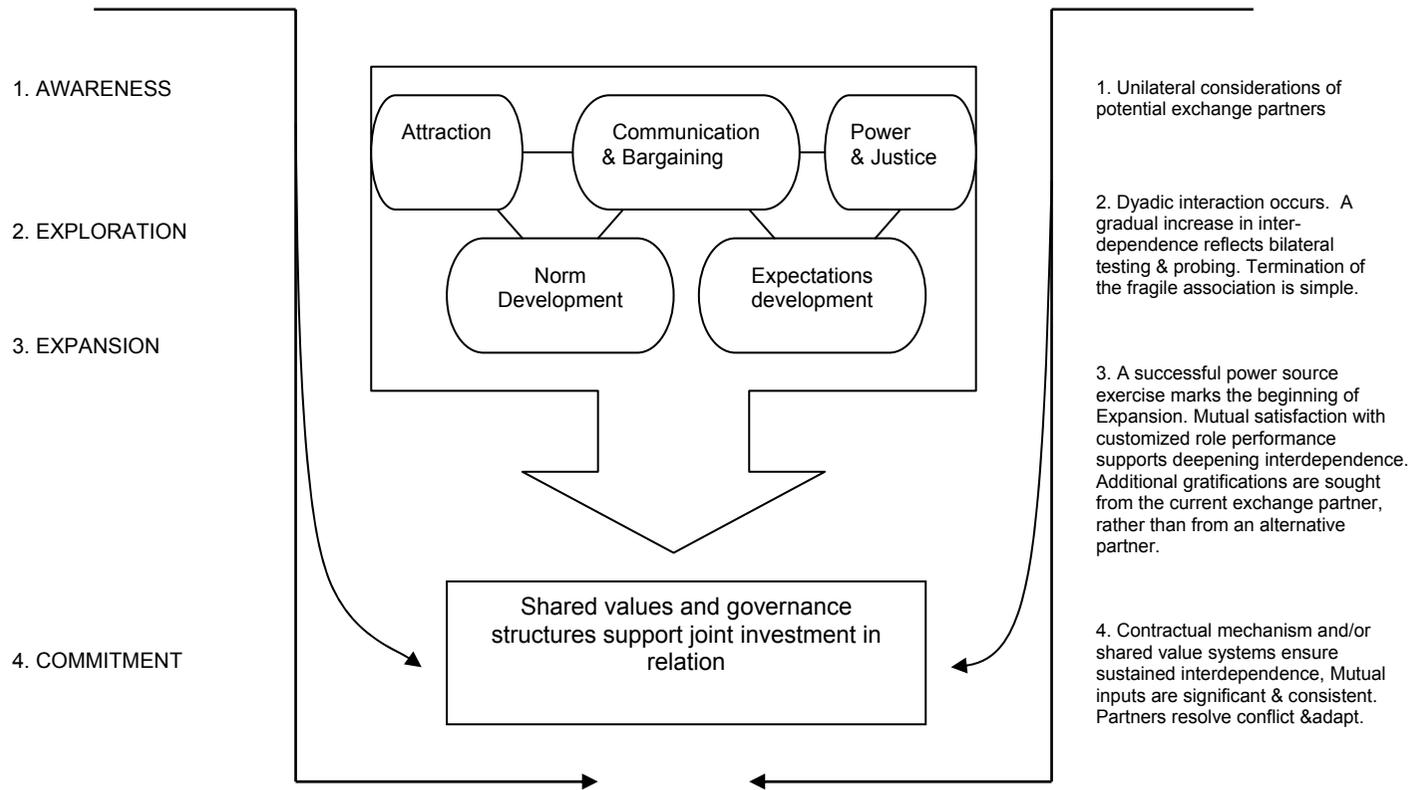


Figure 3: Five-stage model of relationship development (Dwyer, Schurr, and Oh, 1987: 21)

Sheth and Parvatiyar (2000) present a model to describe the development of cooperative and collaborative relationships with customers. The authors develop a generic four stage relationship marketing process model.

The basic components of this model are similar to the five phase model developed by Dwyer, Shurr, and Oh (1987) with the exception of a dissolution phase. Neither model contains a pre-relationship phase. In the formation stage, each party assesses their current status and then scans the environment to determine whether a partner exists that will improve their performance. In terms of classic small group behavior (Thibaut and Kelly, 1959), each party seeks to determine whether the comparison level for alternatives (CLalt) exceeds the current situation (i.e., comparison level – CL). The outcome of this phase is the selection of a partner and the development of structure to guide the relationship.

In the second phase – management and governance – both parties create shared norms of governance. In this phase, the most important issues for the parties involved are: role specification, communication, common bonds, planning process, and process alignment. Sheth and Parvatiyar (2000) argue that if the process is implemented to the satisfaction of both parties, it will ensure the continuation and enhancement of the relationship. In the third phase, feedback mechanisms are used to determine whether the programs are meeting expectations and are sustainable in the long run. The final phase focuses on the evolution of the relationship. During this phase, the parties make decision regarding continuation, termination, enhancement, and modification of the relationship. The authors state that the performance of and satisfaction with the relationship is likely to have a significant impact on the survival of the relationship (see figure below).

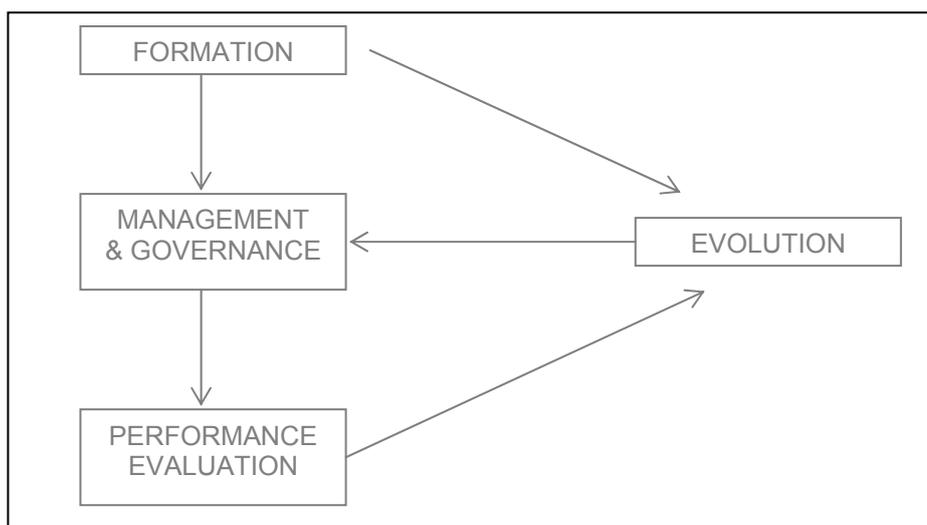


Figure 4: Sheth and Parvatiyar model of relationship development (2000: 16)

In a recent article, Rao and Perry (2002) classified the numerous schools of thought about relationship development into two approaches: stage theory and state theory.

Stage theory considers relationship development as an evolution and progression through increasing resource commitment and interdependence (e.g., Ford, 1980; Dwyer *et al.*, 1987). This process is described as a gradual development taking place in a sequential manner over a long period of time. According to the authors, models that have influenced stage theory are life-cycle models (Porter, 1980; Quinn and Cameron, 1983; Easton *et al.*, 1993) and growth stage models of inter-firm relationships (Ford, 1980; Dwyer *et al.*, 1987; Larson, 1992; Kanter, 1994). Several assumptions limit the usefulness of these models. First, relationship development is assumed to occur in a sequential, incremental, and irreversible manner. Second, the simplicity of stage theory does not allow it to explain fully complex inter-firm relationships, particularly at the boundaries between stages; that is, it provides little explanation for the transition from one stage to another. In a later section, an approach is presented that allows specification of the processes that facilitate transitions between stages.

State theory focuses on the unpredicted state of a relationship at any point in time because strategic moves of exchange actors occur in an unstructured and unpredictable manner. The difference between state and stage theory is the proposed orderly progression of phases over time by stage theory and the importance of circumstance/opportunities at a given point in time by state theory. The figure below contains an example of a model of state theory.

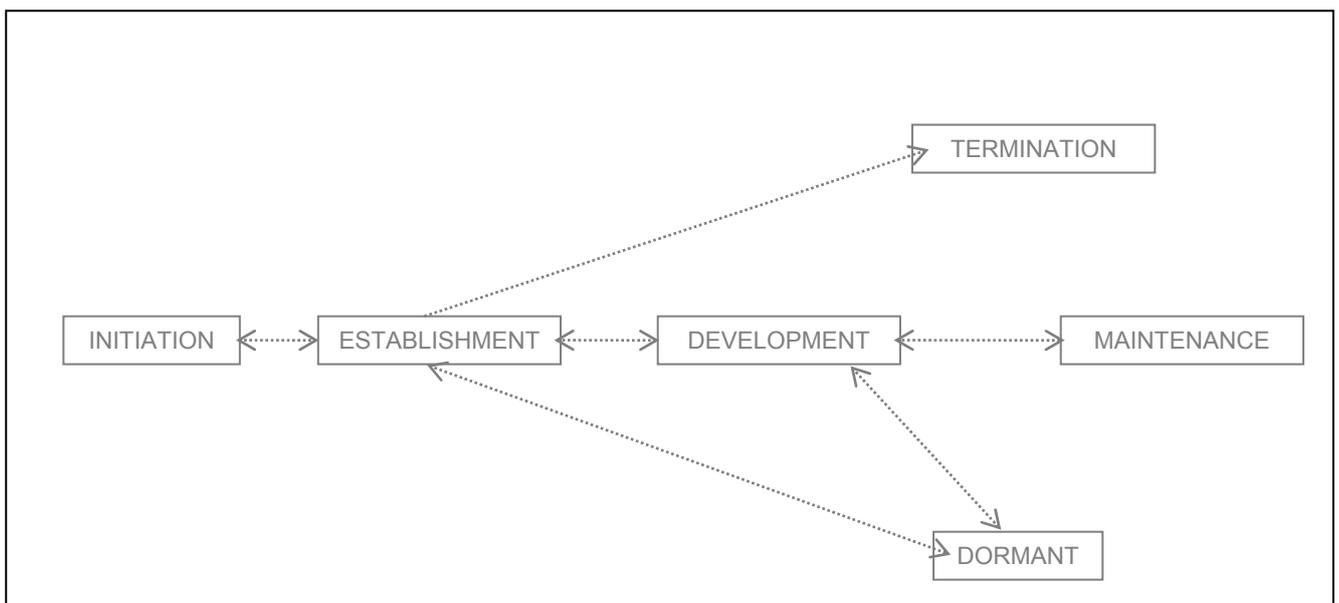


Figure 5: State theory for relationship development (Rao and Perry, 2002: 604)

I have presented three models, each of which contains similar stages. Although these models do address the activities that might occur in each stage, they do not address the pattern among these activities. Each model is also silent with respect to the movement between stages and to the need to consider a pre-contemplation phase of relationship. In the following section, I will discuss process models for understanding the interactions within a relationship.

#### **2.4.2 Models that describe the processes in a relationship**

The basic premise of marketing is described as an exchange between two or more social units. Several researchers have debated the form and components of marketing exchange theories. Much of this debate concerns the boundaries associated with the concept of exchange, the testability of exchange theories, and what is exchanged (e.g., Bagozzi, 1975). In his model, Bagozzi treats goods and services, time, psychological characteristics of the actors, and social forces as endogenous variables influencing the utility of the dyad and treats four other factors as exogenous: situational constraints, social influences between actors, third-party influences, and characteristics of the actor.

Social exchange theory (Thibaut and Kelley, 1959) uses the economic metaphor of costs and benefits to predict behavior. It assumes that individuals and groups choose strategies based on perceived rewards and costs. Social exchange theory asserts that people consider the consequences of their behavior before acting. In general, people want to keep their costs low and their rewards high.

Consider people interacting under conditions in which individual outcomes depend not only on personal behavior but also on another's behavior. If two people, A and B, are acting in a common space, the results A will get from whatever he does will be affected by what B does, and vice versa. Gaining satisfaction from an interaction usually requires some degree of cooperation and coordination of behavior by others involved in that interaction.

When two people interact over a period of time, exchange theory proposes that each wants to maximize his own "pay-off" (i.e., the degree to which rewards exceed costs). There are objections to the pay-off maximizing proposition. There is considerable evidence, mostly regarding economic behavior, that people very often do not try to maximize gain but instead use other criteria for making choices. For example, they may try to minimize loss rather than maximize gain. Or they may "satisfice" rather than continue the process in order to maximize gain. Another objection is that choices are not based on elaborate calculations of gains, costs, differences, and alternatives, however

rapidly they may be computed. Furthermore, people are often faced with making judgments of things which cannot be compared.

If two people have potential control over the behavior of the other, yet each wants to maximize his own pay-off (higher rewards, lower costs), they are in a mixed-motive situation. Each person is motivated to both cooperate with and to compete against the other. The dyad will continue so long as it yields high pay-offs to both members, determining whether the dyad continues to interact or ceases to do so.

In sum, I have shown a distinction between stages and processes, and between the content and motivations that underlie a relationship. None of the theories to date have integrated the stages and processes as well as the activities within each stage. Beyond that, the literature also offers no insights about the dynamics that influence relationship development. The development is simply described as a series of stages and patterns with distinct characteristics, but no explanation is provided about how the client moves from one stage to another in the relationship. Before presenting a model of the relationship marketing literature that tries to explain the integration between processes and stages, I will introduce some authors that describe the development of the relationship in terms of a “ladder of loyalty.”

### **2.4.3 Studies in the field**

Palmer and Bejou (1994) consider the relationship with a customer as consisting of a number of stages which they term a “ladder of loyalty.” The different levels of relationship development and customer loyalty are similar to the stages described in the relationship marketing studies. The authors describe a “prospect” as a potential customer who has no direct relationship with a supplier.

The prospect becomes a customer when he has at least one encounter with the supplier. The customer is defined as a client when he begins to have repeat transactions with the supplier but still acts neutrally toward him. In contrary, a supporter is a client with a strong and positive commitment to the relationship, and advances to advocate status when he actively promotes the supplier with positive word of mouth. Finally, the relationship becomes a partnership when both the supplier and the client are linked through mutually beneficial exchanges. As observed before, dividing the relationship development into stages, or a ladder of loyalty, is a useful tool for enhancing awareness of customer segmentation opportunities and understanding how relationship development works.

Palmer and Bejou (1994) acknowledge that the relative importance of various constructs differs across customer segments. Therefore, sellers must tailor their messages according to the needs of the different segments, which are related to the duration of the buyer - seller relationship. Berry (1995) agrees with the idea of multiple levels of loyalty in relationship development. According to the author, in the first level, the seller must rely primarily on pricing incentives to secure customers loyalty. In the second level, the supplier has to rely on social bonds, although aggressive pricing may be a vital element of the marketing mix. It can certainly drive customer loyalty when competitive differences are not strong. In the third level, the relationship marketing approach relies primarily on structural solutions in solving important customer problems. According to Berry, when relationship marketing can offer value to a target customer by adding benefits that are difficult or expensive for customers to obtain, they create a strong foundation for maintaining and enhancing the relationship. This is designed into the service delivery system rather than being dependent upon the relationship building skills of an individual service provider.

Few attempts have been made to understand how stages and processes are integrated in relationship development, and how changes occur in the relationship between a service provider and a customer. In the section that follows, I present the study of Wilson (1995) to address this first question, that of how stages and processes play together to create relationship development.

#### **2.4.4 An integration of stages and variables: Wilson Integrated Model of the Buyer-Seller Relationship**

Dwyer, Schurr, and Oh (1987) suggested conceptual process models of relationship development, but these models do not integrate existing knowledge about the variables that make for a successful relationship.

Wilson (1995) offers an integration of stages and processes of a relationship. His objective is to develop an integrated model that blends the empirical knowledge about successful relationship variables with conceptual process models. Wilson believes that the constructs have both an active phase, during which they are the center of the relationship development process, and a latent phase, during which they are still important but not under active consideration in relationship interaction.

Wilson considers the four stages model of Borys and Jemison (1989) to build an integrative framework. The stages are: 1) defining the purpose (selection of an appropriate partner; 2) setting the boundaries; 3) value creation; 4) hybrid stability.

Considering the empirical works that exist concerning the topic of relationship development, Wilson proposes an integrated model as follows (see figure below):



Figure 7: An integrated model of buyer-seller relationship (Wilson, 1995: 341)

Although Wilson’s suggestions are useful in understanding relationship development in each phase, it gives no insights about how to produce a change from one stage to another. This issue is addressed in the relationship marketing field as described in the paragraph that follows.

### 2.4.5 Limits of a relationship marketing approach

According to much of the research conducted in the relationship marketing field, the relationship is conceptualized as a series of development stages. This idea seems to unify the different research in the field.

In this section I will identify a key research question related to this field and to our research. It is necessary to understand how a relationship evolves in order to help the pharmacist develop a long-term relationship with his clients. At this point, the relationship can be framed as the integration of stages, processes, and empirical variables that characterize the relationship in each stage, from the initial stage to the maintenance stages of the relationship. However, I have not detailed how to move from one stage to another of the relationship, or how to produce a change. The insights offered by relationship marketing lack dynamism. Moreover, this lack has been documented in the relationship marketing literature.

Sheth and Parvatiyar (2000: 8) state that research concerning relationship marketing needs to be directed at the different stages of the relationship marketing process. Integrative models (e.g., Wilson, 1995) were created to understand, in part, the relationship process model; they look at the stages of the relationship development process, identifying which constructs actively affect the outcome considerations at that stage and which will have a latent influence. But, apart from this, there is a lack of knowledge about how people move from one stage to another of a relationship, and there is no clear explanation about the shift between the stages.

Grönroos (Sheth and Parvatiyar, 2000:112), in line with Sheth and Parvatiyar, asserted that specific research questions should include the investigation of what makes a customer move from a passive to an active model, and that of understanding what allows people to move from one stage to another of the relationship. Berry (1995: 243) invites research into the issue of which customers are most receptive to relationship marketing. Noting that people have different levels of readiness toward change in the stages of relationship development, Wilson (1995: 343) considers focusing on the different stages relevant in gaining a better understanding of how relationships progress. Not much research, according to the author, has been reported on relationship enhancement process and relationship evolution.

The challenge in managing the transition between the stages is associated with the difficulty associated with the fact that people change in different ways and are often in different stages of development.

This difficulty in practical terms means, as Henning *et al.* suggest, that:

*«Different segments of customers might exist with regard to their relational preferences (e.g., the degree to which a relationship is desired by customers). Consumer relational preferences have the potential to change the influence relational benefits and*

*relationship quality constructs have on loyalty and on word of mouth communication» (2002: 244).*

For all those reasons, the authors recommend that future research explores the moderating relationship of consumer relational preferences.

Bendapudi and Berry clearly described this issue:

*«Current conceptualizations in relationship marketing have ignored the issue of whether some customers will be more receptive to maintaining service relationships with others (Barnes, 1994; Sheaves & Barnes, 1996). Clearly not all customers of a service firm will have or even desire long-term relationships. The types of relationships that customers seek vary across service providers, and even across different service situations. Yet, given the lack of research in this area, it is currently not possible to segment customers on the basis of their receptivity to relationship maintenance (Lovell, 1983; Oldano, 1987). Different motivations for maintaining relationships will lead to relationship outcomes that are quite different» (1997: 16).*

What seems to be clear from this last part is that relationship marketing lacks in-depth knowledge of how people move from one stage to another of the relationship, and also how to manage the clients that differ in their levels of relationship disposition.

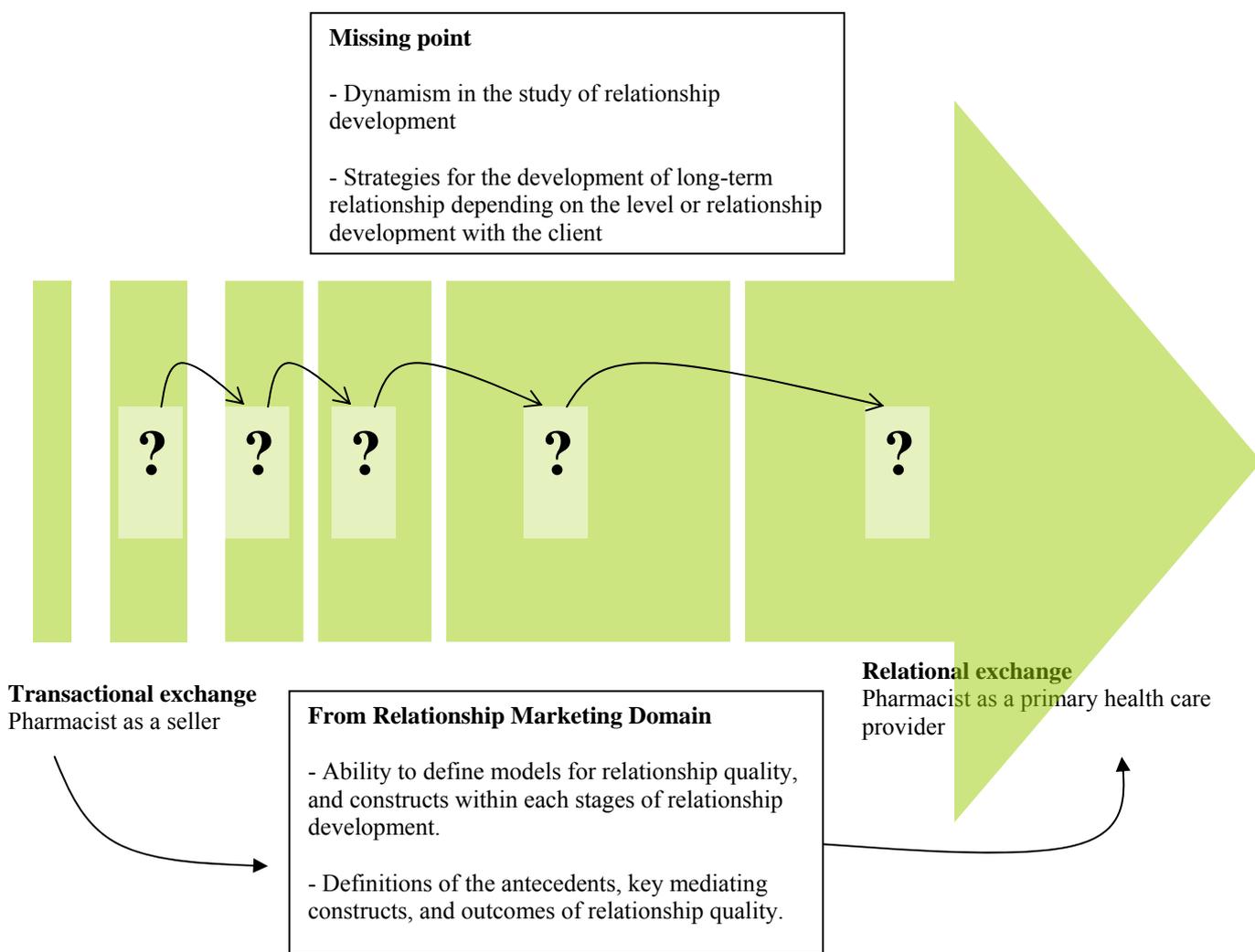


Figure 8: First draft of the theoretical framework

The literature in the pharmacy context attempts to identify some factors significant to the development of a covenant relationship between the pharmacist and the client. Worley and Schommer (1999) suggested that people may have different degrees of commitment and information disclosure behavior to pharmacists. This leads to the necessity of understanding “how individuals with different levels of communication and information disclosure behaviors form quality and committed relationships with their pharmacists” (1999: 170).

There is strong evidence indicating a need for new models including new variables and investigation into whether “other factors are important in establishing a high degree of relationship quality and relationship commitment between the pharmacist and the patient” (1999: 170). In this case, people’s behaviors are mediated by the relational level between the pharmacist and the client.

Clients that go to the pharmacy engage in differing degrees of relationship building behaviors with the pharmacists, and this will affect commitment, quality of the relationship, and consequently, the quality of the service offered.

The relationship marketing approach in a pharmacy context needs to be integrated with other constructs in order to be more relationship-oriented so as to acquire the dynamism which is needed to capture the development of this relationship.

The Stages of Change Model (SOC) from the behavioral change domain provides a theoretical framework to elucidate the transitions from an early developmental stage of a relationship to more the mature, maintenance phase of a relationship.

## **2.5 Introducing some dynamism**

The SOC Model will be integrated with the factors determining the development of a long-term relationship between the pharmacist and his clients. In my overview of relationship marketing, research in this field was mentioned proposing a series of models and constructs and providing a list of factors that characterize the relationship in each stage of development. Those elements will be a component of my framework. This integration of the Stages of Change Model and the traditional determinants of a relationship incorporate a level of dynamism in managing the relationship development and the activities directed towards clients in each stage of development of the relationship.

### **2.5.1 The Stages of Change Model**

The Stages of Change Model is a subset of Prochaska and DiClemente's Transtheoretical Model (1984). The Transtheoretical Model is an "integrative model" that combines key constructs from different theories in different fields and aims to describe and explain behavioral change, in particular how people modify a problem behavior or acquire a positive one (Velicer *et al.*, 2000). The model was developed involving emotions, cognitions, and behaviors, with the intention of including the best that each different therapy system has to offer in terms of change behavior. In fact, the transtheoretical approach arises from a comparative analysis of the 18 leading theories of therapy. Moreover, the transtheoretical model tries to adapt and further a range of existing cognitive theoretical frameworks, such as Health Belief Model, the Theory of Reasoned Action, and the Social Learning Theory (Whitelaw *et al.*, 2000). This assists in attaining a new and more comprehensive approach to behavioral change

The Transtheoretical Framework is composed of a central organizing construct, specifically the Stages of Change Model. It also includes a series of independent variables, the Processes of Change, fundamental in determining behavioral change, and a list of outcome measures such as the Decisional Balance and Self Efficacy - Temptation Scale.

At the core of the Transtheoretical Model lies the notion that two interrelated dimensions are necessary to adequately assess a behavioral change in individuals: the Stages of Change and the Processes of Change (Martin, Velicer and Fava, 1996).

#### **2.5.1.1 The stages of change**

The Stages of Change Model represents the temporal, motivational, and constancy aspects of change (DiClemente *et al.*, 1991, Prochaska and DiClemente, 1984) and allows us to understand when particular shifts in attitude, intentions, and behaviors occur.

Although the number of stages has been modified and redefined, according to the authors, change in individuals occurs over time as a process through a series of five stages that can generally be described in the following progression:

The first stage is called *precontemplation*. People in precontemplation phase have no intention to change behavior in the foreseeable future. They are often unaware that a problem exists. Precontemplators can be classified as resistant, unmotivated, or not ready to change their behavior. The reasons can be different: they can be traced back to the fact

that they are not informed about the consequences of their behavior, or they have tried to change without positive results. In any case, they usually do not admit that there is a problem, and this makes them reluctant to be helped and not able to face their problem. (Prochaska, DiClemente and Norcross, 1992; Velicer *et al.*, 2000; Prochaska, Redding and Evers, 2002; Prochaska, Norcross and DiClemente, 1994).

Unlike precontemplators, people in *contemplation phase* are aware that a problem exists and they seriously think about overcoming it, but they still have not made a clear commitment to act. In the case of contemplators, there is a clear idea about where they want to end up, but they are not quite ready to move. Nevertheless, they start considering possible resolution to the problem behavior. An interesting dynamic in this phase is the weighing of the pros and cons of the problem behavior and the solutions to overcome it. They are willing to talk about their problem with people that try to help them, preferring thinking, reading, and inquiring about the problem to actually acting (Prochaska, DiClemente and Norcross, 1992; Velicer *et al.*, 2000; Prochaska, Redding and Evers, 2002; Prochaska, Norcross and DiClemente, 1994).

People in *preparation phase*, have already made unsuccessful attempts to change their behavior. Usually, they are preparing for actions involving some small behavioral changes, but they have not actually undertaken effective actions. Preparation is defined as the cornerstone of action, and people here do not limit themselves to gathering information about the problem, but rather try to focus on finding the proper solution (Prochaska, DiClemente and Norcross, 1992; Velicer *et al.*, 2000; Prochaska, Redding and Evers, 2002; Prochaska, Norcross and DiClemente, 1994).

The next step is the *action stage*. It requires a consistent amount of commitment, time, and energy. Indeed, it is the step where people start overcoming their problem behavior, including their experiences, environment, and life style. The criterion that distinguishes people in the action stage from the other stages is that they have actually altered their behavior (Prochaska, DiClemente and Norcross, 1992; Velicer *et al.*, 2000; Prochaska, Redding and Evers, 2002; Prochaska, Norcross and DiClemente, 1994).

Only upon moving through to the *maintenance stage* do people have the possibility to solidify the goals they have achieved in action phase. In this phase, people continue to maintain their target behaviors for an undetermined period of time (Prochaska, DiClemente and Norcross, 1992; Velicer *et al.*, 2000; Prochaska, Redding and Evers, 2002; Prochaska, Norcross and DiClemente, 1994).

The model recognizes that individuals differ in their readiness to change, thus different interventions must be developed for each person (or for people within each stage). The

model also recognizes that change is not a one-step process, but rather that it unfolds through a series of stages. I asserted that the Stages of Change Model represents the temporal dimension of a behavioral change. The temporal dimension includes two different categorizations; before the target's behavioral change occurs, the temporal dimension can be conceptualized as "behavioral intention." After the behavioral change has happened, the temporal dimension can be conceptualized in terms of "behavioral duration" (Velicer *et al.*, 2000). In the figure below, this temporal dimension is depicted.

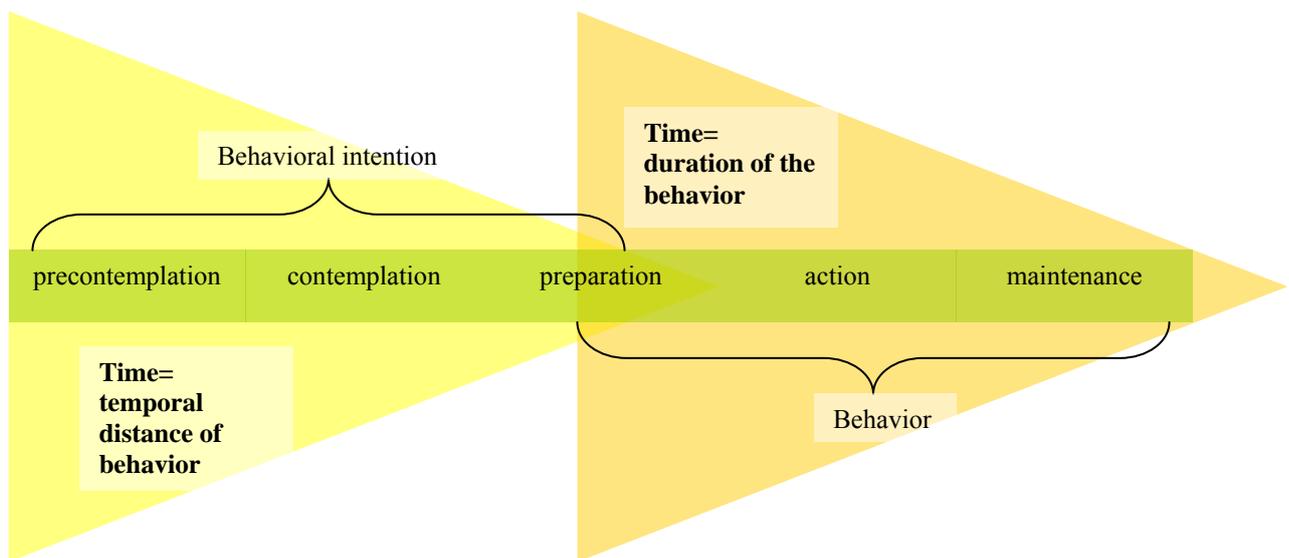


Figure 9: Stages of Change Model: the temporal dimension

### 2.5.1.2 The processes of change

The processes of change focus on activities and events that create the successful modification of a behavior. They can be defined as "copying activities" useful in modifying a behavior (DiClemente *et al.*, 1991; Prochaska, DiClemente and Norcross, 1992). The ten processes that Prochaska and DiClemente (1984; 1983) outlined were:

1. Consciousness raising
2. Dramatic relief
3. Environmental reevaluation
4. Social liberation
5. Self-reevaluation
6. Stimulus control
7. Helping relationship
8. Counter conditioning

9. Reinforcement management
10. Self-liberation

The first five processes can be classified as “experiential processes;” the last five can be labeled “behavioral processes” (Velicer *et al.*, 2000). In the figure below I present a short description of each process as they are presented by Prochaska, DiClemente and Norcross (1992: 1108), by Velicer *et al.* (2000), and by Prochaska, Redding, and Evers (2002).

Consciousness raising	Increased awareness and increasing information about the self and certain causes, consequences and cures for a particular problem. Interventions that can increase awareness include: feedback, education, observations, confrontations, interpretation, and media campaigns.
Dramatic relief	Experiencing and expressing feelings about one’s problems and solutions. Psychodrama, grieving losses, role playing, personal testimonies, personalized risk feed back and media campaign are examples of techniques that can move people emotionally.
Environmental re-evaluation	Combines both affective and cognitive assessments of how one's problem affects the physical environment. Empathy training, documentaries, and family interventions can lead to such re-assessments.
Social liberation	Requires an increase in social opportunities and alternatives for non-problem behaviors, such as advocating for rights, empowering, policy interventions.
Self re-evaluation	Combines both cognitive and affective assessment about how one feels and thinks about oneself with respect to a problem. Values clarification, healthy role models, imagery, corrective emotional experience are techniques that can move people to re-evaluate their self image.
Stimulus control	Involves avoiding or countering stimuli that elicit problem behaviors and adding prompts for healthier alternatives. Restructuring one’s environment (e.g., removing alcohol or fattening foods), avoiding high risk cues, and fading techniques are useful in supporting change and reducing risk of relapse.
Helping relationships	Being open and trusting about problems with someone who cares and who support for healthy behavior change. Rapport building, therapeutic alliances, social support and

Counter conditioning	self-help groups can be sources of social support. By substituting alternatives for problem behaviors, it requires the learning of healthier substitutes for problem behaviors. Relaxation can counter stress, and assertion can counter peer pressure.
Reinforcement management	Rewarding one's self or being rewarded by others for making changes. Examples include contingency contracts, overt and covert reinforcement, and self-rewarding.
Self-liberation	Choosing and committing to act, or belief in one's ability to change. Decision-making therapy, New Year's resolutions, techniques, commitment enhancing techniques are examples.

Figure 10: The processes of change

### 2.5.2 The integration between stages and processes: the discovery of dynamism

As stated earlier, what is promising about the Transtheoretical Model of Prochaska and DiClemente (1983) is that the stages and processes of change are interrelated to give a better understanding of what kind of intervention can produce the desired behavioral change.

The Stages of Change Model details the series of five stages through which people move when they need to change a behavior. The processes of change indicate the dynamics that permit an individual to move from one stage to another within the relationship. In the Transtheoretical Model, different processes are emphasized in different stages and promote progression through the sequence (Sutton, 1996). The integration between stages and processes described by Prochaska and DiClemente (1983) suggests that in early stages people usually apply mostly cognitive, affective, and evaluative processes in order to progress (Prochaska, Redding, Evers 2002). People in later stages rely more on commitments, conditioning, contingencies, environmental controls, and support to progress toward maintenance (Prochaska, Redding, Evers 2002). In general, processes used in precontemplation, increase over the middle stages, and decline over the last stages (Velicer *et al.*, 2000).

During *the precontemplation stage* particularly, people use eight of the ten processes, but in a less significant manner than people in any of the other stages. In this phase, people try to be defensive and avoid changing their behavior (Prochaska and DiClemente, 1983). Indeed, they search for less information about their problem, they do not reevaluate themselves, and they experience fewer emotional reactions to the negative aspects of their behavior. They are less open with other persons, and they do not make

any shift in the environment to overcome their problem (Prochaska, DiClemente and Norcross, 1992). Undoubtedly, precontemplators need first to become aware of a problem behavior that they need to change (Prochaska, Norcross and DiClemente, 1994).

In the *contemplation stage*, the processes of consciousness raising and dramatic relief allow the elevation of emotions. As mentioned, people in this phase become more conscious of themselves and of their problem behavior, and consequently begin to reevaluate their values, problems, and themselves. Contemplators also become aware of the effect that their behavior has on their environments and on those who are close to them. To progress from precontemplation to contemplation, and through the phase of contemplation, people make use of cognitive, affective, and evaluative processes of change (Prochaska, DiClemente and Norcross, 1992). In sum, because contemplators think seriously about changing, for example, addictive behavior, they begin to gather information about their problem. By virtue of the fact that they are more generally aware, they start reevaluating themselves (Prochaska, Norcross and DiClemente, 1994).

People in *preparation stage* begin to take small steps toward action. They occasionally use counter conditioning and stimulus control (Prochaska, DiClemente and Norcross, 1992). Mostly, however, self re-evaluation is the process in use during the phase of transition between contemplation and action (Prochaska and DiClemente, 1983). In preparation for the *action stage*, people need to achieve a higher level of self-liberation. In the action stage, people making use of behavioral processes such as counter conditioning and stimulus control. Because the action stage is a particularly stressful phase, individuals rely increasingly on the support and understanding of helping relationships (Prochaska, DiClemente and Norcross, 1992). In the action stage people become ready to commit to changing behavior.

The *maintenance stage* refers not only to maintaining the change but also to maintaining the use of change processes. Counter conditioning and stimulus control processes are utilized in bridging the action and maintenance stages, rather than solely exercised in the action stage. According to Prochaska, DiClemente, and Norcross (1992), successful maintenance builds upon each of the preceding processes.

The combination of stages and processes has been documented by empirical works, and in the figure below this synthesis of the stages and processes described above can be visualized (Prochaska, DiClemente and Norcross 1992: 1109).

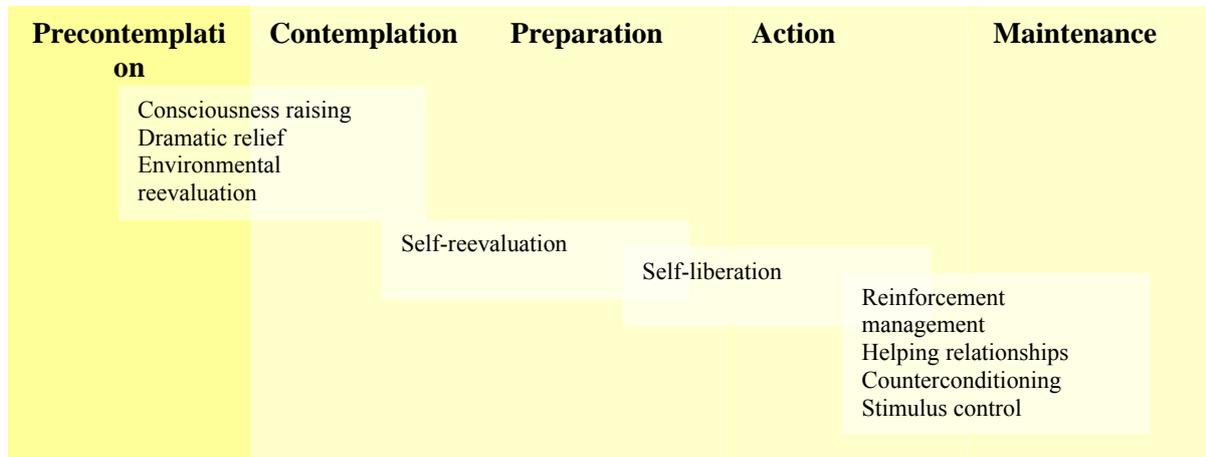


Figure 11: The integration between stages and processes

### 2.5.3 The application of the Stages of Change Model

How does the change occur? The authors of the Stages of Change Model (Prochaska and DiClemente 1983) suggest that interventions to produce change should be tailored to the stage currently occupied by the individual. Tailoring starts by ascertaining an individual's stage and then refining an approach to include the other variables of the model, such as processes of change, decisional balance, and situational temptation (Velicer *et al.*, 2000). The success of the stage-based intervention is contingent upon one's ability to identify stages accurately and efficiently (Weinstein *et al.*, 1998).

According to the authors, it is possible to produce change by applying the right process at the right stage. The most common application involves tailored communication which matches intervention messages to an individual's particular needs (Prochaska, Redding and Evers, 2002).

Littel and Girvin (2002) wrote a critique of the Stages of Change Model, and in the article they present a literature review of the specific studies related to the Stages of Change Model. They identify more than 175 empirical studies related to the Transtheoretical Model. Of these, 87 provided evidence concerning the Stages of Change Model; the remainder focused on other key constructs (the decisional balance, self-efficacy, temptations, and processes of change). According to the authors, most studies of the Stages of Change Model have been cross-sectional, although longitudinal evidence is beginning to appear. Convenience samples were used in all but a few studies. Sample sizes vary, but most published reports involve more than 200 participants and several include more than 1000.

## **2.5.4 Fields of application**

The Stages of Change Model have been applied in a variety of settings, especially in the health field, with a wide scope of topics. The first and most popular application of the Stages of Change Model was in the field of smoking cessation, but its application expanded rapidly in range to address low fat diets, eating disorders and obesity, radon testing, alcohol abuse, weight control, condom use, organizational change, needle sharing, hypertension medication compliance, diabetes testing and compliance, sun protection behaviors, HIV medication compliance, seat belt use, quitting cocaine, organ donation, delinquency, dietary fiber, stress management, birth control compliance, mammography screening, preventing domestic violence, exercise for lower back pain, sedentary lifestyles, and health promotion (Velicer *et al.*, 2000; Prochaska, Redding and Evers, 2002; Whitelaw *et al.*, 2000).

### **2.5.4.1 A population based application: the Stages of Change Model and smoking cessation**

In the case of applying the Stages of Change Model to modify and change the behavior of smokers, several studies have been conducted (Aveyard *et al.*, 1999; Curry *et al.*, 1995; Dijkstra, DeVries and Rijackers, 1999; O'Neill, Gillespie and Slobin, 2000; Pallonen *et al.*, 1994, 1998; Prochaska, DiClemente, Velicer and Rossi, 1993; Prochaska *et al.*, 2001a2001b; Strecher *et al.*, 1994; Velicer *et al.* 1999).

Results of these interventions show that the amount of progress participants<sup>2</sup> make in following health promotion programs is directly related to the stage they occupied at the start of the intervention (Prochaska *et al.*, 2001). Comparing progress made across stages, people in the contemplation stage were about two-thirds more successful than those in precontemplation after six-, twelve-, and eighteen- month follow-ups. The same results were found for people in the preparation stage compared to those in contemplation stage (Prochaska *et al.*, 2001b).

These processes have been identified after fifteen years of research. To help guide individuals at each stage of change, computer-based expert systems have been developed to deliver individualized and interactive interventions to entire population.

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<sup>2</sup> People have been recruited in the right stage using proactive recruitment methods and stage matched interventions (with self-help manuals, computer feedback reports and counsellor protocols based on the computer methods).

#### **2.5.4.2 An application in the field of Mammography screening**

Another interesting field in which SOC has been applied involves mammography screening. Breast cancer is the second leading cause of cancer deaths among women. The most effective method of detecting and reducing mortality from breast cancer is a mammography. The Stages of Change Model to increase women's participation in mammography screening has been applied in several studies within a variety of populations (Rakowski *et al.*, 1992). People in the precontemplation phase are those who have never had a mammography screening; people in contemplation phase never had a mammography screening but plan to have one in the coming two years. People in the action stage had one mammography and intend to have another one. People in the maintenance stage have had at least two mammograms and intend to undergo another. Two other stages have been included in this specific application: relapse – when people have had a mammogram but they do not intend to have another – and risk for relapse – when people had regular mammograms but they are planning not to have another one. Studies have compared people who received either no materials or standard materials with people who received mailed, stage-matched, tailored interventions. The results show the effectiveness of the Stages of Change application with regards to this important health behavior, even with minimal amounts of stage-matched materials mailed to participants (Prochaska *et al.*, 2002).

#### **2.5.5 Integration of the Stages of Change Model to relationship development**

The research inspecting the pharmacist - client relationship and relationship marketing research lack the tools necessary to capture the dynamism during unfolding relationship formation and maintenance.

The Stages of Change Model seems to capture such dynamism, even if it has never been applied to the context of pharmacist - client relationship. My research will try to study the value of the integration of such a model in this context to determine whether this more dynamic approach helps to better explain relationship formation and development.

If one views the stages and processes in a relationship as a dynamic, ongoing series of behavioral changes, then the Stages of Change Model can be incorporated to identify the specific motivations needed to move from one stage to another. In the part that follows, I propose an approach to apply the Stages of Change perspective to relationship creation and development.

### **2.5.5.1. Stages of Change and relationship development**

Precontemplation is a period in which the consumer is not thinking about making any changes (either in their current relationship or in entering in a new relationship). Contemplation is the period of time in which the consumer considers the benefits and risks associated with a change in relationship (or the initiation of a new relationship). Preparation is a time in which the consumer, who has thought about relationship changes, begins the actions needed for change. Action is a period when these behaviors are enacted. Maintenance is defined as the period after action has started and behaviors have become routine.

The processes of change are divided according to the transitions between stages. For example, the processes used to move individuals from preparation to action will not be the same as those used to move from action to maintenance.

The model suggests that:

- a) to move precontemplatives to contemplation, consciousness raising, dramatic relief and environmental reevaluation should be used;
- b) to move from contemplation to preparation the model suggests self-reevaluation;
- c) to move from preparation to action self-liberation is necessary;
- d) to move from action to maintenance, reinforcement management, helping relationships, counter-conditioning, and stimulus control should be used.

When applied to changing relationships, these steps might be considered as follows:

- a1) raising consciousness involves increasing awareness of a particular need through information concerning causes and consequences.
- a2) environmental re-evaluation concerns both emotional and cognitive assessments of how one's behavior affects one's relationship and how changing would affect the relationship.
- b1) self re-evaluation concerns how the individual would feel and think if his need was satisfied.
- c1) self-liberation concerns social opportunities to become involved in the relationship.
- d1) a helping relationship means engaging a trusting, caring person, and being assisted in maintaining the relationship
- d1) reinforcement management is related to reinforcement structures such as rewards that help maintain a relationship.

d2) counter conditioning is the process of learning the new behavior, which will replace the current behavior.

The integration between the Stages of Change Model and the other constructs currently in use in the research about the formation and maintenance of the relationships allows us to capture the dynamism that characterizes relationship development.

In the next part of the work I will try to apply an integrated model in the context of the pharmacist - client relationship.

## 2.6 An integrated framework for studying the pharmacist - client relationship

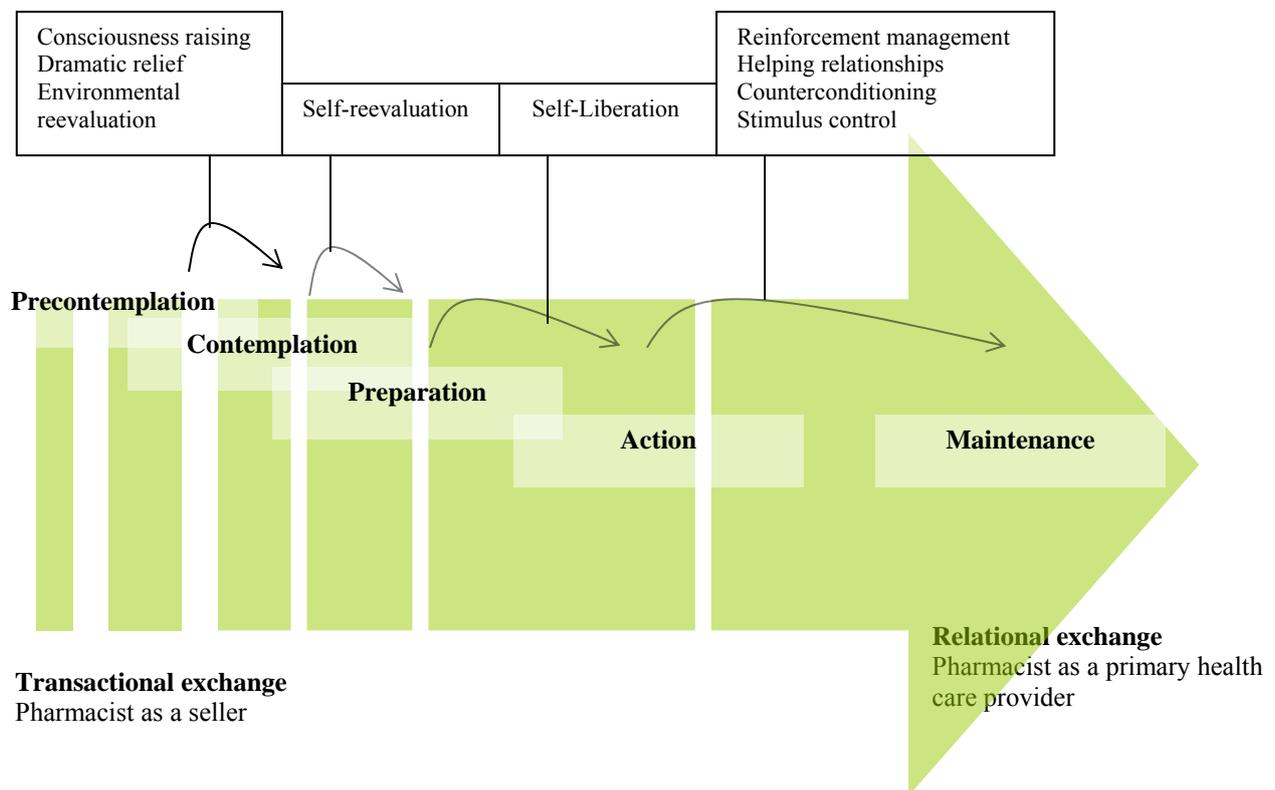


Figure 12: An integrated framework for pharmacist – client relationship

The framework above shows the direction in studying the dynamics of the pharmacist - client relationship.

The integration can be seen as a contribution to the relationship marketing literature by identifying key variables in the different stages of the relationship (perceived expertise,

trust, transactional and relational orientations). The Stages of Change Model can offer indications about how to manage the relationship in the different stages of development and indications about how to understand the dynamism in the relationship (that is, how to move from one stage to another of the relationship).

After having presented the research questions that will be tested in the empirical part of the dissertation, I will introduce the operationalization of the variables in the next chapter so as to translate the framework into measures for evaluating the relationship between the pharmacist and his clients.

## **2.7 Research questions**

Throughout this first section, I investigated the pharmacist -client relationship. In particular, I have emphasized the importance of the analysis and the study of factors that allow the pharmacist to establish a relationship with his clients, the search for criteria that allow the pharmacist to target and to personalize the provision of health care services and information to his clients, and the approach the pharmacist must use with his clients in order to know them better, and to motivate them to turn to the pharmacist as a primary health care provider.

### **2.7.1 Two research questions**

Therefore, one basic research question I will examine is:

- What strategies can the pharmacist use to establish, develop, and maintain a relationship with his clients?

Two specific concerns arise from this general question:

- Does the application of a Stages of Change approach to create a long-term relationship between the pharmacist and the client:
  - 1) Enhance the relationship and
  - 2) Bring the pharmacist to a deeper understanding of the patient's condition?

These concerns are motivated by the view that the outcomes of long-term relationships will result not only in greater client loyalty, but also in better use of the pharmacist's services and health care prevention knowledge, resulting in a better quality of life.

## **Chapter 3: Model Development**

### **Introduction**

The chapter that follows presents the steps and the ideas that underlie the creation of the conceptual model for the empirical part of my dissertation.

The first chapter shows the gaps and the research needs related to the pharmacy context. The research in the field documented the emerging issue of the need to examine the dynamic of the pharmacist – client relationship. In particular, to become a more relevant health care provider and to develop a covenant relationship with clients, pharmacists need to develop a long-term relationship that produces trust and the necessary frequent interactions that allow clients to rely on pharmacists and to be able to turn to them as health care providers.

In the second chapter, I described some limits in the existing research on the development of a long-term, trusting relationship, both within the service provider – client context and in the pharmacy context. In particular, the key element that existing research lacks is the ability to capture and describe the dynamism in the pharmacist - client relationship. As a consequence, one limitation in the extant research is the inability to identify strategies to move clients from one stage of the relationship to another. To fill this gap, I proposed at the end of the second chapter to integrate the current models of relationship development and maintenance with constructs from the Stages of Change model.

In this chapter, I will first present the models that guide my framework and that offer useful insights in understanding the factors that play a significant role in relationship development. Second, I will define the constructs and the variables that I consider relevant to my aims. Finally, I will propose the empirical framework and the hypotheses that guide my research and the model that I intend to evaluate.

### **3.1 Key drivers of relationship development**

The literature review we presented shows us the limits in the relationship marketing approach to the study of the relationships. The authors illustrate with their empirical studies and theoretical reflections that an established relationship will follow a development which is influenced by different processes. The relationship can be described as occupying different phases from its birth to its maintenance.

The research, however, does not speak to:

- Strategies and processes that produce the behavioral change necessary to go from one stage to another of the relationship.

Before concentrating on the development of the theoretical framework of my thesis, I would like to remind the reader that in the relationship marketing approach, numerous models have been created in order to explain which constructs play a relevant role in the development of the relationship.

Those models define the relevant variables in each stage that influence the success or the failure of the relationship. As Wilson (1995) states, there is little evidence concerning which processes that allow the relationship to mature. Dwyer, Shurr and Oh (1987), for example, presented a conceptual model of relationship development, but this model does not integrate the knowledge about the variables that make for a successful relationship.

An important goal in relationship marketing theory is the identification of key drivers that influence important outcomes for the service provider and providing a better understanding of the causal relations between drivers and outcomes (Hennig-Thurau *et al.*, 2002). Relationship marketing outcomes (e.g., loyalty and word of mouth) are divided into a univariate approach (which analyzes the relationship between relationship marketing outcomes and a single variable, postulated to play a key role in relationship marketing) and the multivariate approach (which is not restricted to a single construct but investigates the impact of two or more constructs simultaneously on relationship outcomes.)

The figure below depicts the most important approaches in explaining long-term relational outcomes (Hennig-Thurau *et al.* 2002: 233).

**TABLE 1**  
**Selected Approaches Explaining Long-Term Relational Outcomes**

<i>Name</i>	<i>Type</i>	<i>Description</i>	<i>Key Construct</i>	<i>Illustrative Research</i>
Satisfaction approach	Univariate	Customer satisfaction as antecedent of relational outcomes (i.e., customer loyalty and positive word-of-mouth communication)	Customer satisfaction with the service provider's performance	Anderson (1998); Anderson and Sullivan (1993); Fornell (1992); Hallowell (1996)
Service quality approach	Univariate	Service quality as antecedent of relational outcomes	Perceived quality of service delivered by the provider	Boulding, Kalra, and Staelin (1993); Zeithaml, Berry, and Parasuraman (1996)
Trust approach	Univariate	Trust as antecedent to relational outcomes	Customer trust in the relationship partner (i.e., the service provider)	Bendapudi and Berry (1997); Moorman, Zaltman, and Deshpandé (1992)
Commitment approach	Univariate	Commitment as antecedent of relational outcomes	Customer commitment to the relationship	Pritchard, Havitz, and Howard (1999)
Commitment-trust theory	Multivariate	Commitment and trust as key mediating variables between antecedents and relational outcomes	Customer commitment and trust	Kalafatis and Miller (1997); Morgan and Hunt (1994)
Service profit chain	Multivariate	Customer loyalty as antecedent to firm profitability in a causal chain of several loyalty-determining constructs	Service quality, satisfaction, employee loyalty, employee satisfaction, internal service quality	Heskett et al. (1994); Loveman (1998)
Value-situation model	Multivariate	Perceived value and situational variables predict repeat purchase behavior	Value of the service as perceived by the customer and the customer's individual situation	Blackwell et al. (1999)
Relationship content approach	Multivariate	Three basic relationship contents fundamentally shape the process of relationship building	Economic content of the relationship, resource content, social content	Crutchfield (1998); Morgan (2000); Morgan, Crutchfield, and Lacey (2000)
Relationship quality approach	Multivariate	Customer evaluation of transactions and the relationship as a whole predict relational outcomes	Satisfaction, trust, commitment, various other constructs	Crosby, Evans, and Cowles (1990); Hennig-Thurau and Klee (1997); Smith (1998)
Relational benefits approach	Multivariate	Relational outcomes for the firm are dependent upon the customer's receiving certain relational benefits	Different types of relational benefits include confidence benefits, social benefits, and special treatment benefits	Gwinner, Gremler, and Bitner (1998); Reynolds and Beatty (1999a)

Figure 6: Selected approaches explaining long-term relational outcomes (Henning-Thurau *et al.*, 2002: 233)

Upon looking at the table above, and as Hennig-Thurau et al. (2002) clearly observe, some constructs are often present and used more than others in the relationship marketing literature. According to the authors, the principal constructs that influence relationship development include customer satisfaction, service quality, commitment, and trust.

### 3.2 Quality as the key for successful relationship development

The most promising factor that leads to successful relationship development, according to the literature both in pharmacy context and in the relationship marketing field, is the quality of the relationship. Numerous studies have been devoted to the understanding of the variables that might lead to better relationship quality, and those studies clearly show that quality can produce the customer loyalty necessary for a long - term relationship.

In this section I will briefly present two models that most inspired the construction of my framework of relationship development. In the next paragraphs, I include the description

of Worley and Schommer's Model for quality in the pharmacist - client relationship and Hennig – Thurau *et al.*'s Model. The first model was chosen because of its focus on relationship development from the client's point of view in a pharmacy context. The second was selected because of its emphasis on relationship marketing constructs.

### **3.2.1 Worley and Schommer's Model of Relationship Quality**

Worley and Schommer (1999) propose that the antecedents of relationship quality are the perceived expertise of the pharmacist (how the client perceives the expertise of the pharmacist as a health professional), contact intensity and mutual disclosure (that Crosby *et al.* -1990- in their model define as relationship selling behavior). These antecedents are hypothesized to create a quality relationship.

According to the authors, relationship quality involves “the ability of the patient to rely on the pharmacist's integrity, and that the patient has confidence in the pharmacist's future performance because the level of past performance has consistently been satisfactory” (1999: 161). Relationship quality is thus characterized by two dimensions: trust in the pharmacist and satisfaction with the pharmacist<sup>3</sup>.

#### **3.2.1.1 Description of the constructs**

*Perceived expertise.* Based on previous studies related to the same objective (Crosby *et al.* 1990; Swan *et al.* 1985), Worley and Schommer include perceived expertise as “the patient's perception of a pharmacist's expertise” (1999: 160), because it allows the consumer to identify and to evaluate the relevant competencies associated with the provision of health care services from the point of view of the clients. As the authors assert, expertise “has been shown to be an important criterion in determining customer satisfaction and trust” (1999: 160), two key components of relationship quality.

*Contact intensity.* The construct is explained by the authors as: “the frequency with which the pharmacist communicates with the patient” (1999: 160). Contact intensity is considered significant from Worley and Schommer's point of view because it signals the pharmacist's attempt to keep communication channels open with the client and his willingness to commit to the relationship<sup>4</sup>.

*Mutual disclosure.* Mutual disclosure is defined as: “the perception that another party is engaging in information disclosure behavior that is reciprocal and at the same level of

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<sup>3</sup> Relationship quality comprised of the two dimensions trust and satisfaction, was operationalized as one construct based on the evidence from the work of Crosby *et al.* (1990)

<sup>4</sup> See also Crosby *et al.* (1990).

disclosure provided by oneself” (Worley and Schommer, 1999: 161<sup>5</sup>). According to the authors this construct is meaningful for establishing and maintaining an interpersonal relationship. It differs from the construct of contact intensity because “it captures personal and social aspects of information disclosure behavior between the pharmacist and the patient” (1999: 160-161).

*Relationship Quality.* At the core of Worley and Schommer’s model is relationship quality; that is, “the ability of the patient to rely on the pharmacist’s integrity, and the fact that the patient has confidence in the pharmacist’s future performance because the level of past performance has consistently been satisfactory” (1999: 161).

The authors, following the suggestions of Crosby *et al.* (1990), see relationship quality as “a higher order construct” composed of trust in the pharmacist and satisfaction with the pharmacist. Worley and Schommer (1999) treated trust and satisfaction as a single construct representing relationship quality, but both constructs can be assessed independently. The authors define *trust* as “the confident belief that the pharmacist can be relied upon to behave in such a manner that the long term interest of the patient will be served”<sup>6</sup> (1999: 161). *Satisfaction* is defined as “the emotional state that occurs in response to an evaluation of interaction experiences with the pharmacist” (1999: 161).

*Relationship quality outcomes.* Worley and Schommer (1999) view “relationship commitment” as an important outcome variable. This involves “a patient’s likelihood of seeking future contact with the pharmacist” (Worley and Schommer, 1999)<sup>7</sup>. According to the authors, high relationship commitment could be a sign of a “favorable perception of the current relationship,” and conversely that low relationship commitment could be “an outgrowth of current relational problems” (1999: 162). The figure below presents the model that Worley and Schommer tested in pharmacist -client relationship.

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<sup>5</sup> See also Crosby *et al.* (1990).

<sup>6</sup> See also Crosby *et al.* 1990; Swan *et al.* 1985.

<sup>7</sup> See also Crosby *et al.* (1990)

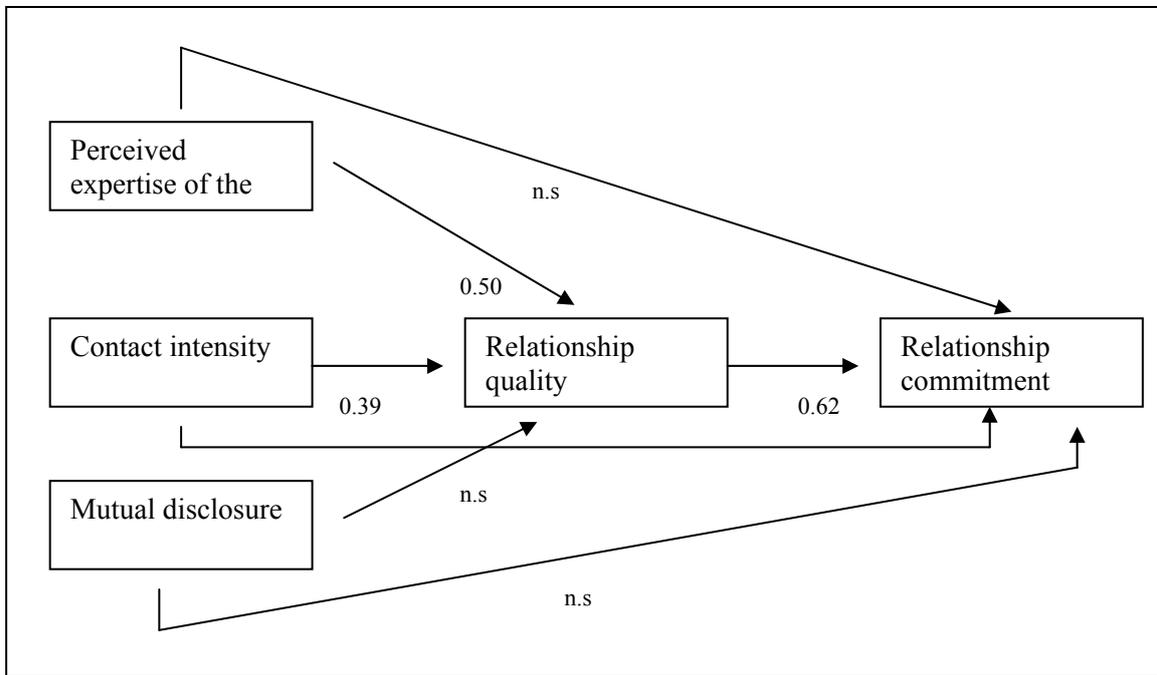


Figure 13: The Relationship Quality Model (Worley and Schommer, 1999: 161)

The results clearly show that perceived expertise has a direct influence on relationship quality (0.50), but do not show any direct effect of that variable on relationship commitment. Contact intensity had a direct effect on relationship quality (0.39), but no direct effect on relationship commitment. Mutual disclosure had no direct influence either on relationship quality or in relationship commitment. Relationship quality had a direct effect on relationship commitment (0.62).

Worley and Schommer found that perceived expertise has more influence on the relationship quality than contact intensity (frequency of the interactions). Mutual disclosure seems not to play a role on quality of the relationship and commitment<sup>8</sup>.

Relationship quality (i.e., trust and satisfaction) mediates the effects of perceived expertise and mutual disclosure. This means that although the client may consider the pharmacist to be an expert and the number of interactions between them may be high, a good level of quality must exist before a committed relationship can develop.

<sup>8</sup> Nevertheless, the authors consider significant the construct, most of all to obtain a good exchange of information.

### **3.2.2 The perspective of Hennig – Thureau, Gwinner and Gremler (2002): the integration of relational benefits and relationship quality**

Hennig, Gwinner, and Gremler (2002) try to unify two distinct approaches from the relationship marketing field to “identify the key drivers that influence important outcomes for a firm or a service provider and a better understanding of the causal relations between these drivers and outcomes” (2002: 231), (Crosby *et al.*, 1991; Crosby, Evans and Cowles, 1990; Dorsch, Swanson and Kelly, 1998; Smith, 1998) and the relational benefits approach (Bendapudi and Berry, 1997; Gwinner, Gremler and Bitner, 1998; Reynolds and Beatty, 1999).

In the conceptual framework, the authors propose satisfaction and commitment (considered features of relationship quality) as mediating the relationship between three types of relational benefits (confidence, social and special treatment benefits) and the two outcomes variables of customer loyalty and word of mouth communication.

#### **3.2.2.1 Description of the constructs**

*Relational benefits.* Henning – Thureau *et al.*, in their integration of the Relationship Quality Model (Crosby *et al.*, 1990<sup>9</sup>) with relational benefits constructs, argue that focusing on the benefits that consumers receive from the relational point of view and simultaneously working on relationship quality allows a better understanding of the dynamics that lead to relationship development and maintenance. Thus, the authors pose relational benefits (confidence benefits, social benefits and special treatment benefits<sup>10</sup>) as antecedents of relationship quality. The added value of the Henning – Thureau *et al.* perspective is the integration of the relational benefits constructs in the relationship quality model.

I decided to include their approach because “it assumes that both the parties in a relationship must benefit for it to continue in the long run” (2002: 234). Their assertion is close to own vision of a covenant relationship between the pharmacist as health care provider and his clients. Certainly, it is not just the core service that the customer considers when he chooses a service provider, but also the relationship itself.

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<sup>9</sup> The research conducted by Worley and Schommer (1999) was inspired by the results obtained by Crosby *et al.* 1990. They applied the Relationship Quality Model in a different context: the pharmacist – patient relationship.

<sup>10</sup> For a detailed description of the three relational benefits construct see the paragraph “Limits of the models and perspectives”.

*Relationship Quality.* Traditionally, relationship quality has been seen as composed of satisfaction, trust and commitment. In their work, Henning – Thureau *et al.* (2002) define relationship quality as composed of commitment and satisfaction<sup>11</sup>.

The authors describe *commitment* as “a customer’s long term orientation toward a business relationship that is grounded on both emotional bonds, and the customers’ conviction that remaining in the relationship will yield higher net benefits than terminating it” (2002: 232).

*Satisfaction.* Satisfaction is defined as “customer’s emotional or feeling reaction to the perceived difference between performance appraisal and expectations” (2002: 232).

*Relationship quality outcomes.* The authors argue that two key relationship marketing outcomes are: customer loyalty and customer word of mouth. They differ from those mentioned by Worley and Schommer because they consider commitment as an element that leads to desired loyalty and to relationship development and maintenance.

The authors conceptualize *customer loyalty* as “the customer’s repeat purchase behavior” that in the long run can produce an escalation of benefits and profitability and a reduction of costs (Henning – Thureau *et al.*, 2002: 231).

*Positive word of mouth* is conceptualized as “informal communications between a customer and others concerning evaluation of goods or services, includes relating pleasant, vivid personal novel experiences; recommendations to others; and even conspicuous display” (2002: 231-232)<sup>12</sup>.

The figure below displays their conceptual framework.

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<sup>11</sup> The reason of not including trust is due to the construct of confidence benefits that in some sense can substitute according to the authors the trust construct.

<sup>12</sup> See also Anderson. E.W. (1998: 6).

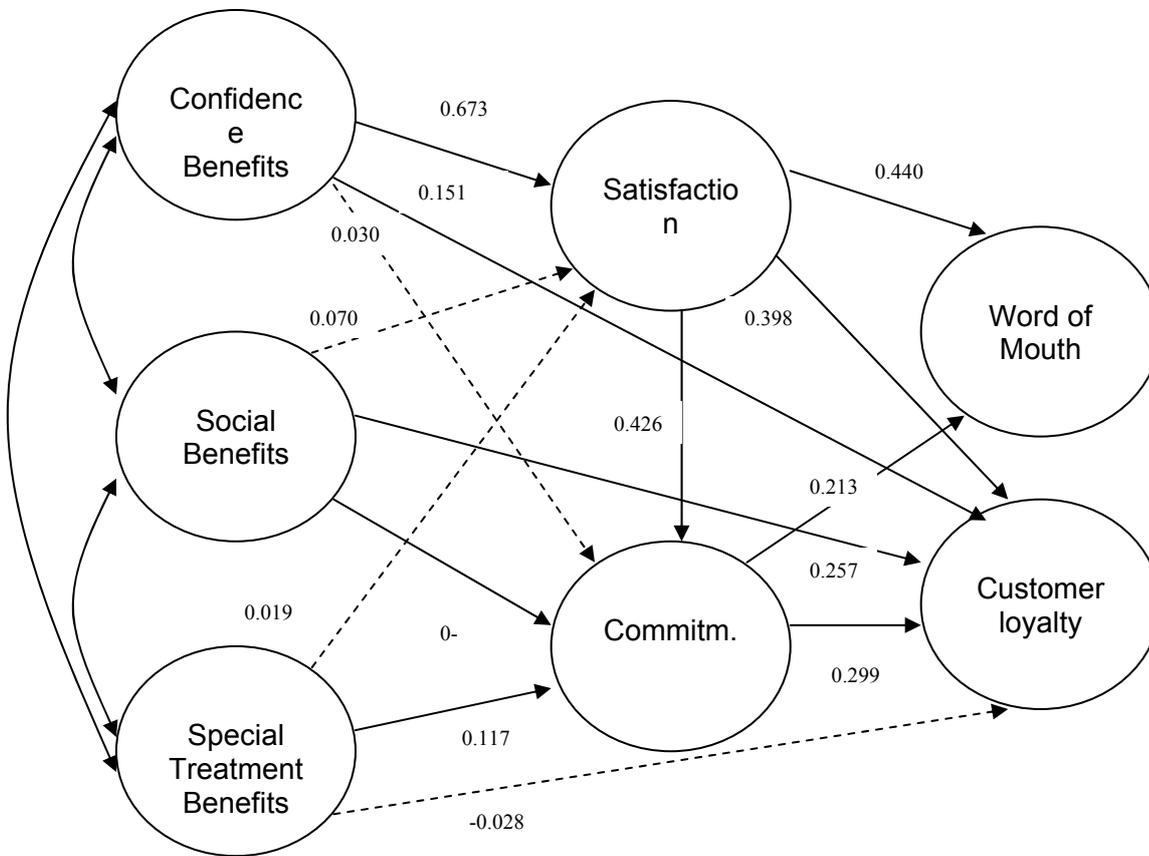


Figure 14: An integrative Model of the determinants of key relationship marketing outcomes (Hennig – Thureau et al. 2003: 235)

The results indicated that this model explains more than 81% of the variance in the customer loyalty construct and more than 35% of the variance in the word of mouth constructs

Satisfaction, commitment, confidence and social benefits are all good predictors of loyalty and positive word of mouth. Satisfaction and commitment (which the authors consider as indicators of quality in a relationship) have a significant impact on word of mouth communication. There is support in the integrated model that the antecedent constructs (except for special treatment benefits) are significant predictors of customer loyalty.

The results of Henning – Thureau *et al.* (2002) are consistent with the contribution of Crosby *et al.* (1991) and Worley and Schommer (1999), and support the assertion that satisfaction, commitment and trust are determinants of loyalty and are the dimensions of

relationship quality. The difference between the two models is that Hennig- Thureau *et al.* use commitment not as an outcome and sign of loyalty, but rather as a predictor of loyalty. In addition, the authors found that social benefits have more positive and relevant influence on relationship marketing outcomes than the technical quality of the service offered.

### **3.3 Limits of the models and perspectives**

The evidence from the empirical work of Worley and Schommer (1999), Crosby *et al.* (1990), and Henning – Thureau *et al.* (2002) are useful for my aims. As already stated in the theoretical chapter, they were able to demonstrate that the constructs purported to influence relationship development and maintenance behave as predicted. The authors agree that trust, satisfaction and commitment play an important role in obtaining customer loyalty.

Based on the empirical findings and the discussion by the authors, some questions remain unresolved. The models presented and discussed provide useful ideas about the main factors that lead to relationship development and maintenance. One unresolved issue lies in the need to develop and apply a framework that will serve to motivate people to move from an early developmental stage of the relationship to a more committed (maintenance) stage of the relationship, and to maintain a long-term committed relationship for people that already are in the maintenance phase. The integration of the Stages of Changes model with the general relationship development models proposed by Worley and Schommer (1999) and Henning-Thureau *et al.* (2002) is intended to capture the dynamism in the relationship between the pharmacist and his clients.

### **3.4 Hypothesized models**

My empirical work was built on the findings of the previous authors. The two models I have presented identify the constructs that lead to relationship development and maintenance.

The final outcome, as well documented in the literature, is a long-term relationship where trust and loyalty play an important role. I will propose a multivariate approach, where I can identify some antecedents relevant to trust that, in the long run, support the creation of a loyal, long-term relationship.

In the paragraphs that follow, I will present the constructs in my structural model. I will provide a rationale for each construct and will explain how to integrate the Stages of Change model to capture the dynamism in the relationship.

Hence, I will propose two models: a “static model” that contains the relevant constructs to describe relationship development and maintenance. The inspiration for this model is found in the research by the Worley and Schommer (1999) and Henning-Thurau *et al.* (2002).

I will then propose a second model: a “dynamic model,” where the constructs from the static model will be integrated with the Stages of Change model constructs to describe the factors that allow relationship development and that allow the determination of whether dynamism in relationship development (as captured by the Stages of Change model application) is a significant predictor of trust, and loyalty.

The hypothesis at the basis of my empirical investigation is that:

*The static model of the pharmacist - client relationship will explain less of the variance than the application of a dynamic model.*

### **3.4.1 Static model**

In the development of the static model, I follow the suggestions by Crosby *et al.* (1990), Worley and Schommer (1999) and Henning – Thurau *et al.* (2002). The model was built by taking into consideration that the desired outcome of a long-term relationship; that is, a loyal client in a trusting relationship with the pharmacist because of his experiences and ability to interact with the patient.

The “static model” includes the classical approach to relationship development and maintenance and does not consider the dynamism between the pharmacist and the client.

#### **3.4.1.1 Constructs<sup>13</sup>**

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<sup>13</sup> We included in the questionnaire several constructs (e.g., satisfaction, commitment, word of mouth) that were included in models by previous authors [e.g. Worley and Schommer, 1999; Henning-Thurau *et al.* 2002) but will not be included in the hypothesized model because our interest is focused on relational constructs (such as relationship selling behavior and relational benefits) and characteristics of the pharmacist (i.e., expertise) as antecedents to our key outcome measures of trust and loyalty. We will, however, conduct some supplemental analyses that examine the role of satisfaction and commitment as determinants of trust and loyalty.

*Perceived expertise of pharmacist.* Following the insights offered by Crosby *et al.* (1990) and Worley and Schommer (1999), I include perceived expertise of the pharmacist as an antecedent of relationship development and maintenance. Perceived expertise seems to play an important role in determining trust in the relationship and can play a significant role in determining whether the client will be able to recognize the pharmacist as a primary health care provider.

The construct was developed by taking into consideration the insights of Worley and Schommer (1999) and Smith, Salkind and Jolly (1990), who developed a comprehensive assessment of primary health care advice given by community pharmacists. In chapter five, the items that characterize perceived expertise will be presented in detail.

*Relationship selling behavior.* Relationship selling behavior is a construct composed of mutual disclosure and contact intensity. Following the work of Crosby *et al.* (1990) and Worley and Schommer (1999), I included this construct because it provides information about how the exchange of information between the pharmacist and their clients develops.

*Perceived Relational Benefits.* As Henning - Thureau *et al.* (2002) find, the client will evaluate the core service of the pharmacist (as primary health care provider, evaluated by perceived expertise) as well as the benefits that the involvement in a relationship with the pharmacist will produce. In the next chapter, I will provide the measures used to assess this construct. I believe that those benefits, as perceived by the clients, will influence the development and maintenance of a long - term relationship.

*Stages of Change Model.* As discussed in the first chapter, I propose including the Stages of Change Model construct as an independent variable. In this case, I expect clients in different stages to perceive and react to the stage of the relationship in different ways. To date, this construct has not been applied to the study of relationships. The Stages of Change Model gives a better understanding of the dynamics that influence relationship development and maintenance. In chapter five, a detailed description of the operationalization of this variable will follow.

*Trust.* Thinking about a covenant long - term relationship implies the adoption and evaluation of trust. Trust is a key construct for relationship development and maintenance. Loyalty in a relationship cannot be achieved without trust. From my perspective, the perceived expertise of the pharmacists (cores services evaluation), perceived relational benefits, and relationship selling behavior of the pharmacists are all antecedents of trust. Pharmacist expertise, an open exchange of information, and realizing that some benefits of a different nature exist in developing the relationship

allow the client to start to trust the pharmacist. The greater the quantity of these antecedents, the more trust will be developed. I consider trust as the key determinant of relationship development, particularly in the context of the relationship between a health professional and a patient.

*Loyalty as the intention to frequent the pharmacy in the future.* The final outcome of my model will be loyalty, or more accurately, an initial signal of loyalty: the intention to frequent the pharmacy in the future. I used the intention to continue to visit the pharmacist as a proxy for loyalty because the study took place during a relatively short time frame.

The hypothesized static model is illustrated in the figure below<sup>14</sup>.

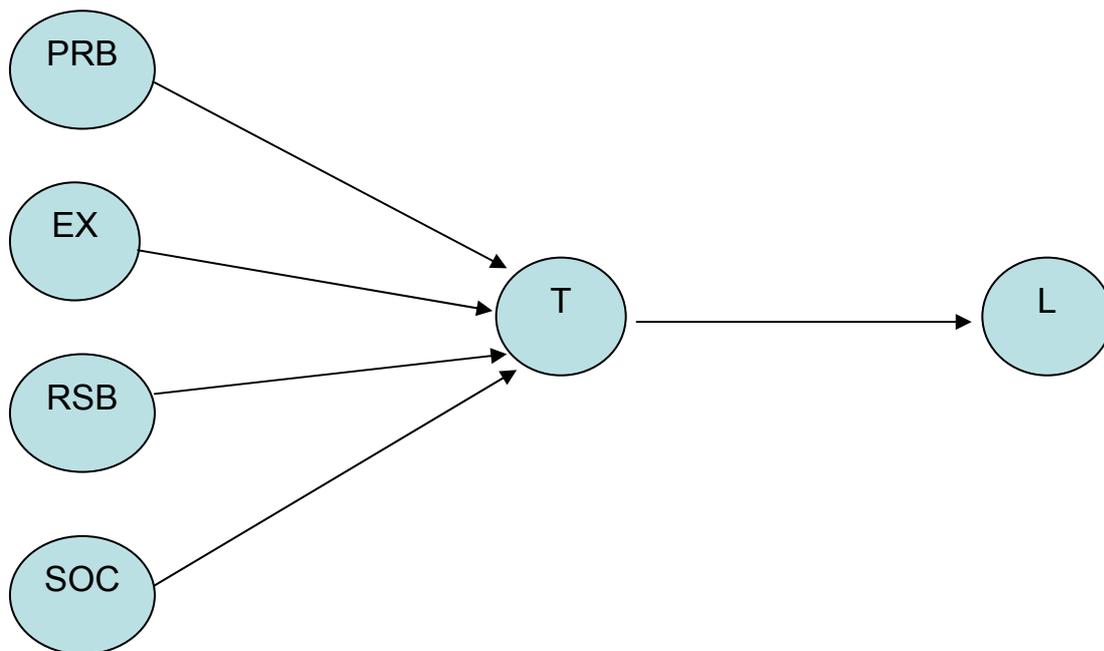


Figure 15: Static model of relationship development

The hypotheses about the relationships between variables can be presented as follows:

H1: Expertise of the pharmacist has a direct influence on the way the client will trust the pharmacist as primary health care provider.

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<sup>14</sup> In the model estimation the exogenous variables were allowed to co vary.

H2: Perceived relational benefits have a direct influence on the way the client will trust the pharmacist as primary health care provider.

H3: Relationship selling behaviors have a direct influence on the way the client trusts the pharmacist.

H4: The stage of change clients are in will have a direct influence on the way they trust the pharmacist as primary health care provider.

H5: The more the client trusts the pharmacist in the relationship, the more he will be willing to remain loyal to the pharmacy in the future.

### 3.4.2 Dynamic model

The dynamic model I intend to evaluate is the core of my conceptual vision. It is intended to explain and represent dynamism in the relationship. In particular, I believe that the static model will be enhanced by taking into consideration that the Stages of Change Model not only has a direct influence on trust, but at the same time moderates the relationship between the other antecedents and trust. Clients in different stages will perceive the expertise, benefits, and relationship selling behavior of the pharmacist in different ways. As a consequence, different strategies need to be developed to move people from one stage to another of the relationship.

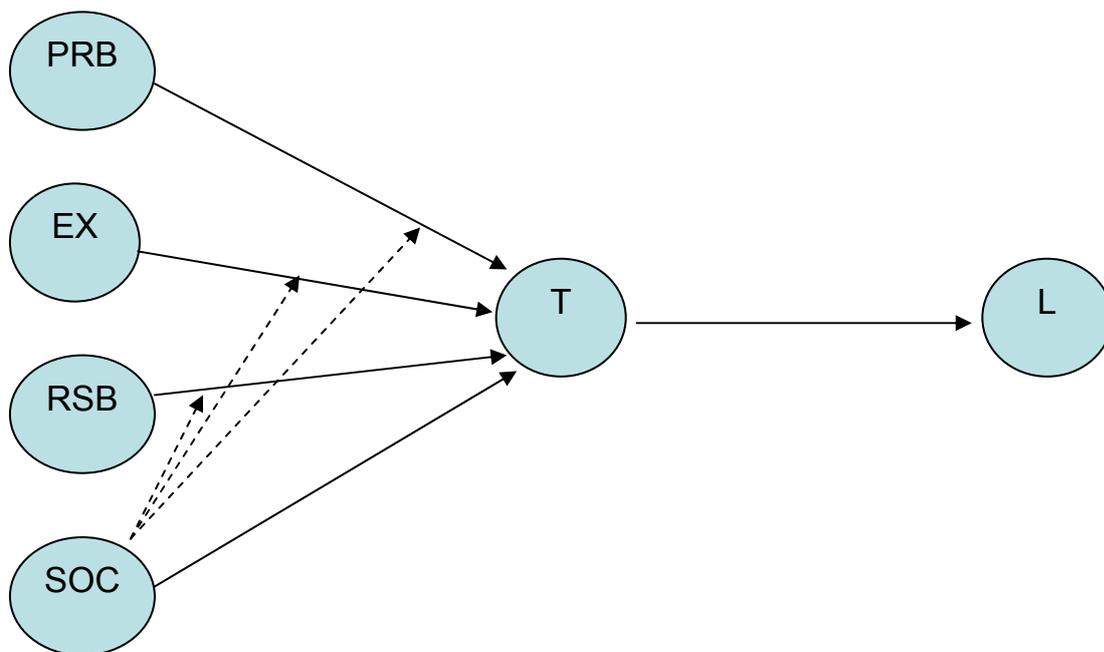


Figure 16: Dynamic model of relationship development

In analyzing the results, I will test the two models with the expectation that the dynamic model explains more variance than the static one.

## **Chapter 4: Project design and methodology of Phase 1 and Phase 2**

### **Introduction**

The chapter that follows contains a detailed description of the project context, design and the methodology that guide my empirical investigation.

I will also define the population that has been included in my empirical investigation, and the criteria that guide my definition of the sample selected to take part.

### **4.1 Project context**

The static and dynamic models will be evaluated in the context of the relationship between pharmacists and clients in Tessin.

The Health Care Communication Laboratory collaborated with the Order of Pharmacists of Tessin from May 2003 until September 2005 concerning the enhancement of the pharmacists - client relationship. The Order of Pharmacists of Tessin is the primary association that gathers information about pharmacists that practice in the territory.

Before describing the measurement of the constructs in the two models, I will discuss important features of the context in which the research was conducted. First, I will present some relevant data about the structure of the pharmacies in Tessin. I will then present the important functions of the pharmacists, the legal barriers they face in their profession, arriving at a discussion of current pharmacists - client interactions as they have been described by some pharmacists I interviewed before starting the empirical investigation.

At the end of the chapter, I will define the current role of the pharmacist in Tessin and the relevant aspects in need of enhancing in his relationship with clients.

#### **4.1.2 Current situation of pharmacies in Tessin**

##### **4.1.2.1 Structure and density of the Tessin pharmacies**

Tessin has approximately 310.000 inhabitants in an area of about 2.812 km<sup>2</sup>. This information is relevant to understanding the peculiar situation of pharmacies and pharmacist in Tessin. At present, 177 pharmacies are open to the public, with a business volume of 260 millions CHF per year. The overall number of clients visiting pharmacies in the Canton is about 20.000 / 25.000 units per days<sup>15</sup>.

One might infer that the high number of pharmacies in a limited territory causes a high concentration of pharmacies and produces a strong competition. In Tessin, there are no strong limitations to opening a pharmacy. The only prerequisites the legislation requires are:

- The achievement of a federal degree, and following this, the practice of the profession for two years in a pharmacy.
- A shop of at least 30 m<sup>2</sup>, a laboratory of 15-20 m<sup>2</sup>, a storehouse of 15-20 m<sup>2</sup>, and toilets<sup>16</sup>.

The low barriers to opening a pharmacy have created a competitive environment that has become more complicated through the years. This situation differs from Italy's, for example, where not only the above conditions must be met, but the number of pharmacies is strictly bound by the number of inhabitants. In the town centers with more than 12.500 citizens there must be one pharmacy for each of 4000 inhabitants; in the cities with less than 12.500 individuals there must be a pharmacy for each of 5000 inhabitants<sup>17</sup>.

A direct consequence of this strong concentration of pharmacies in Tessin is increased competition among them, which has forced Tessin pharmacists in the past few years to identify new ways to retain their clients, focusing in particular on a better quality of the services offered, sales for those products that support these services, (therapeutic agents, aliments, cosmetics, health products), and on advertisements for the services offered (sales, health services, health counseling, etc.)<sup>18</sup>.

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<sup>15</sup> [www.ofct.ch/servizi\\_di\\_interesse\\_publico.htm](http://www.ofct.ch/servizi_di_interesse_publico.htm), last visit January 2006

<sup>16</sup> Art. 83 legge sanitaria; art. 42-46 regolamento concernente l'esercizio delle arti maggiori.

<sup>17</sup> [www.ministerosalute.it](http://www.ministerosalute.it)

<sup>18</sup> Art. 70 Legge Sanitaria; direttive UICM sulla pubblicità degli agenti terapeutici del 23 novembre 1995; sentenza Tribunale federale maggio 1996;

#### **4.1.2.2 Functions and duties of pharmacists in Tessin: rules and legal barriers**

According to the SSPh<sup>19</sup> Deontology Code, pharmacists are required to secure the well-being of the entire population, of their clients, without any kind of distinctions. They must be aware and be knowledgeable about medicines, the treatment of clients, and the improvement of their health. They also must educate people to take care of their health and to become active participants of the health care system.

All the pharmacists, especially in recent years, are strongly encouraged to continue their education with courses that give them the possibility to obtain an FPH title (Foederatio Pharmaceutica Helvetiae). This is a new title in “specialist of public pharmacy and hospital pharmacy” created by the Swiss Society of Pharmacists (SSPh) as a seal of quality recognizable clients and other health professionals. Obtaining the title can be seen as an attempt to make the pharmacist more competitive and more health oriented.

Pharmacists in Tessin are not allowed to prescribe medicines, but can counsel clients about over the counter products, and can advise them about minor ailments without infringing on the doctor responsibilities<sup>20</sup>.

Since July 1st, 2001, compensation for pharmacists’ service as health care provider was incorporated as part of the overall costs of the prescription medicine they sell. In synthesis, the price of the prescription medicines is composed of:

- a fixed tax of 4.20 CHF for the pharmacist’s service
- the price “ex factory” (which depends on the medicines and goes to the manufacturer)
- costs of distribution (that it is divided between the pharmacist and the wholeseller)

According to new norms, the pharmacist tax includes services of the pharmacist such as: the filling of prescriptions, recommendations and counseling of patients about the use of medicines, etc.

It is important to highlight that this source of economic benefit for pharmacists only includes prescription medicines.

The figure of the pharmacist as health care provider, at a financial level, is not recognized. This creates some barriers and difficulties for the pharmacists in acting as health care providers, and tends to position them as simply “dispensers of medicines”.

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<sup>19</sup> Société Suisse des Pharmaciens

<sup>20</sup> art. 54; art.57; art.58; Regolamento concernente l’esercizio delle professioni sanitarie con formazione accademica (31.10.1958)

## **4.2 Project overview: the reasons for a three phases - design study**

A three phase study was chosen to evaluate the research hypotheses.

- Phase 1: explorative study
- Phase 2: descriptive study
- Phase 3: intervention study

In addressing the research hypotheses in the Tessin context it is necessary to know:

- 1) If the research issues identified from the literature are similar in the Tessin context.
- 2) The current configuration of the pharmacist - client relationship, according to the factors identified in the models included in the literature overview,
- 3) Criteria to build useful strategies in developing pharmacist – client relationship.

These three research needs are related to each other, and answering each individually question may allow the clarification of the pharmacist - client relationship development .

Given these assertions, the project design was divided in three phases.

### **4.2.1 Phase 1**

The purpose of Phase 1 was to explore the current gaps and needs in the pharmacist - client relationship, as understood by the pharmacists. In the literature review, the role of the pharmacist was predicted to evolve into that of a more primary provider of health information as the costs of health care increase.

The aim of this first explorative study was to understand if the research need and gaps I identify in the literature were close to the research needs of pharmacists in Tessin.

#### **4.2.1.1 Methods and Procedures**

In February 2003, before defining the design of my empirical investigation, I conducted some preliminary interviews with five Tessin pharmacists in collaboration with the Order of pharmacists of Tessin. I used semi – structured face-to-face interviews so as to better understand the factors that characterize the pharmacist - client relationship in Tessin, to understand the issues related to the retention of clients in Tessin, and the potential barriers to becoming health care providers. The preliminary interviews were

conducted at the pharmacy and lasted about one hour. All interviews were recorded using an MP3 recorder.

Questions were asked about the current situation of pharmacies and pharmacist in Tessin, their current role in the health care system, legal barriers, difficulties in acting as health care providers, characteristics of the clients, and characteristics of the pharmacist – patient relationship (in Appendix 1 contains a grid with all the questions included in the exploratory study). A synthesis of the insights provided by the pharmacists is contained within the first section of the results chapter.

#### **4.2.2 Phase 2**

The purpose of Phase 2 was the definition of criteria that segment clients who frequent pharmacies in order to allow the design of targeted information and services based on the level of relationship the clients have established with the pharmacists. The results of Phase 2 were used to support the design of an intervention in the third phase of the research.

The questionnaire in this phase focused on the key determinants of relationship trust and loyalty, the level of development of their relationship with pharmacist, and general information about their health behaviors.

##### **4.2.2.1 Methods and Procedures**

I decided to conduct face-to-face interviews outside some pharmacies<sup>21</sup> in Tessin, using a questionnaire to capture the characteristics of a typical client that visits a Tessin pharmacy. The questionnaire (see Appendix 2) included questions that operationalized the constructs in the static and dynamic models described in Chapter two. I included items that were discussed by the pharmacists in the face-to-face interviews from Phase 1. Measures included in the questionnaire classify clients according to the frequency of client visits to the pharmacy<sup>22</sup>. First time clients responded to health behavior, habits, and demographic sections, and were not asked to respond to questions that evaluated the relationship with the pharmacist.

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<sup>21</sup> Indications were provided to interviewers to waiting for the client after his / her purchasing in the pharmacy.

<sup>22</sup> Two different questions were asked about first time clients and not-first time clients.

<sup>21</sup> For no first time clients another question was asked about frequency to the pharmacies.

The questionnaire was divided in six sections: perceived expertise of the pharmacist, perceived relational benefits, evaluation of relationship selling behaviors of the pharmacist, measures of loyalty and satisfaction, measures of trust, word of mouth measures, health behavior and habits, purchasing habits in pharmacy, two applications of the Stages of Change Model (both considering how the clients evaluate the pharmacist as health care provider, and considering their relationship with pharmacists), and finally some demographics information<sup>23</sup>.

#### **4.2.2.2 The population and the selection of the sample**

I first selected a sampling frame to represent the pharmacies in Tessin, then established the number of clients to be interviewed, and chose the characteristics of the sample to be interviewed.

The overall number of pharmacies in Tessin is 177. Pharmacies are more concentrated around an urban center, and become less prevalent further away from them. If one looks to the geographical configuration of Tessin, the urban centers (with more than 5000 inhabitants<sup>24</sup>) are<sup>25</sup>:

1. Lugano	51410
2. Bellinzona	16870
3. Locarno	14506
4. Chiasso	7969
5. Giubiasco	7618
6. Mendrisio (and Salarino)	6564
7. Minusio	6496
8. Losone	6094
9. Massagno	6006
10. Biasca	5904
11. Ascona	5080

Based on this information, I included randomly pharmacies in the sample that are located: in Lugano, in Bellinzona, in Locarno, in Giubiasco, in Mendrisio, in Losone,

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<sup>24</sup> We considered the most populated urban center, because here one can find also the highest level of concentration of the population.

<sup>25</sup> <http://www.ti.ch/can/comuni/default.asp>, last visit March 2006

and in Ascona<sup>26</sup>. Given that Lugano (which includes Lugano city and other villages near the urban center) has the highest number of citizens, the sample of pharmacies chosen was specially taken into consideration. Aside from this, I selected a random stratified sample by dividing the territory of Tessin in different zones.

- Lugano (down town and blocks)
  - Towns near to Lugano
  - Some urban centers in Tessin (with a population of more than 5000 inhabitants)

Beyond this, I included some mall pharmacies in Tessin in the sample. Based on the classification of clients suggested in the preliminary interviews, I selected some pharmacies where the clients have different motivations and needs in comparison with clients of urban centers and little towns.

Based on those criteria, I randomly choose 29 pharmacies out of 177 and respectively:

Categories	List of pharmacies' sample
<u>Down town pharmacies - Lugano</u>	<ul style="list-style-type: none"> <li>▪ Farmacia della Piazzetta</li> <li>▪ Farmacia Moderna</li> <li>▪ Farmacia S. Luca</li> <li>▪ Farmacia Solari</li> </ul>
<u>Blocks pharmacies - Lugano</u>	<ul style="list-style-type: none"> <li>▪ Farmacia della Posta - Breganzona</li> <li>▪ Farmacia Airone - Molino Nuovo</li> <li>▪ Farmacia Cassarate – Cassarate</li> <li>▪ Farmacia Loreto - Loreto</li> <li>▪ Farmacia Stella - Trevano</li> <li>▪ Farmacia Salus – Centro</li> <li>▪ Farmacia Trevano – Trevano</li> <li>▪ Farmacia Bozzoreda – Pregassona</li> <li>▪ Farmacia del Crocifisso – Savosa</li> <li>▪ Farmacia Trezzini - Viganello</li> </ul>
<u>Little town pharmacies near to Lugano</u>	<ul style="list-style-type: none"> <li>▪ Farmacia Federale – Massagno</li> <li>▪ Farmacia S.Gottardo – Massagno</li> <li>▪ Farmacia Collina D'Oro – Montagnola</li> <li>▪ Farmacia Paradiso – Paradiso</li> <li>▪ Farmacia Lepori - Tesserete</li> </ul>

<sup>26</sup> Living apart Chiasso, one might object that my sample is just a convenient one. The city of Chiasso, however, has many residents from Italy; therefore it had been excluded from my sample.

<u>Tessin urban centers pharmacies</u>	<ul style="list-style-type: none"> <li>▪ Farmacia Nuova – Ascona</li> <li>▪ Farmacia S. Rocco – Bellinzona</li> <li>▪ Farmacia Stazione – Bellinzona</li> <li>▪ Farmacia Pedrazzetti – Giubiasco</li> <li>▪ Farmacia Varini – Locarno</li> <li>▪ Farmacia Lafranchi - Locarno</li> </ul>
<u>Trading centers pharmacies</u>	<ul style="list-style-type: none"> <li>▪ Farmacia Centro Breggia – Balerna</li> <li>▪ Farmacia Beretta Piccoli – Canobbio</li> <li>▪ Farmacia Arcobaleno – Grancia</li> <li>▪ Farmacia Realini - Losone</li> </ul>

#### 4.2.2.3 Measures

##### *Preliminary questions*

*Frequency to the pharmacy* was measured as the number of times a client visited a pharmacy during the three months before the interview. This time span was selected, in part, based on suggestions by the pharmacists interviewed in the preliminary stage and the concern that clients would have difficulty remembering the number of pharmacy visits beyond a three month period.

(b) How many times in the last **3 months** have you been visiting this specific pharmacy?

The individuals then were categorized according to the following options: 1-2, 2-3, 3-4, 4-5, and finally *more than 5*.

##### *Pharmacist – client relationship constructs*

*Perceived expertise* was measured by integrating the items proposed by Worley and Schommer<sup>27</sup> (1999) with two items that were tested in the study of Smith, Salkind and Jolly (1990). The justification for the integration is that Worley and Schommer consider the pharmacist - client relationship from a “traditional point of view”, while Smith *et al.* (1990) suggest some new significant tasks that need to be included in the definition of “expertise of the pharmacist,” if the pharmacist is to be considered a primary health care provider. I added an item, an important component of the concrete

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<sup>27</sup> The items they proposed, as I have already asserted, are based on empirical evidence provided by Crosby *et al.* (1990) that they readapted in the context of pharmacist – client relationship.

expertise of the pharmacist: his ability to listen to the client and to be able to counsel him/her in a proper way.

I decided to readapt the items considering the expertise of the pharmacist (as perceived by clients) in performing his new role of primary health care provider. In my view, the pharmacist has not only to act as a provider of drug-related information, but must offer services and advice about health prevention and health.

The items we used to measure the client's perception of pharmacist expertise were as follows:

- (1) The staff of the pharmacy <sup>28</sup> provides me information about potential side effects that my medication may cause (Worley and Schommer, 1999).
- (2) The staff of the pharmacy is able to explain me how to take medication correctly (Worley and Schommer, 1999).
- (3) The staff of the pharmacy is open to listening to and discussing my health related concerns with me.
- (4) The staff of the pharmacy advises me about health disease preventive measures (Smith *et al.*, 1990).
- (5) The staff of the pharmacy is able to answer all of my medication *and health status questions* (Worley and Schommer, 1990 – readapted).
- (6) The staff of the pharmacy is a source that I use and I appreciate *in acquiring information about the cure of my health* (Worley and Schommer, 1999 – readapted).

A 5-point Likert scale was used then to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Perceived relational benefit* constructs were included considering the evidence provided by Gwinner, Gremler and Bitner (1998) and Hennig – Thurau *et al.* (2002). The idea is that clients are more likely to receive these benefits as the result of a long – term relationship with the pharmacist.

The authors talk about three different types of relational benefits: social, confidence and special treatment benefits. I decided to include shorter lists of items that represent each of the three relational benefits<sup>29</sup>.

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<sup>28</sup> The entire questionnaire was built asking to clients about their relationship with the staff of the pharmacy, because usually there are more pharmacists and more assistants at the desk.

<sup>29</sup> The risk was indeed to design a questionnaire to much longer and redundant for the client.

The items in my questionnaire represent relational benefits as follows:

- (1) When I speak with anyone of the staff I know that I am dealing with somebody that I am used to and who knows me (*Social benefit*).
- (2) I feel in good hands when I go there (*Social benefit*).
- (3) I know it is going to be good a satisfactory experience advance, or if something does go wrong it will be taken care of it (*Confidence benefit*).
- (4) I get a good services and I do not loose time to look for another pharmacy (*Confidence benefit*).
- (5) Here I receive a preferential treatment (*Special treatment benefit*).

A 5-point Likert scale was used then to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Relationship selling behavior* is a construct originally created by Crosby *et al.* (1990) and then adopted by Worley and Schommer (1999). It includes mutual disclosure and contact intensity. They refer to the pharmacists' behavioral tendency to cultivate their relationship with clients and to tend to the maintenance and growth. I decided to include a shorter version of this composite construct in the questionnaire:

- (1) The majority of times that I visit my pharmacy, I have conversation with somebody of the staff (*Contact intensity*).
- (2) In the past I have expressed my liking and respect to someone of the staff for him/her as a person (*Mutual disclosure*).
- (3) Often someone of the staff and I share information about family-related events and my personal life (*Mutual disclosure*).

A 5-point Likert scale was used then to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Satisfaction* was defined using two different references: Worley and Schommer (1999) and Grunig and Hon (1999). My intent was to assess clients' general satisfaction with the pharmacy and interaction with the pharmacy staff.

Items of satisfaction were as follows:

- (1) I am happy with the staff of this pharmacy (Grunig, 1990).
- (2) A lot of people like me are satisfied with this pharmacy (Grunig,1990).
- (3) Both the staff of the pharmacy and I benefit with the relationship we have established (Grunig, 1990).

- (4) I always leave the pharmacy satisfied with the staff (Worley and Schommer, 1999).
- (5) I always leave the pharmacy feeling that I received useful information about the medications I have bought (Worley and Schommer, 1999).
- (6) I am grateful for the personalized attention the staff of the pharmacy offers me (Worley and Schommer, 1999).

Also in this case, a 5-point Likert scale was used then to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Trust* was operationalized based on findings by Swan *et al.* (1985). The authors assert that customer trust in a salesperson increases to the extent that the salesperson is perceived as exhibiting dependability, honesty, competence, customer orientation and likeability. In this case, I adapted their items:

The statement: "*You consider the staff of your pharmacy*" could be answered in the following ways:

- (1) Confident
- (2) Competent
- (3) Honest
- (4) With a good problem solving
- (5) Insincere sometimes

A 5-point Likert scale was used then to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Word of Mouth* was measured by asking clients:

- (1) Did you ever suggest this pharmacy to someone else?
- (2) If YES, How many people? .....

Personal communication is viewed as a more reliable source of information than non-personal communication. *Word of mouth communication* is a powerful force in influencing future buying decisions, particularly when the service delivered is of high risk for the customer.

I used a yes/no scale for the question "Did you ever suggest this pharmacy to someone else?"

Regarding *commitment*, I asked the following:

- (1) Do you usually use alternative pharmacies?
- (2) If Yes, how many? .....
- (3) How much times do you usually spent with the staff of the pharmacy for a purchasing? .....

I used a yes/no scale for the question “Do you usually use alternative pharmacies?”

*The health behaviors and habits* section contains questions related to the clients’ health behavior and habits. It helps to understand the health status of the client, how they use the pharmacy, the reasons that lead them to the pharmacy, and the types of products bought. Anderson (1998) provides insights into the measures of this construct as well as the preliminary interviews of the Tessin pharmacists. The items contained within this section were as follows:

- (1) Which source do you prefer to get informed about your health?
- (2) Do you ask the staff of the pharmacy about health information you heard and read in other sources?
- (3) How do you consider you health status?

For items (1) and (3), the client answered in an open-ended format. For question (2) a yes/no scale was chosen.

- (4) I consider the staff of the pharmacy a valid support in improving the quality of my life.
- (5) I consider important pharmacy services in improving the quality of my life.

Items (4) and (5) were created to assess the attitude of clients toward the staff of the pharmacy and the services offered by the staff of the pharmacy. A 5-point Likert scale was used to assess the clients’ evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

- (6) Which type of product do you buy here most of all?

This item was used to understand the type of products purchased most frequently by the clients. We provided three options: Prescription, OTC, Cosmetics.

- (7) Which are the main reasons that lead you to choose this pharmacy?

The alternatives for this question were based on the responses from the face-to-face interviews with the Tessin pharmacists. The response options were: Parking, Near where I work, Near to my house, Prices are reasonable, I like the staff I like the store.

The *Stages of Change Model* was applied to test two different aspects: the stage of change of the clients regarding their use of pharmacy's services, and the health information they receive there. This measure was useful in understanding how Tessin clients are prepared to use health care services and information provided by the staff of the pharmacy.

The construct was also applied to assess the stage of change occupied by clients in regards to the relationship they have with the staff of the pharmacy, and the loyalty they have to the pharmacy. This measure is important because it provides the opportunity to segment the sample according to the relationship established with the pharmacists. It will also allow the integration of the current relationship development model in order to capture dynamism in the pharmacist - client relationship.

In both cases, *Stage of Change* was assessed using an algorithm. This staging algorithm has been used in the literature and is reliable across a range of behaviors (Prochaska *et al.*, 2002).

In determining client readiness to use pharmacy' services and health information, clients answered yes or no to the following questions:

- (1) Have you tried to improve the quality of your health status by looking for services and prevention communication in pharmacies for more than three months?
- (2) In the past month, have you actively looked for services and information for the maintenance of your health status in the pharmacy?
- (3) Are you seriously considering looking for information to maintain your health status in the pharmacy during the next three months?

In determining readiness for loyalty to the pharmacy<sup>30</sup>, clients had to answer yes or no to the following questions:

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<sup>30</sup> In the literature, and in the vast amount of applications of Stage of Change Model, researchers have not used that construct to test readiness for being loyal to the pharmacy, in order to segment people according to the relationship they have established with the staff of the pharmacy. For that reason, items were adapted to our aim, in the new context.

- (1) Have you preferred this pharmacy, rather than other pharmacies, for more than three months?
- (2) In the past month, have you actively looked for this specific pharmacy/pharmacist?
- (3) Are you seriously considering remaining loyal to this specific pharmacy in the next three months?

In both cases, individuals were categorized into the appropriate stage using the following algorithm:

	<b>P</b> <sup>31</sup>	<b>C</b> <sup>32</sup>	<b>A</b> <sup>33</sup>	<b>M</b> <sup>34</sup>
<b>Question 1</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>Yes</b>
<b>Question 2</b>	<b>No</b>	<b>No</b>	<b>Yes</b>	-
<b>Question 3</b>	<b>No</b>	<b>Yes</b>	-	-

*Demographic information* was limited to factors that allow characterization of the sample. The items were as follows:

- (1) Age
- (2) Gender
- (3) Marital status
- (4) Last degree
- (5) Place where the person live<sup>35</sup>
- (6) Pharmacy where the interview took place

### 4.2.3 Phase 3

The purpose of Phase 3 was the definition and the creation of effective health care services and information to be provided by the pharmacist to clients in Tessin.

Based on the results of Phase 2, the third phase implemented an intervention to evaluate the effectiveness of stage-appropriate messages for the improvement of the relationship between the pharmacist as health care provider and his clients. The details regarding Phase 3 (i.e., the methods, procedures, constructs, measurements and results) will be discussed in Chapter 6.

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<sup>31</sup> P= Precontemplation

<sup>32</sup> C= Contemplation

<sup>33</sup> A= Action

<sup>34</sup> M= Maintenance

<sup>35</sup> For people that live in Lugano we asked to specify the blocks where they live.

## Chapter 5: Results Phase 1 and Phase 2

### Introduction

The chapter contains the results of Phase 1 and Phase 2. In the first part of the chapter, I will briefly present the preliminary interviews I conducted with five Tessin pharmacists. This will delineate the current situation in Tessin concerning the pharmacist – client relationship and capture, according to the pharmacists, the relevant factors and barriers to a long term development of the relationship.

In the second part of the chapter I will present an analysis of the data collected in Phase 2 by first presenting the descriptive statistics of the key constructs of the model, and then presenting the regression analysis to evaluate the hypotheses presented in Chapter 3.

### 5.1 Phase 1: Interactions between pharmacists and clients in Tessin

The preliminary interviews allowed me to better understand the context I intended to study and to identify some relevant factors and components that characterize pharmacist - client interaction in Tessin.

The first relevant information the pharmacists<sup>36</sup> reported was about the distribution of pharmacies in the territory of Tessin. According to the pharmacists interviewed, pharmacies can be categorized depending on where they are located. In town centers, one can distinguish between *downtown pharmacies*, where clients are more anonymous due to the rush of everyday life, *block pharmacies*, where clients tend to be more loyal to their pharmacist because they know each other better; and *pharmacies in small villages* outside the town centers, where the pharmacist is often the only practicing source of health information.

In particular, people who frequent block or small village pharmacies consider quality to be the element that makes a difference and that often can lead to the word of mouth promotion necessary for the pharmacist to retain more clients. As pharmacist B asserts:

*“In terms of small villages, the retention of clients and the development of relationships with clients can be realized by aiming at the quality of the health care service. Quality*

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<sup>36</sup> To preserve the privacy of pharmacists, every time I will cite one of them I will use capital letters (e.g. Pharmacist A, B, C, and E).

*leads to the word of mouth that outweighs the effectiveness of sales and promotions in relationship development”.*

According to pharmacists that practice downtown and on blocks, clients are attracted by the ability to park near the pharmacy, by sales (i.e., lower prices), and by the convenience of the pharmacy location (near the place where people live or where people work). The retention of clients downtown or in town centers is harder, because of the strong competition between pharmacies. As pharmacist C said:

*“Hinging on sales and promotions can pay for a short period, but only quality offers benefits in the long run, and produce that loyalty necessary to know better the client”.*

Quality is defined as the key determinant for the development of long-term relationship. As noted in the literature, this is one factor requiring investigation and is evaluated in the empirical part of the project.

Beyond this, the pharmacist considers his role and that of the staff he chooses as a key element in having meaningful interactions with clients.

*“The more people know the staff and rely on it, the more they will open themselves and help the pharmacist to become familiar with their health problems and gaps”* (Pharmacist B).

This can be ascribed to the fact that the majority of persons visiting a pharmacy are old or sick, and frequently return to the same pharmacist who knows them and how to serve them in a suitable manner. As *pharmacists A* says:

*“If there is continuity in the staff it becomes easier to retain clients. In the rest of Switzerland there is a perfect management in the pharmacies, but there is no relationship at the front office. In Tessin, people appreciate being served as individuals by the staff”.*

The quality of the staff guarantees that the pharmacist and patient know each other better in the long-run, as pharmacist C says:

*“The staff is important; clients learn how to use us as source of information and as a support to the management of their health”.*

Good staff quality also allows the possibility of “overcoming the strong competition with experience and preparation of the pharmacist and his entourage”, asserts pharmacist D.

### 5.1.2 The changing role with clients

Pharmacists agree about some peculiar characteristics of their clients. As pharmacist A says “*usually it is not the product sold that decides what the clients need to know, but the client himself*”. It is crucial to understand the patient, his situation, and his needs for an effective provision of the service.

Pharmacist B asserts:

*“Clients pose questions only if they rely on the pharmacist, and loyalty is something that we build in time”.*

All the pharmacists are convinced that a strong and deep relationship leads to better knowledge of the clients. This is why pharmacists consider loyalty and the retention of clients not only as a means to cut competition, but also as a way to facilitate their role as health care provider.

In preliminary interviews, pharmacists delineated some relevant features of clients that usually enter a pharmacy. First, not all the patients who are served and informed in the same way have similar progress in the relationship. This depends on “*the environment, on their health on their experience, and on what we teach them,*” asserts pharmacist D.

Also, clients that enter a pharmacy are typically women, chronic patients or old people. Some clients pay attention more to sales and prices, others attend more to the quality of what pharmacists told and offered to them. Some patients demand more attention, depending on their level of education, on what they read to become informed about their health, or on what the doctor told them (Pharmacist C).

### 5.1.3 Current role

Throughout the preliminary interviews I tried to understand the pharmacists’ view of their profession, duties, and responsibilities. Pharmacists recognize and agree with the phases described in the first theoretical chapter of my thesis that have produce changes in the pharmacist profession<sup>37</sup>. In the last few years, pharmacists have focused their attention on their role as a health care provider. In answering the question, “*How could you define your role as pharmacist, in Tessin?*” pharmacists answer:

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<sup>37</sup> See chapter 1 from compound of medicines, to just a dispenser, to the new role of health care provider

*“We are the outpost of the health care service. We are in a pharmaceutical triage and we can help clients to take their primary decisions about health and diseases”.*

Their role, if well done, allows cost containment for the health care system because people can go to the pharmacist for free and without an appointment. Further, pharmacists have a monopoly in their interactions with clients, so their service is unique. Pharmacists in Tessin report that their presence is more significant than that of pharmacists in the rest of Switzerland, and consequently that their professionalism and relationship with clients carries greater weight.

In sum, there is strong agreement about the need for pharmacists to act as health care providers. Pharmacists recognize that they need to expand beyond serving as dispensers of medicines and to be able to identify benefits of acting as health care provider for patients.

Nevertheless, to become healthcare provider, pharmacists recognize the importance of knowing better the clients, and often this is difficult considering the fact that the pharmacist is a seller. The pharmacists are all convinced that only after having improved the level of loyalty to the pharmacy, the number of interactions, and the frequency of the visit a relationship can be established, and deeper knowledge of the client can be reached.

The empirical investigation will try to provide insights for the pharmacists in becoming effective health care providers.

## **5.2 Phase 2**

The part that follows contains the analysis of the results of the second phase of the empirical study. This phase focused on the characteristics of the current pharmacist – client relationship in Tessin, as measured by the variables presented in chapter three. After I present some descriptive statistics of the sample and of the variables that characterize the relationship, I will use a regression analysis to evaluate the two different models: a static model and a dynamic one, to see which model best fits the sample and better explains the pharmacist-client relationship.

### **5.2.1 The sample: demographic information**

We collected data from 897 respondents. The average age of the respondents was 50 years old (s.d. = 4.16, with a range from 14 – 95). I created four categories of age with

similar percentages: 14-38 (26%); 39-52 (24%); 53-64 (23%); 65-95 (26.5%). The sample was composed of 625 females (69.7%), and 272 males (30.3%).

The majority of the sample was married (55.2%), with 23.9% unmarried, 7.4% was divorced, 7.8% was widow/widower and finally 2.7% was separate. Approximately 38% of the clients interviewed had a diploma (professional school, etc); 18% of the sample has a degree; about 14% attended junior school, 12% obtained a school living certificate, about 10% has an apprenticeship, and finally 3.7% attended the primary school.

### **5.2.2 Client segments**

In all my subsequent analyses, I focused on respondents who had been to the pharmacy at least one time in order for them to be eligible to complete the questions associated with the pharmacist. The final sample was composed by 733 clients. The demographic characteristics of the remaining sample were similar to the full sample.

The average age of the respondents was 52 (s.d. = 4.10, with a range from 14 – 95). We created four categories of age with similar percentages: 14-38 (26%); 39-52 (24%); 53-64 (23%); 65-95 (26.5%). The sample was composed of 517 females (70%), and 216 males (30%).

### **5.2.3 Frequency to the pharmacy for clients who had been at least once**

Respondents indicated that, on average, they had been to the pharmacist 3.26 times (s.d.= 1.24). Approximately 37% of the respondents had visited the pharmacy more than 5 times in three months; 21.4% had visited the pharmacy 2-3 times in three months, 17.6% 1-2 in three months; 15.7 % 3-4 in three months and finally 8% 4-5 times three months.

I conducted several analyses to determine whether there were significant differences among the categories of pharmacies. I compared pharmacies that were located in Lugano (and since in Lugano there is a bigger concentration of pharmacies, I selected some downtown pharmacies and some block pharmacies), in little counties near Lugano, in the main urban centers of Tessin (selected in towns with more than 5000 inhabitants), and finally in mall pharmacies.

I conducted a one-way analysis of variance on demographic factors and the main theoretical constructs (perceived expertise, perceived relational benefits, relationship

selling behaviors, and trust). I found that respondents who visited a mall pharmacy were younger ( $F = 7.94$ ;  $df = 4,728$ ;  $p < .01$ ), less likely to trust the pharmacist ( $F = 9.21$ ;  $df = 4,728$ ;  $p < .01$ ), perceive the benefits of visiting the pharmacist ( $F = 14.47$ ;  $df = 4,728$ ;  $p < .01$ ), and were more likely to be in an earlier stage of the relationship with the pharmacist ( $F = 10.73$ ;  $df = 4,728$ ;  $p < .01$ ). There was no difference in education or the frequency of visiting the pharmacy.

I conducted analyses with both the full sample and the reduced sample without the mall pharmacies. The results were the same, so I will present the analyses with the full data set.

### **5.3 Measurements development**

I assessed the psychometric properties of the constructs included in the static and dynamic models by examining the correlations among measures for each construct, item-total correlations, and exploratory factor analyses.

The correlations among the six items used to represent the construct of “perceived expertise” reveals that all the items have similar correlations, with a range of .332 - .549. This suggests that a single factor solution may be an appropriate interpretation among these items. Cronbach’s  $\alpha$  was .80. I then conducted an exploratory factor analysis to empirically evaluate the number of dimensions that may be used to describe the factor structure underlying these items. I conducted a principal components analysis using a varimax rotation to examine the factor structure. I found that a single factor best describes the relations among these items. The first dimension accounted for over 50% of the total variance among the six items and no other dimensions accounted for more than 15% of the variance among the six items<sup>38</sup>.

The correlations among the three items for relationship selling behavior were similar, with a range of .477 - .529, suggesting that a single factor solution may be an appropriate interpretation among these items. Cronbach’s  $\alpha$  was .76. I then conducted an exploratory factor analysis and found that a single factor best describes the relations among these items. The first dimension accounted for over 67% of the total variance among the 3 items.

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<sup>38</sup> We also did conduct a confirmatory factor analyses for those constructs with three or more measures. The findings were consistent with the set of analyses reported, although the overall model fit tended to reflect significant deviation from the hypothesized model because of the large sample size ( $N = 733$ ). We will focus our presentation of the psychometric properties of each construct based on the series of tests reported in the above paragraph.

There was some variation among the correlations for the construct of perceived relational benefits, with a range of .239 - .569, suggesting that a single factor solution may not be an appropriate interpretation for these items. Based on an inspection and preliminary exploratory factor analysis, two items (familiarity with the staff and special treatment) loaded on a separate dimension and had lower correlations than the other three items (feel in good hands, fairness of staff, and good services). Cronbach's  $\alpha$  for the three item scale was .78. I then conducted an exploratory factor analysis which revealed that a single factor best describes the relations among these items. The first dimension accounted for about 69% of the total variance among these 3 items.

For the construct of trust, the correlations among the items were not homogeneous, suggesting that more than one factor underlies these items. Based on an exploratory factor analysis, I found that the characteristics of confidence, competence, and honesty all loaded on the same dimension, accounted for 78% of the variance, and had a Cronbach's  $\alpha$  of .86. The items "sometimes insincere" and "problem solving orientation", were not included in the measure of trust.

All the items that represent satisfaction were highly correlated suggesting that a single factor solution may best represent these items. The exploratory factor analysis suggested that a single factor best describes the relation among the items. The first dimension accounted for more than 61% of the total variance. Cronbach's  $\alpha$  was .84.

### **5.3.1 Stage of change**

As can be observed in the table below, using the algorithm for Stages of Change of clients, the majority of clients are in the maintenance phase (70%), 14% are in the action stage, 7% in the contemplation stage, and 9% in the precontemplation stage.

### **5.3.2 Correlations among constructs**

All the correlations between the determinants and the outcome measure are significant (Table 1).

	Perceived expertise	Relationship selling behavior	soc	satisfaction	Trust	Perceived relational benefits
Perceived expertise	1					
Relationship selling behavior	.379(**)	1				
soc	.321(**)	.305(**)	1			
satisfaction	.608(**)	.420(**)	.400(**)	1		
trust	.571(**)	.252(**)	.389(**)	.686(**)	1	
Perceived relational benefits	.584(**)	.539(**)	.468(**)	.723(**)	.607(**)	1

\*\* Correlation is significant at the 0.01 level (2-tailed).

Table 1: Correlation among constructs

#### 5.4. Regression analysis

I examined several models to assess the determinants of trust and subsequently, loyalty. As stated in chapter 3, trust is the key construct when speaking about relationship development, particularly that of a health professional and a patient/client.

In the initial model, I regressed trust onto perceived relational benefits, relationship selling behaviors, and perceived expertise (see Fig. 16). The overall hypothesized model provided a good fit with the data ( $R^2 = .452$ ). Each predictor was significantly related to trust (for perceived expertise,  $\beta = .191$ ;  $CR = 10.08$ ;  $p < .01$ ; for relationship selling behavior,  $\beta = -.048$ ;  $CR = -4.20$ ;  $p < .01$ ; for perceived relational benefits,  $\beta = .319$ ;  $CR = 9.204$ ;  $p < .01$ )

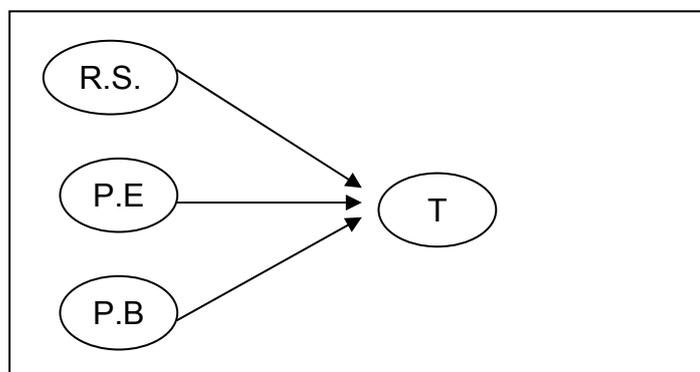


Figure 17: Trust regressed onto perceived relational benefits, relationship selling behaviors and perceived expertise

I added Stages of Change as a predictor variable to the regression model described above (Fig. 17). The overall hypothesized model provided a good fit with the data ( $R^2 = .464$ ). Each predictor was significantly related to trust (for perceived expertise,  $\beta = .333$ ;  $CR = 9.93$ ;  $p < .01$ ; for relationship selling behavior,  $\beta = -.051$ ;  $CR = -4.49$ ;  $p < .01$ ; for perceived relational benefits,  $\beta = .287$ ;  $CR = 11.16$ ;  $p < .01$ ; for stages of change,  $\beta = .062$ ;  $CR = 4.02$ ;  $p < .01$ ). There was a significant improvement in the fit of the model (increase in the  $R^2$  with the inclusion of stages of change ( $F = 16.2$ ;  $df = 2,725$ ;  $p < .01$ )). Figure 18 contains this model.

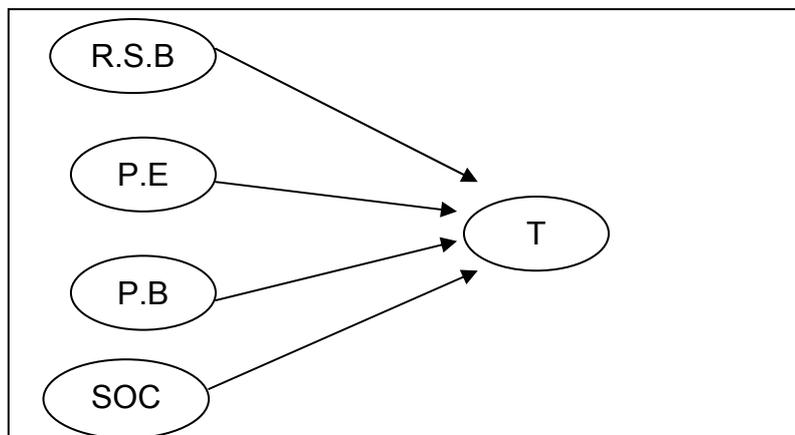


Figure 18: Trust regressed onto perceived relational benefits, relationship selling behaviors, perceived expertise and Stages of Change construct

Based on my hypothesized model, I added stages of change as a moderator of the relationships between perceived expertise, relationship selling behavior, and perceived relational benefits. (Fig. 19). I mean centered the predictor variables to decrease the collinearity among these variables (Jaccard and Turrisi 2003).

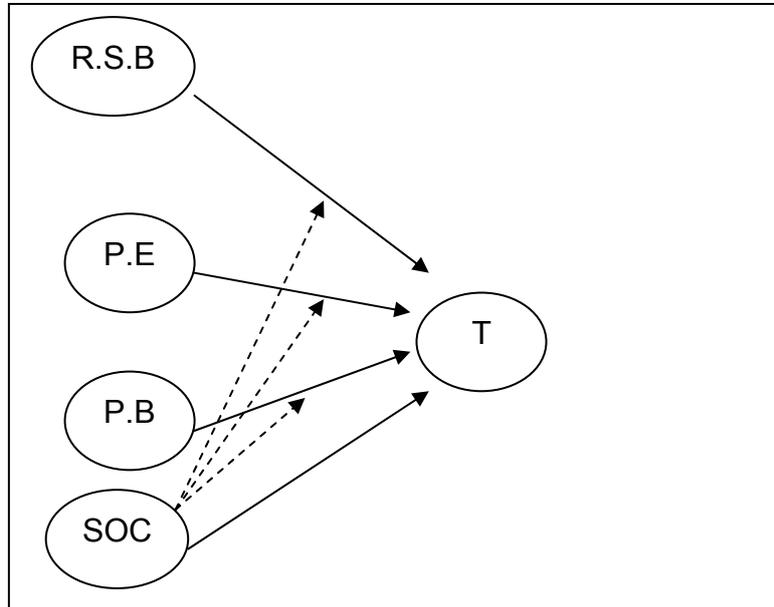


Figure 19: The stages of change construct as a moderator

I created interaction terms between the Stages of Change and the three predictor variables. The overall model was significant ( $R^2 = .474$ ) and the full model provided a significantly better fit to the observations than the reduced model ( $F = 4.58$ ;  $df = 3,722$ ;  $p < .01$ ).

Each of the main constructs remained significantly related to trust (for perceived expertise,  $\beta = .143$ ;  $CR = 4.243$ ;  $p < .01$ ; for relationship selling behavior,  $\beta = -.063$ ;  $CR = -3.18$ ;  $p < .01$ ; for perceived relational benefits,  $\beta = .418$ ;  $CR = 9.48$ ;  $p < .01$ ; for stages of change,  $\beta = .061$ ;  $CR = 4.02$ ;  $p < .01$ ). Stages of Change significantly moderated the relationship between perceived relational benefits and trust ( $\beta = -.086$ ;  $CR = -3.68$ ;  $p < .01$ ). Stages of Changes also moderated perceived expertise in the expected direction, although this effect only approached significance ( $\beta = .027$ ;  $CR = 1.44$ ;  $p < .15$ ).

I further analyzed the affect of Stages of Change on the perceived relational benefits – trust and perceived expertise – trust relationship. For the relationship between perceived relational benefits and trust, precontemplative respondents had a slope of .33; contemplative respondents, .25; action-staged respondents, .16; and respondents in the maintenance stage, .075. As an individual progresses through the Stages of Change, the relationship between perceived relational benefits and trust become weaker; that is, I expect a greater change in trust when perceived relational benefits change for precontemplative respondents and very little change in trust when perceived relational benefits change for maintenance respondents.

For the perceived expertise – trust relationship, respondents who were in the precontemplative stage had a slope of .17, for the contemplative group, the slope was .197, for the action group, the slope was .224; and for the maintenance group, the slope was .25. As an individual progresses through the Stages of Change, the relationship between perceived expertise and trust becomes stronger; that is, a greater change in trust is expected when perceived expertise changes for maintenance respondents and less change in trust when perceived expertise changes for precontemplative respondents.

The nature of these two interactions suggests that an intervention to move clients from an early, developmental, precontemplative stage to a more mature, maintenance phase should emphasize perceived relational benefits because of the greater change in trust that occurs for precontemplative clients compared to the change in the mature (maintenance) group. For clients in a more mature, maintenance stage, a message that emphasizes perceived expertise is likely to have more of an impact.

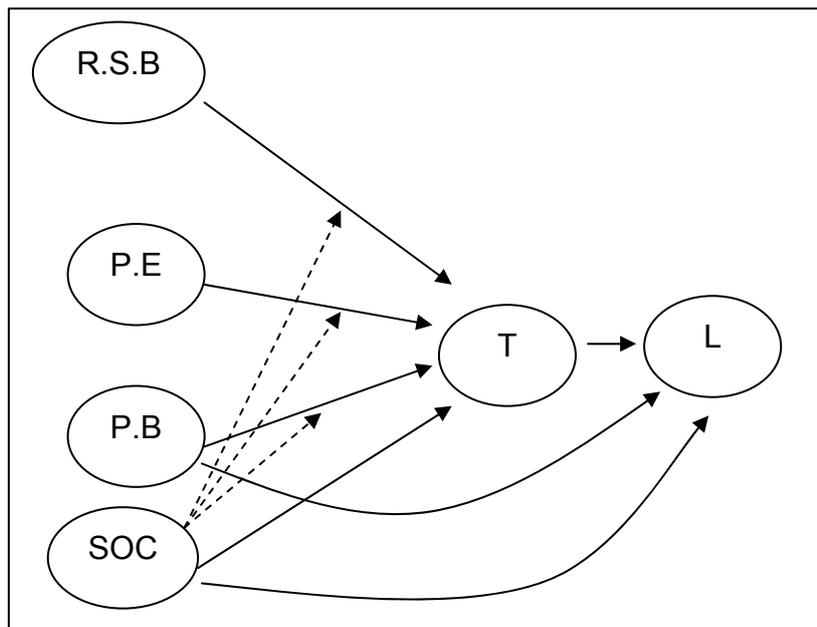


Figure 20: Trust as a mediator of intention to frequent the pharmacy in the future

I also evaluated a model that examined client intention to remain loyal to the pharmacy in the future<sup>39</sup>. In the previous model (Figure 18), Stages of Change was used as a segmentation construct to evaluate the dynamic nature of the relationship and to

<sup>39</sup> We included all the respondents in the analysis rather than use a cross-validation strategy to decrease the standard error associated with the parameter estimates and to provide a more accurate estimate of these parameters.

determine whether different intervention strategies would be useful for respondents at a different stages in their relationships. In this last model (figure 20) I also included loyalty (the intention to remain loyal to the pharmacy) as an outcome variable and trust as a mediator. I found that the model provides good fit for the data (Chi-square=1.223; df=4; p=.874)<sup>40</sup>

Each of the main constructs remained significantly related to trust (for perceived expertise,  $\beta = .144$ ; CR = 4.239;  $p < .01$ ; for relationship selling behavior,  $\beta = -.064$ ; CR = -3.11;  $p < .01$ ; for perceived relational benefits,  $\beta = .418$ ; CR = 9.44;  $p < .01$ ; for stages of change,  $\beta = .061$ ; CR = 4.02;  $p < .01$ ). Stages of Change significantly moderated the relationship between perceived relational benefits and trust ( $\beta = -.086$ ; CR = -3.67;  $p < .01$ ). Stages of Change also moderated perceived expertise in the expected direction, although this effect only approached significance ( $\beta = .027$ ; CR = 1.44;  $p < .15$ ).

Trust is significantly related to the intention to remain loyal to the pharmacy in the future ( $\beta = .035$ ; CR = 1.95;  $p < .05$ ), as is for perceived relational benefits ( $\beta = .042$ ; CR = 3.37;  $p < .01$ ) and for stages of change ( $\beta = .213$ ; CR = 28.399;  $p < .01$ ).

Based on my analysis of the models in Figures 17 – 20, I find support for the hypothesis that perceived relational benefits, relationship selling behaviors, and perceived expertise are predictors of trust. I also find that Stages of Change is a significant predictor of trust and that Stages of Change moderates the relationship between perceived relational benefits and trust. Specifically, respondents in an early stage of a relationship are more likely to be influenced by a message that focuses on the relationship. I also found a tendency for respondents in a more mature stage of the relationship to be more likely influenced by the pharmacist's expertise.

My analysis of the model that included loyalty as an outcome measure found that trust, perceived expertise, Stages of Change, and perceived relational benefits were significant predictors of loyalty (as the intention to frequent the pharmacy in the future) and that perceived relational benefits, relationship selling behaviors, and perceived expertise were all significant predictors of trust. Given the findings from the analyses of these models predicting trust and loyalty, I focused on two factors influencing subsequent client loyalty: perceived relational benefits and perceived expertise. My hypothesis was that clients in an early stage of the relationship would be more influenced by a message that emphasized perceived relational benefits and that clients in a more mature stage of the

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<sup>40</sup> We also evaluated this model using a Bayesian estimation procedure in AMOS 7.0 which allows us to examine an ordered categorical endogenous variable such as yes/no without making the same distribution assumptions found in MLE or OLS estimation procedure. Both the model fit and the parameter estimates were the same using both the traditional and Bayesian estimation procedure. We will report the traditional estimation for simplicity.

relationship would be more influenced by a message that emphasized perceived expertise.

## **Chapter 6: Methodology Phase 3: building an intervention study**

### **Introduction**

In the analyses of the models in Phase 2, I found that perceived relational benefits were likely to have a more substantial impact on trust (and indirectly on loyalty) in the developmental, precontemplative stage of the relationship. I also found that there was a tendency for perceived expertise to have a greater impact on trust (and indirectly on loyalty) for the more mature, maintenance stage of the relationship. My hypothesis is that the stage appropriate message would have a more substantial impact on the client's intention to visit the pharmacy in the near future.

*H1:* Clients in the developmental (precontemplative) stage of a relationship will be more likely to revisit a pharmacy in the next three months if they receive a message that emphasizes relational benefits compared to a group that receives a message that emphasizes the expertise of the pharmacist or a control group that does not receive any messages.

*H2:* Clients in the mature (maintenance) stage of the relationship will be more likely to revisit a pharmacy in the next three months if they receive a message that emphasizes the expertise of the pharmacist rather than a message that emphasized relational benefits or a control group that does not receive any messages.

The chapter that follows contains a description of the methodology, a description of the intervention, and an evaluation of the impact of the intervention.

### **6.1 The selection of the sample**

Nine pharmacies were chosen for this phase of the study: three for the intervention that focused on relational benefits, three for the intervention that focused on expertise, and three did not receive an intervention.

#### **6.2.1 Structure of the Intervention Study**

**Control Group.** The control group represents the current situation of pharmacies in Tessin. Clients of the control group received the usual service in the pharmacy, and after having purchased the products they needed, were interviewed outside the pharmacy about the information they received from the pharmacist and their relationship with the

pharmacist. Clients of the control group answered the same questionnaire presented to the clients in either intervention group.

**Relational Benefits Intervention.** This intervention focused on the relational benefits for clients in engaging in a relationship with pharmacists. I developed a flyer which contained a list of the functions of the pharmacist as a primary health care provider. It explained his role, his duties, tasks in the health care system, and how he can help his clients.

Throughout the flyer, I intended to make the patients aware of the importance of the pharmacist for their health, his responsibilities, and how the clients can turn to the pharmacist. The leaflet was prepared based on the evidenced collected in the first phase of the study, and was edited with the support and collaboration of some Tessin pharmacists<sup>41</sup>.

The pharmacists who took part in this intervention gave the flyer to their clients, after the purchase by the patient or in the course of counseling the client. After handing the flyer to the client, the pharmacist provided a brief explanation of the contents and invited the client to start making use of the pharmacy as a part of the health care system.

**Expertise Intervention.** This intervention focused on the expertise of pharmacist. In particular, I asked pharmacists to offer counseling in specific health topics after the clients complete their purchase. I prepared leaflets offered by Mepha concerning different health topics:

- arthritis
- cholesterol
- diabetes
- pains in general
- generic drugs
- hypertension
- back pain

The pharmacists were expected to take the characteristics of the patient into consideration in offering them specific health advice on one of those topics. After having advised them, the pharmacists handed the clients a leaflet. In each pharmacy that

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<sup>41</sup> Go to Appendix 5 to see the leaflet.

participated in the intervention, a poster was present at the counter to explain the initiative and this new activity of the pharmacist<sup>42</sup>.

I conducted a pretest to determine whether clients perceived the intervention as emphasizing perceived relational benefits or perceived expertise. I presented the flyer to 30 clients and asked them to evaluate the flyers using a five-point strongly-agree-strongly disagree scale for the following questions:

- My pharmacist is knowledgeable about many different ailments (e.g., diabetes, hypertension, and cholesterol).
- My pharmacist is able to offer me advice on both the prevention and treatment of my ailments.
- My pharmacist is an expert in the area of general healthcare.
- My pharmacist cares about me and my health as evidenced by the fact that I can contact him any time with questions regarding my health.
- My pharmacist wants to know me well in order to provide good healthcare.
- My relationship with the pharmacist is important because he can inform me of the correct ways to take medicine and the relevant side effects.

I collected data from 30 pharmacy clients and asked them to evaluate the relationally-oriented and expertise-oriented messages. Fifteen respondents received the relational message, and fifteen received the expertise message. The first three questions were intended to measure the expertise of the pharmacist. I created a composite measure by summing these three scales. Cronbach's  $\alpha$  was .74. The second set comprised of three questions was intended to measure a relationship focus. Cronbach's  $\alpha$  was .83.

I then conducted a simple t-test to determine whether the flyers were perceived as reflecting the expertise of the pharmacist. I found that the expertise message was perceived as reflecting significantly greater pharmacist expertise than the relationally-oriented message ( $t = 2.20$ ;  $df = 28$ ;  $p < .05$ ;  $\bar{x} = 3.78$  and  $3.12$  for the expertise and relational message, respectively). There was no significant difference between the two messages in its relational orientation; that is, both messages were perceived as similar in their relational content. This result is not surprising because both messages included content about the pharmacist - client relationship. The messages differed only in the level of pharmacist expertise communicated to the client.

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<sup>42</sup> Go to Appendix 6 to see the poster.

## 6.2.2 Methods and procedures

The analysis of the second phase of this project identified factors that are relevant to two market segments that usually visit Tessin pharmacies: clients in the mature (maintenance) stage of a relationship (i.e., visited a particular pharmacy more than three times over a three month period) and clients in the developmental (precontemplative) stage of the relationship (i.e., visited a particular pharmacy less than three times over a three month period). I applied the frequency measure as a proxy for the Stage of Change for three reasons: 1) Stage of Change and frequency of visiting a pharmacy were significantly correlated ( $r = .303$ ,  $df = 730$ ;  $p < .001$ )<sup>43</sup>; 2) the median value for the frequency measure was 3 visits per month, and 3) interviews with the pharmacists suggested that more than three visits reflected a loyal client (or one which was in a “mature” relationship with the pharmacist).

The purpose of the third phase of the project was to understand if health communication and information offered by the pharmacists and targeted at the relationship level of the clients produces effective changes in clients, in terms of relationship development and maintenance in the future.

### 6.2.2.1 Experimental Design

I constructed a message (relational benefits, expertise, no message), by relationship stage (developmental/precontemplative; mature/maintenance)<sup>44</sup> design. I aggregated the information from each of the three pharmacies within each of the three message conditions.

The pharmacists were asked to randomly distribute a leaflet to 25 clients: 15 to clients who had visited the pharmacy more than three times during the prior three months, and to 10 clients who had visited the pharmacy three or fewer times during the prior three months. I collected information from approximately 75 respondents in each intervention (25 per pharmacy x 3 pharmacies per intervention). The control (no information) group was composed of three pharmacies and a total sample of 75 clients. I selected three pharmacies similar in location to the pharmacies included in the intervention study.

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<sup>43</sup> The health status of the client is not related to the frequency of visiting a pharmacist ( $r = -.072$ , ns).

<sup>44</sup> We reduced the four stages in the SOC model to two stages (pre-action – precontemplative and contemplative and action (action and maintenance) to evaluate the impact of the intervention in motivating the client to become more loyal to the pharmacist.

I expect that people who received any information will be more likely to return to the pharmacy compared with the control group. I also expect that stage-appropriate messages are more likely to lead to a greater likelihood of return to the pharmacy.

In the next paragraph I will introduce the questionnaire that was presented to the clients at the end of the intervention study.

### **6.2.3 Collection of data**

At the end of the four-month intervention study, I called the clients that received the intervention in order to administer a survey about their experiences in receiving the targeted health information services.

The questionnaire given to the clients in the control group was similar to the one used for clients in the intervention groups. The only difference between the questionnaires used in the experimental and control groups was the absence of questions associated with the intervention for respondents in the control group. In both cases, I asked clients to answer the questions referring to the informational services the pharmacists provide them<sup>45</sup>.

#### **6.2.3.1 Measures**

##### *Preliminary questions*

*Frequency of going to the pharmacy* was assessed by asking clients how often they had visited the pharmacy during the prior three months. This time frame was suggested by the pharmacists involved in the preliminary interviews. The question was as follows:

(b) How many times in the last **3 months** have you been visiting this specific pharmacy?

The individuals were then placed in the following categories: *1-2*, *2-3*, *3-4*, *4-5*, and finally *more than 5*.

##### *Pharmacist – patient relationship constructs*

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<sup>45</sup> In the case of clients in the intervention study, we explicitly ask them to answer considering what they received the day when pharmacists gave them specific information and leaved them some material.

*Perceived expertise* was measured using the same scales and items adopted in the first phase questionnaire<sup>46</sup>. The items used were as follows:

- (1) The staff of the pharmacy<sup>47</sup> provides me with information about potential side effects that my medication may cause (Worley and Schommer 1999).
- (2) The staff of the pharmacy is able to explain to me how to take medication correctly (Worley & Schommer 1999).
- (3) The staff of the pharmacy is open to listening to and discussing with me my health related concerns.
- (4) When I suffer from a minor ailment – e.g. head ache, cold, stomach ache, skin disorders, etc. – the staff of the pharmacy helps me and provides me with health preventive measures and useful advice to stay healthy (Smith et al. 1990 - readapted).
- (5) The staff of the pharmacy is able to answer all of my medication *and health related questions* (Worley and Schommer 1990 – readapted).
- (6) The staff of the pharmacy is a source that I use and I appreciate *in acquiring information about the cure of my health* (Worley and Schommer 1999 – readapted).

A 5-point Likert scale was used to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree)<sup>48</sup>.

*Relationship selling behavior* was also assessed in the second questionnaire. I decided to include a shorter version of this composite construct based on a scale developed based on the analyses presented in the previous chapter.

The items were asked as follows:

- (1) The majority of times that I visit my pharmacy, I have a conversation with somebody of the staff (*Contact intensity*).
- (2) If I was not satisfied with the service received, I communicate this to the staff of the pharmacy. (*Mutual disclosure*).

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<sup>46</sup> The only difference is in item number 4. For this item, we developed the expression “health disease preventive measures”, to capture the most important information the pharmacist offers. An example should indeed help clients to remember what the pharmacist told them.

<sup>47</sup> The entire questionnaire was built asking to clients about their relationship with the staff of the pharmacy because usually there are more pharmacists and more assistants at the desk.

<sup>48</sup> Also if a Likert scale is strictly speaking an ordinal scale, I follow in many works the stream of research that considers it as an interval scale.

- (3) Often someone of the staff and I share information about family related events and my personal life (*Mutual disclosure*).

A 5-point Likert scale was used to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Relationship provider behavior* is a new construct I created to assess the clients' perception regarding the pharmacists' skills and ability in respect to their role as primary health care providers. The items were formulated by taking into consideration the most important skills the pharmacist needs to have as a primary health care provider when dealing with clients.

The items were formulated as follows:

- (1) I think of my pharmacist as my collaborator in maintaining my health.
- (2) I view my pharmacist as more than just a seller of pills.
- (3) I feel free to ask everything I need to know about my medications and my health.

A 5-point Likert scale was used to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Trust* was assessed using the following items (based on the scale development analyses conducted earlier)<sup>49</sup>

- (1) Confident
- (2) Competent
- (3) Honest

A 5-point Likert scale was used to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Commitment* was assessed in this second questionnaire using three items suggested by Worley and Schommer (1999). I consider the construct adopted by Henning-Thurau *et al.* (2002) significant for my aims. According to the authors, commitment can be described as the customer's long term orientation toward the pharmacist relationship that is grounded on both emotional bonds and the customer's conviction that remaining in the relationship will yield higher benefits than terminating it (2002: 232).

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<sup>49</sup> In this case we decided to include the items selected after the interaction analysis in the first study.

According to the authors (2002: 244), commitment<sup>50</sup> was operationalized as follows:

- (1) My relationship to this specific service provider is something that I am very committed to.
- (2) My relationship to this specific service provider is very important to me and to my health.
- (3) My relationship to this specific service provider is something I really care about.

A 5-point Likert scale was used to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Word of Mouth* was measured by simply asking people if they have suggested the pharmacy to someone else using a yes/no scale.

- (1) Did you ever suggest this pharmacy to someone else?

#### *Evaluation of the intervention*<sup>51</sup>

In this section I will present all the variables I intend to test in order to understand the effectiveness of the intervention.

*Memory / Awareness* items regard the ability of clients to remember if the pharmacists advised them, offered them counseling the day they received the intervention, and their memory of the topic.

Memory / awareness were operationalized as follows:

- (1) Did you ever suggest this pharmacy to someone else?  
- If YES, do you remember what kind of information you gave?

*Satisfaction* was assessed not only with respect to the pharmacist and his job, but also with respect to the information received. We used Grunig (1990) and Worley and

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<sup>50</sup> Commitment included also two extra questions, useful and interesting for pharmacists but that we did not use for our analysis. The questions were:

- (1) Do you usually visit other pharmacies?  
- If YES, why? .....

<sup>51</sup> (Targeted health communication for people treated, usual service for people in the control group).

Schommer (1999) as a guide to develop this construct. The items were readapted and reduced as follows:

- (1) I am happy with the health information I received (Grunig 1990 - readapted).
- (2) I am grateful for the personalized attention the staff of the pharmacy offered me (Worley & Schommer 1999).
- (3) I am happy with the staff of this pharmacy (Grunig 1990 - readapted).

A 5-point Likert scale was used to assess clients' evaluations. (1= totally disagree, 2= disagree, 3= do not know/no answer, 4= agree, 5= totally agree).

*Value of the information* assessed the client's ability to recognize the benefits associated with the services received and to recognize their value pertaining to his personal situation. To measure value, I referred to the operationalization offered by Sirdeshmukh et al. (2002).

Value was assessed as follows:

- (1) How would you evaluate the information you received in a scale from 1 to 5?
- (2) Would you change anything in terms of the information you received?  
- If YES, what?

For question (1), I used a 5-point Likert scale to assess clients' evaluations. (1= not at all valuable, 2= not valuable, 3= do not know/no answer, 4= valuable, 5= extremely valuable).

*General Health Literacy* is intended to assess whether the clients, after counseling by the pharmacist, consider themselves more informed about some specific topic. The construct of General Health Literacy was created by defining health literacy as: "*The capacity of individuals to obtain, process, and understand the basic health information and services needed to make appropriate health decisions*" (Selden et al., 2000). Beyond that, I also included a series of questions related to the intention of the clients to turn to the pharmacist in the future to ask about the information he/she heard in the intervention/control group.

General Health Literacy was operationalized as follows:

- (1) How much more knowledgeable do you feel about maintaining your health?
- (2) How much more knowledgeable do you feel about preventing diseases?
- (3) Do you feel more informed about the topic you heard about?

For questions (1), (2) and (3), a 5-point Likert scale was used to assess clients' evaluations. (1= not at all, 2= a little, 3= moderately, 4= enough, 5= extremely).

- (4) Did you tell someone else what the pharmacist told you during counseling?
- (5) Would you be willing to speak with the staff about your diseases and your health?
- (6) Is the first time that you heard the staff speak about this?

For all questions, a yes/no scale was adopted.

*Function of the pharmacist* is a specific section that referred to the purpose of the pharmacist as explained in the flyer on relational benefits. I intend to understand whether clients who received the intervention are able to remember all the skills of the pharmacists as primary health care provider. To measure this ability I prepared a check list as follows:

- a) Selling of medicines
- b) Counseling about physiology and side effects
- c) Counseling about minor diseases
- d) Provision of health information
- e) Provision of information about lifestyle, nutrition, etc.
- f) Selling of cosmetics
- g) Other.....

The interviewer asked the client: "*According to you, which are the most important functions of the pharmacist?*" and recorded the client's response.

*Advanced Health Literacy* was created to capture what the clients learned, to whom they felt they could turn for information on specific diseases, and if they viewed the pharmacist as a person who provides information about specific diseases.

Advanced Health Literacy was operationalized as follows:

- (1) If you or one of your relatives had a minor disease – for example, a head ache, stomach ache, cold, fever, skin ailments, etc - how likely is it that you turn to the pharmacist instead of a doctor?
- (2) When you want to obtain information related to health – for example, about diabetes, cholesterol, hypertension, back pain - how likely is it that you turn to the pharmacist instead of a doctor?

- (3) To maintain good health status, and to find information about life style, nutrition, and physical activities, how likely is that you turn to the pharmacist instead of a doctor?
- (4) If you want to know how to prevent minor diseases, how likely is it that you turn to the pharmacist instead of a doctor?

For questions (1), (2), and (3), a 5-point Likert scale was used to assess clients' evaluations. (1= not at all likely, 2= a little likely, 3= moderately likely, 4= enough likely, 5= extremely likely).

The *Stages of Change Construct* was applied to the clients' future use of pharmacy services and health information. This measure was useful in understanding how Tessin clients are prepared to use health care services and information provided by the staff of the pharmacy.

*Stages of Change* was assessed using the staging algorithm in the literature and has been found to be reliable across a range of behaviors (Prochaska et al. 2002). In regards to the readiness of using a pharmacy's services and health information, clients had to answer yes or no at to following questions:

- (1) Have you tried to improve the quality of your health status by looking for services and communication addressing prevention in pharmacies for more than three months?
- (2) In the past month, have you active looked for services and information regarding the status of your health in the pharmacy?
- (3) Are you seriously considering looking for information in the pharmacy in the next three months about preserving your health status?

Our key outcome variable in evaluating the effectiveness of the intervention was whether the client would be willing to return to the pharmacy during the next three months.

- (1) Are you seriously considering remaining loyal to this specific pharmacy in the next three months?

*Demographic information* was limited to factors that allow us to characterized the sample. The items were as follows:

- (1) Age
- (2) Gender
- (3) Marital status
- (4) Last degree

- (5) Place where you live<sup>52</sup>
- (6) Pharmacy where the interview is taking place

### **6.3 Method of analysis**

I will focus the analyses on assessing whether the intervention was effective in increasing the likelihood of the client returning to the pharmacy. My initial analysis was a 3 (message) by 2 (relationship stage), between subjects ANOVA. I focused on the willingness to return to the pharmacy as the key outcome variable.

I conducted a subsequent analysis in which I focused on the stage match/mismatch message and stage of the relationship. I then included some of the constructs evaluated in the third phase as covariates in order to hold constant possible differences among the groups in the levels of trust, perceived expertise, and relationship selling behaviors.

I then conducted a final analysis treating General health literacy as additional covariates.

#### **6.3.1 Analyses including no message - control group**

I conducted a 3 (relational message, expertise message, no message) x 2 (developing relationship, mature relationship) between subjects ANOVA. The outcome measure was whether the client would return to the pharmacist in the next three months (1 = yes, they would return, 2 = no, they would not return). I found the stage of the relationship to be significantly related to the likelihood of returning to the pharmacist ( $F = 26$ ;  $df = 1,179$ );  $p < .01$ ;  $\bar{x} = 1.28$  and  $1.03$  for developing and mature relationships) There was also a significant interaction between the treatment and the stage of the relationship ( $F = 2.92$ ;  $df = 2,179$ ;  $p < .056$ ). Figure 21 contains a plot of this interaction.

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<sup>52</sup> For people that live in Lugano we asked to specify the blocks where they live.

### Plot of Relationship Stage x Intervention Interaction

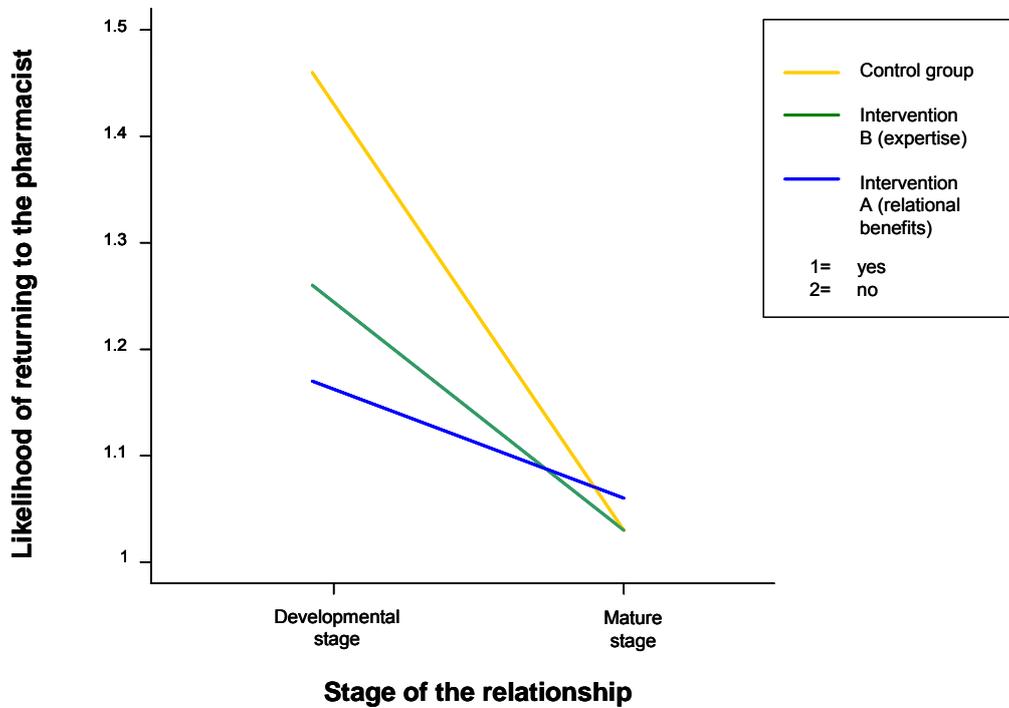


Figure 21: Plot of Relationship stage x intervention Interaction

For mature relationships, the type of message did not influence whether the client would return to the pharmacist. All mature clients were highly likely to return to the pharmacist. For developing relationships, however, the differences among the group showed the following tendency: clients who received no message were less likely to return to the pharmacist than the clients that received the matched message ( $F= 2.761$ ;  $df= 2$ ;  $p < .070 = .85$  for matched message and  $.57$  for control group).

#### 6.3.2 Analyses of Stage-Appropriate Messages

I included only those respondents who had any recall that they had received information from the pharmacist. I conducted a 2 (message) x 2 (stage of the relationship) between subjects ANOVA and focused on the likelihood that the person would return to the pharmacy in the next three months. There was a significant effect of stage of the relationship ( $F = 11.89$ ;  $df = 1,95$ ;  $p < .01$ ;  $\bar{x} = 1.23$  and  $1.02$  for developing and mature relationships). The main effect of message was not significant, nor was the interaction relationship by message interaction.

I then refined this analysis by holding constant any potential differences in the respondents based on the constructs identified in Phase 2 as the key determinants of trust and loyalty. I treated perceived expertise, relationship selling behaviors, and trust as covariates in a 2 (message) x 2 (stage of the relationship) between subjects ANOVA. The main effect of stage of the relationship remained significant ( $F = 11.2$ ;  $df = 1,87$ ;  $p < .01$ ).

I then refined this analysis further by holding constant general health literacy (see page 104 for a description of these measures) by treating these variables as additional covariates in the 2 x 2 between subjects ANOVA. The main effect of stage of the relationship remains significant ( $F = 8.22$   $df = 1,81$ ;  $p < .01$ ;  $\bar{x} = 1.22$  and 1.04 for developing and mature relationships). The interaction between message and stage of the relationship was significant. ( $F = 3.94$ ;  $df = 1,81$ ;  $p < .01$ ). Figure 22 contains the nature of this interaction.

### Plot of Relationship Stage x Intervention Interaction

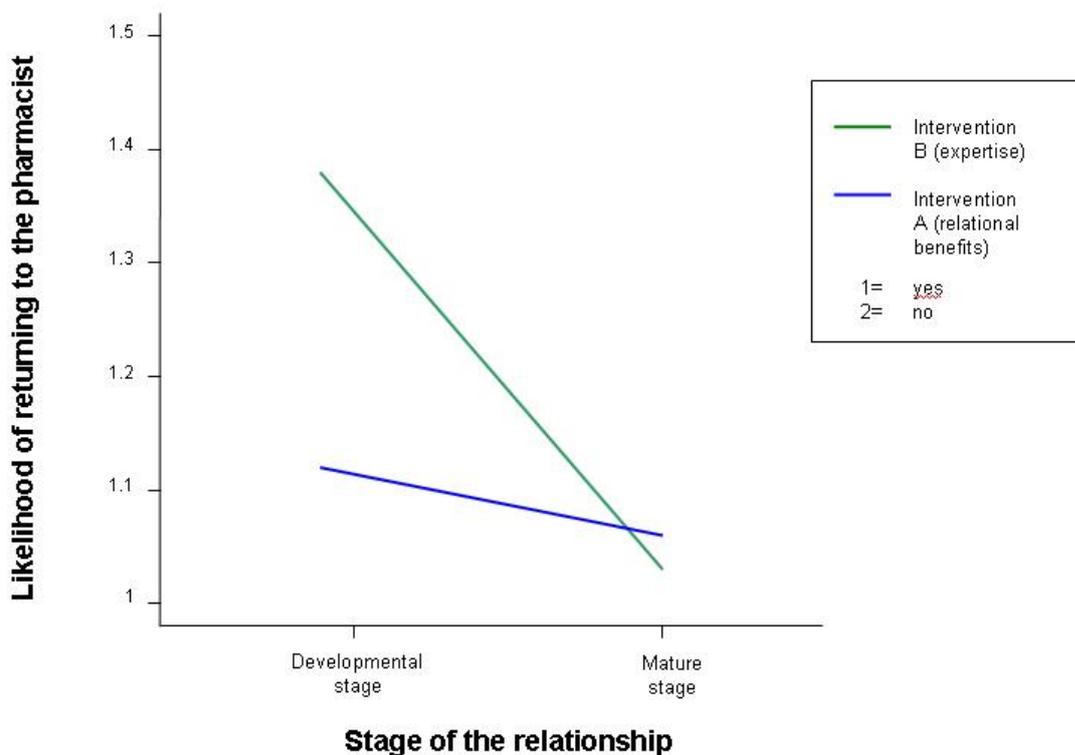


Figure 22: Plot of relationship stage x intervention interaction

The pattern of this interaction is consistent with the impact of the hypothesized stage-appropriate messages. Pharmacy clients who were in the developmental stage of a relationship and who received the relationally-oriented message were more likely to return to the pharmacy than clients who received the expertise message. When clients were in the mature stage of a relationship, they were very likely to return to the pharmacy and there were no differences in the impact of the type of message on the likelihood of returning to the pharmacy.

### **6.3.3 Additional Outcome Measures**

I examined additional outcome variables to determine whether the stage of the relationship or the type of message influenced these measures. None of the health literacy measures (see pg. 104-105 for a description of these measures) were significantly affected by the stage of the relationship or the type of message. These independent variables also did not influence whether the client would discuss the pharmacist with their friends.

## **Conclusion**

### **Discussion**

How does one develop and maintain a relationship between the pharmacist and the client?

In the last few years, research in the pharmacy context has been focused on strategies to develop and maintain a relationship between the pharmacist and the client. In particular, by examining the experience of health professionals in other fields, it has been asserted that a trusting relationship with a health professional can contribute to the enhancement of patient health outcomes and quality of life in the long-run. This is relevant and promising in the context of pharmacist – client relationship.

The change in the focus of the pharmacist's profession, from a product-oriented approach to a more patient oriented approach, has also created an interest around the development and maintenance of the pharmacist – client relationship.

Numerous difficulties and barriers (time, space, education, and financial reasons) exist for the pharmacist in approaching the client and interacting with him to better understand his needs and to provide proper feedback. Furthermore, even if the pharmacist is an expert in the provision of health care services and advises the client in the recommended way, the advice will be ineffective if the client is not ready and willing to accept and to interact with the pharmacist. The acceptance of the message depends on the level of trust and loyalty the client has to the pharmacist. In other words, message acceptance depends on the stage of their relationship, (e.g. developmental stage of the relationship / maintenance stage of the relationship).

The original idea behind my dissertation arises from this point: a long-term relationship between a healthcare provider and a client can help the healthcare provider to approach the client effectively in order to offer counsel and address his informational needs.

The relationship marketing literature does not contain, however, recommendations and indications on strategies which can help the pharmacist to develop and maintain a relationship with his clients, particularly given that the pharmacist - client relationship is likely to be in different stages.

I hypothesized that targeting health information according to the level of the relationship with the clients (adopting the Stages of Change Model) can produce the necessary loyalty in the client to commit to the pharmacist. In the long run, this will enhance the

acceptance and the effectiveness of the health care message and hence could help the pharmacist to be more effective in the provision of his services.

In summary, the pharmacist has to know which strategies to use keep the client loyal in the different stages of a relationship (developmental / maintenance), and to facilitate his provision of healthcare services.

In my dissertation I have proposed the integration of the Stages of Change Model with the models currently in use to describe relationship development and maintenance in the pharmacy context and in the relationship marketing field.

In Phase 2, two models of relationship development were tested: a static and a dynamic one (the first without the moderation of SOC, the second including the moderation of SOC). Trust is influenced by the perceived expertise of the pharmacist, relationship selling behaviors, and perceived direct relational benefits. The Stages of Change model moderated the relationship between perceived relational benefits and trust, and approached significance in moderating the relationship between perceived expertise and trust.

This moderated relationship influences the way an intervention to increase client loyalty should be structured. Specifically, the message should be tailored depending on the stage of the relationship. I expected that targeting health messages according to the level of client relationship (developmental stage/maintenance stage) and building the messages focusing on the variables more influential in the particular relationship stage would bring about a more “loyal client” in the future.

Results in the intervention study show that for people in the developmental stage, a targeted message which focused on relational benefits was more effective than either no message or a stage mismatched message.

These results tell us that if the pharmacist tailors health messages at the relationship level of the client, this will help him in approaching the client and in creating a more loyal client in the future. The intention to remain loyal to a pharmacy is a prerequisite for the growth of the relationship, an important component for a more responsible provision of health care services by the pharmacist, and a important for proper acceptance by the client. This is especially true for clients who are in a developmental stage of the relationship, as clients in the maintenance stage are already committed and loyal to the pharmacist.

Before offering specific information, the pharmacist has to present the client with the benefits of treating and dealing with the pharmacist as a healthcare provider. This means that the pharmacist, before offering detailed healthcare services, should first understand the client before acting as a primary source of personalized health information.

### **Practical implications**

It is possible to identify some practice implications from the research for the pharmacists' profession, particularly about how they can approach and interact with clients that are still in developmental stage of the relationship with the pharmacist. The intervention shows that the targeted health messages for people in the developmental stage help the clients to increase their intention to frequent the pharmacy in the future.

Based on those results, I recommend to pharmacists that deal with clients in the developmental stage to:

- present themselves, their duties and functions,
- make the client aware of the source he has to answer his health informational needs.

In line with my intervention, this could be done by using a flyer, for example (See Appendix 5). The pharmacist has to offer it to the client, after a purchase or a question the client poses. The presentation of the pharmacy and the pharmacist as credible sources for medicine, counselling and information will help the client to know who to ask about preventive health information.

For clients in the maintenance phase, the effectiveness of a message that focused on the pharmacists' expertise and the benefits of the relationship did not differ in effectiveness. This suggests that when the client is loyal, minimal information is needed to reinforce the relationship. I, in part, expected this result because people in the maintenance stage of the relationship are already committed to the relationship and are already loyal. Further research should be conducted focusing on this segment and on their capability to turn to the pharmacist as a primary health care provider.

### **Theoretical implications**

According to the results of our research, the integration of Stages of Change provided insights into the content of a tailored message. This dynamic model gives us useful

information in preparing an effective intervention to increase the intention of frequenting the pharmacy in the future.

I think that this model helps in considering the dynamic side of the relationship, capturing the relationship development as an ongoing series of change processes. For these reasons, the integration of this model with more static models of relationships will provide insights into the dynamics of relationship development and maintenance, where a relationship between a service provider and a client exists, and where a clear differentiation among clients and among groups exist that cannot be totally explained by other types of segmentation.

Nevertheless, the application of this model has some limitations which will be underlined in the next paragraph.

### **Limits of the research**

I focused solely on the application of models from the relationship marketing literature in examining ways to enhance the pharmacist – client relationship. I recognize that models developed in other disciplines may provide additional insights into ways to enhance this relationship, and I suggest that future research efforts examine these other models in the context of the pharmacist – client relationship.

In this thesis, I intended to test the effectiveness of targeted health messages to increase a client's loyalty to the pharmacist. I measured the "intention to remain loyal" rather than a more direct measure of loyalty because of the need to apply a longitudinal design, yielding a more accurate assessment of loyalty. One direction for future research is to conduct a longitudinal study to look at the implications of my intervention in the long run.

Beyond loyalty, it would be interesting to test if an improvement in the intention to frequent the pharmacy in the future is related to an improvement in the health literacy level of the clients, particularly whether the client will turn to the pharmacist for specific health information. I anticipate that issues affecting health literacy are more likely to be found in a longitudinal study because it is difficult to obtain a change in the health literacy level of clients using a single, simple, one-time intervention.

In Phase 3, I conducted an intervention with three groups: control group, people in the maintenance stage and people in the developmental stage. The process to collect the information necessary to re-contact the client occurred at the end of the client visit and was difficult for the pharmacists because they had to ask the client private information.

In the intervention of Phase 3, the pharmacist was the key actor that offered the targeted health information. The quality of my intervention was influenced by the expertise and ethics of pharmacists that agreed to collaborate with us. They were recognized from the Order of Tessin Pharmacists to be professional and well-trained in counselling clients. I know that the success of the intervention built depends also on the expertise and the peculiar characteristics of pharmacists that have to deliver the health information.

### **Future research**

In the thesis I conducted an exploration and in-depth analysis of how the pharmacist may develop a trusting relationship with his clients, how to maintain the relationship over time, how to make this relationship grows, how to become more familiar with the client, and how to be more patient oriented in the health care services and information provision.

I suggested some useful strategies and communication initiatives that increase the probability that a new client or a client in a developmental stage of a relationship will remain loyal in the future (through next three months) to the pharmacist.

Throughout the thesis I tried to build a framework for motivating people to move from an early developmental stage of a relationship to a more committed (maintenance) stage of a relationship, and for maintaining a long-run, committed relationship for people that already are in the maintenance stage of the relationship.

The results of Phase 3 suggest that targeting health messages to the relationship level of the client is effective for the achievement of the basic conditions for loyalty in the future (intention to frequent the pharmacy in the future).

Future research should focus on longitudinal studies where testing the framework examines intention to frequent the pharmacy.

Second, if those longitudinal studies confirm the findings and suggest that an integrated framework of the pharmacist – client relationship with the Stages of Change Model better explains relationship development and maintenance, I strongly recommend more work on the study of the relationship between loyalty and improvement of the health literacy level of the clients.

Given the limited amount of time spent on collecting data and to conducting interviews, it was impossible for me to determine improvement in the health literacy aspect of my thesis. Future research should also consider the inclusion and analysis of different variables that play a role in the framework of relationship development, including other fields of research and models within other contexts.

## **Appendix 1: Phase 1 – Preliminary interview**

- 1) According to your experience, how do you think the pharmacists' role is considered by the other components of the health care systems?
- 2) What are the legal barriers that could limit the development of a relationship with your clients?
- 3) How could you describe your role?
- 4) What do you consider to be an active collaboration between you and your clients?
- 5) In your service, do you offer health prevention counseling or provision of healthcare communication?
- 6) What are the barriers to acting as health care providers?
- 7) What services do you offer?
- 8) What are the medicines that you sell most?
- 9) What types of question about medicines do clients ask you most about? Are there differences if it is an OTC product, a prescription medicine or a natural product?
- 10) How well are clients informed about health and medicines?
- 11) Are there any differences between pharmacies in different location?
- 12) Are there restrictions about what information you provide to clients about health and medicines?
- 13) Do you have refresher courses?
- 14) How many clients that you see in your pharmacy do you consider "loyal"?

## Appendix 2: Phase 2 - Questionnaire

Yes      No

a. Is this your first visit to this pharmacy?

(If the answer is yes go directly to question numbers:

7, 8, 10, 12)

b. (If No) How many times in the last **3 months** have you been visiting this specific pharmacy?

1-2      2-3      3-4      4-5      more than 5

**1. Please evaluate the following assertions considering how the staff of the pharmacy serves you, choosing between 5 options:**

- The staff of the pharmacy provides me information about potential side effects that my medication may cause

-

Tot. Disagree      Tot. Agree

1      2      3      4      5

- The staff of the pharmacy is able to explain me how to take medications correctly

Tot. Disagree      Tot. Agree

1      2      3      4      5

- The staff of the pharmacy is open to listening to and discussing my health related concerns with me

Tot. Disagree      Tot. Agree

1      2      3      4      5

- The staff of the pharmacy advises me about health diseases preventive measures

Tot. Disagree      Tot. Agree

1      2      3      4      5

- The staff is able to answer all of my medication and health status questions

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- The staff of the pharmacy is a source that I use and appreciate in acquiring information about the cure of my health.

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

**2. Evaluate the following assertions noting if you agree or disagree, and choosing between the 5 options:**

- When I speak with anyone on the staff, I know that I am dealing with somebody that I am used to and who knows me

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I feel that I am in good hands when I go there

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I know it is going to be a satisfactory experience advance, or if something does go wrong, it will be taken care of it

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I get good services and I do not loose time by looking for another pharmacy

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I receive a preferential treatment here

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

**3. Evaluate the following assertions stating if you agree or disagree, according to the 5 options:**

- The majority of times that I visit my pharmacy, I have a conversation with somebody of the staff

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- In the past, I have expressed my liking and respect for someone on the staff as a person

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- Often, someone on the staff and I share information about family related-events and personal life

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

**4. Evaluate the following assertions stating if you agree or disagree, according to the 5 options:**

- I am happy with the staff of this pharmacy

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- A lot of people like me are satisfied with this pharmacy

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- Both the staff of the pharmacy and I benefit with the relationship we have established

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I always leave the pharmacy satisfied with the staff

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I always leave the pharmacy feeling that I received useful information about the medications I have bought

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I am grateful for the personalized attention the staff of the pharmacist offers me

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

**5. Do you consider the staff of your pharmacy:**

	Tot. Disagree				Tot. Agree
	1	2	3	4	5
- Confident	<input type="radio"/>				

	Tot. Disagree				Tot. Agree
	1	2	3	4	5
- Competent	<input type="radio"/>				

	Tot. Disagree				Tot. Agree
	1	2	3	4	5
- Honest	<input type="radio"/>				

	Tot. Disagree				Tot. Agree
	1	2	3	4	5
- Good at problem solving	<input type="radio"/>				

	Tot. Disagree				Tot. Agree
	1	2	3	4	5
- Sometimes insincere	<input type="radio"/>				



- Which are the main reasons that lead you to choose this pharmacy?

Parking

It is near where I work

It is near to my house

Prices are convenient

I like the staff

I like the store

**8. Please, answer the following questions:**

- Have you tried to improve the quality of your health status by looking for services and prevention communication in pharmacies for more than three months?

Yes    No

- In the past month, have you actively looked for services and information about the preservation of your health status in the pharmacy?

Yes    No

- Are you seriously considering looking for information concerning the preservation of your health status in pharmacy during the next three months?

Yes    No

**9. Please answer the following questions:**

- Did you prefer to go to this pharmacy, rather than other pharmacies, for more than 3 months?

Yes    No

- In the past month have you actively looked for this specific pharmacy/pharmacist?

Yes      No

- Are you seriously considering remaining loyal to this specific pharmacy in the next 3 months?

Yes      No

**10. Demographic information:**

- Age
- Gender: M / F
- Marital status
- Last degree
- Place where you live
- Pharmacy where the interview is taking place

## Appendix 3: Phase 2 – Descriptive statistics

### Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
	male	272	30.3	30.3	30.3
	female	625	69.7	69.7	100.0
	Total	897	100.0	100.0	

### Marital Status

	Frequency	Percent	Valid Percent	Cumulative Percent
missing	4	.4	.4	.4
divorced	66	7.4	7.4	7.8
married	495	55.2	55.2	63.0
separate	24	2.7	2.7	65.7
unmarried	239	26.6	26.6	92.3
widow	59	6.6	6.6	98.9
widower	10	1.1	1.1	100.0
Total	897	100.0	100.0	

### Age

Item	Mean	$\sigma^2$	skewness	kurtosis	range	min	max
Age	49.9186	17.35305	.079	-.922	81	14	95

### Typology of clients

#### Loyal clients and not loyal clients

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	733	81.7	81.7	81.7
	yes	164	18.3	18.3	100.0
	Total	897	100.0	100.0	

### Frequency

	Frequency	Percent	Valid Percent	Cumulative Percent
--	-----------	---------	---------------	--------------------

Valid	1-2	129	17.6	17.6	17.6
	2-3	157	21.4	21.4	39.0
	3-4	115	15.7	15.7	54.7
	4-5	59	8.0	8.0	62.8
	more than 5	273	37.2	37.2	100.0
	Total	733	100.0	100.0	

Item	Mean	$\sigma^2$	skewness	kurtosis
Frequency	3.259	1.5571	-.123	-1.541

### Perceived expertise

Items	Mean	$\sigma^2$	skewness	kurtosis
Side effects information	3.862	1.4330	-.961	-.494
How to assume medications	4.520	.9730	-2.273	4.623
Listen health related problems	4.512	.8709	-1.940	3.565
Advises preventive measures	3.649	1.4687	-.692	-.909
Ability to answer	4.544	.8587	-2.234	5.167
Pharmacy as a source of health care information	3.824	1.4878	-.932	-.653

### Perceived benefits

Items	Mean	$\sigma^2$	skewness	kurtosis
Familiarity with the staff	4.263	1.2911	-1.656	1.346
Feel in good hands	4.675	.7039	-2.747	8.778
Fairness of the staff	4.692	.6656	-2.594	7.804
Good services	4.707	.7032	-3.089	10.897
Special treatment	3.134	1.6400	-.178	-1.561

### Relationship selling behaviors

Items	Mean	$\sigma^2$	skewness	kurtosis
Conversation with the staff	3.503	1.6572	-.595	-1.352
Expression of liking & respect	2.542	1.7020	.415	-1.584
Confidence with staff	2.223	1.6477	.793	-1.160

### Satisfaction

Items	Mean	$\sigma^2$	skewness	kurtosis
Satisfaction with the staff	4.746	.5972	-3.009	10.962
Other clients' satisfaction	3.923	1.0832	-.541	-.493
Benefits from the relationship	4.064	1.1042	-.917	-.030
Client satisfaction	4.690	.6602	-2.683	8.607
Satisfaction with the information received	4.447	.9657	-2.001	3.735
Satisfaction with the attention by the staff	4.621	.7639	-2.400	6.283

### Trust

Items	Mean	$\sigma^2$	skewness	kurtosis
Confident	4.796	.5368	-3.371	13.890
Competent	4.791	.5373	-3.361	14.476
Honest	4.801	.5268	-3.441	15.212
Problem solving orientation	4.607	.7747	-2.483	7.292
Insincere sometimes	4.769	.7119	-3.448	12.300

## Appendix 4: Phase 3 - Questionnaire

a. Is this your first visit to this pharmacy?

(If the answer is yes go directly to questions number:  
7, 8, 10, 12)

Yes      No  
     

b. (If No) How many times in the last **3 months** have you been visiting this specific pharmacy?

1          2          3          4          5 or more then 5  
                       

**1. Think about how you were served in that pharmacy the day you left your personal data for this interview, and evaluate the following sentences about the competences of the pharmacy' staff. Choose between the 5 options below:**

- The staff of the pharmacy is able to explain me how to take medications correctly

Tot. Disagree      Tot. Agree  
1          2          3          4          5  
                       

- The staff of the pharmacy provides me with information about potential side effects that my medication may cause

-  
Tot. Disagree      Tot. Agree  
1          2          3          4          5  
                       

- The staff of the pharmacy is open to listening to me and discussing while I am explaining my health related concerns

Tot. Disagree      Tot. Agree  
1          2          3          4          5

- When I suffer from a minor ailment – e.g. head ache, cold, stomach ache, skin disorders etc. – the staff of the pharmacy helps me and provides me with health preventive measures and useful means to stay better

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

- The staff is able to answer to all of my questions about these minor ailments

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

- The staff of the pharmacy is a reliable source that I use and I appreciate to acquire information about the cure of my health.

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

**2. Now I'll ask you about the interactions between you and the staff of the pharmacy:**

- The majority of times that I visit my pharmacy to buy a medicine, I have a conversation with somebody on the staff

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

- If I was not satisfied with the service received, I communicate this to the staff of the pharmacy

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

- Often someone on the staff and I share information about family related events and my personal life

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

**3. Think about the pharmacist and please tell me if you agree or disagree:**

- I think of the my pharmacist as a collaborator in maintaining my health

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I view my pharmacist as more than just a seller of prescription medicine

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I fell free to ask everything I need to know about my medications and my health

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

**4. Trust**

- confident

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- competent

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- honest

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

**5. Please answer the following questions thinking about the relationship you have established with your pharmacist:**

- My relationship with this specific service provider is something that I am very committed to

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

- My relationship to this specific service provider is very important to me and to my health

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

- My relationship to this specific service provider is something I really care about

Tot. Disagree					Tot. Agree	
1	2	3	4	5		
<input type="radio"/>						

**6. Word of mouth**

- Did you ever suggest this pharmacy to someone else? 

Yes	No
<input type="radio"/>	<input type="radio"/>

- Do you usually visit other pharmacies, also? 

Yes	No
<input type="radio"/>	<input type="radio"/>

- If Yes, Why?.....

**7. Section about the intervention:**

- Did the pharmacist provide you with oral or written information about health beyond the giving you the medicine you need?

Yes	No
<input type="radio"/>	<input type="radio"/>

- If YES, do you remember what kind of information?

**7(a). Think about the information you received when the pharmacist proposed counseling and answer the following questions:**

- I am happy with the health information I received

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I am grateful for the individualized attention I receive from my pharmacist

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

- I am happy with the staff of this pharmacy

Tot. Disagree					Tot. Agree
1	2	3	4	5	
<input type="radio"/>					

**7(b). Think about the information you received when the pharmacist proposes counseling and answer the following questions:**

- How do you evaluate the information you received on a scale from 1 to 5?

not at all valuable				extremely valuable
1	2	3	4	5
<input type="radio"/>				

- Would you change some of the information you received?

Yes	No
<input type="radio"/>	<input type="radio"/>

- If Yes what?.....

**7(c). After having received that information from your pharmacist please answer the following questions:**

- How much more knowledgeable do you feel about maintaining your health?

not at all				extremely
1	2	3	4	5
<input type="radio"/>				

- How much more knowledgeable do you feel about preventing diseases?

not at all				extremely
1	2	3	4	5
<input type="radio"/>				

- Do you feel more informed about the topic you heard about?

not at all				extremely
1	2	3	4	5
<input type="radio"/>				

- Did you tell someone else what the pharmacist said to you that day?
- Would you be willing to speak with the staff about his/her diseases and your health?
- Is the first time that you heard the staff speak about this topic?

**7(e) After having received information from your pharmacist please answer the following questions:**

- According to you, which are the most important functions of the pharmacist?
  - sell medicines
  - counseling about side effects
  - counseling about minor diseases
  - provide information about health
  - information about life style, nutrition
  - sell cosmetics
  - other.....

**7(d) Please tell me how likely you are to act in the following ways:**

- If you or one of your relatives had a minor disease, how likely is that you turn to the pharmacist instead of the doctor?
- When you want to obtain information related to health (diabetes, cholesterol, hypertension, back pain), how likely is that you turn to the pharmacist instead of the doctor?
- To maintain good health, and to look for info about lifestyle, nutrition, physical activity, how is likely that you turn to the pharmacist instead of the doctor?
- If you want to know how to prevent minor diseases, how is likely is it that you turn to the pharmacist instead of the doctor?

**8. Please answer the following questions:**

- Have you tried to improve the quality of your health status by looking for services and prevention communication in pharmacies for more than three months?  
Yes      No
  
- In the past month have you actively looked for services and information for the preservation of your health status in the pharmacy?  
Yes      No
  
- Are you seriously considering looking for information for the preservation of your health status in pharmacy in the next three months?  
Yes      No

**9. Please answer the following questions:**

- Have you preferred this pharmacy, rather than other pharmacies, for more than 3 months?  
Yes      No
  
- In the past month have you been actively looking for this specific pharmacy/pharmacist?  
Yes      No
  
- Are you seriously considering remaining loyal to this specific pharmacy in the next 3 months?  
Yes      No

**10. Demographic information:**

- Age
- Gender: M / F

- Marital status
- Last degree
- Place where you lived
- Pharmacy where the interview is taking place

## Appendix 5: Phase 3 - Flyer Intervention A

Come il farmacista si prende cura della sua salute?

### 1. Quando ha bisogno di un farmaco

Il farmacista non si limita a consegnarle il prodotto che le serve o che le ha prescritto il medico, ma le spiega come assumerlo correttamente, quali sono gli effetti collaterali più rilevanti e le eventuali interazioni con altri medicinali. I farmaci sono dei preziosi alleati per la cura dei nostri disturbi, ma se mal utilizzati possono rivelarsi nocivi.

Il farmacista può aiutarla a conoscerli meglio.



### 2. Quando non si sente bene e non sa cosa fare

Se non si sente bene, può rivolgersi al suo farmacista che le può fornire consigli per affrontare il suo disturbo:

- Se non è grave o non richiede particolari cure, le può anche consigliare di non utilizzare nessun medicamento.
- Può consigliarle un prodotto che allievi i disturbi o risolva il problema.
- Può consigliarle una visita medica, nel caso in cui i sintomi siano tali da richiedere l'intervento di un medico.



### 3. Quando desidera ricevere informazioni sulla salute o sulla prevenzione delle malattie

Al farmacista può chiedere informazioni riguardanti: alimentazione, obesità, diabete, colesterolo, malattie cardiache, ipertensione, vitamine, allergie; può offrirle consigli per i viaggi (vaccinazioni, prevenzione malaria, farmacia da viaggio), per smettere di fumare. Le può fornire indicazioni su come prevenire alcuni disturbi che possono compromettere la sua salute.

Può rivolgersi al farmacista ogni volta che lo desidera e senza appuntamento. Il farmacista l'aiuterà ad ampliare le sue conoscenze, e risponderà alle sue domande, per farle meglio comprendere come prendersi cura della sua salute e come ottenere un miglior stile di vita.

**Quali sono i disturbi riguardo ai quali la farmacia può essere considerata un punto di riferimento?** Per esempio: bruciore di stomaco, vomito, diarrea, costipazione, emorroidi, disturbi della pelle (acne, eczemi, psoriasi), funghi vaginali, infezioni urinarie, lesioni da sport, febbre, emicrania, insonnia, influenza, raffreddore, tosse, allergie, problemi agli occhi/orecchie...

**Quali sono i principali servizi che può richiedere direttamente in farmacia?** In farmacia è possibile per esempio: misurare la pressione, controllare il proprio peso. Il farmacista può medicare piccole ferite, abrasioni, scottature...

Farmacia Zanini, Stabio

## Appendix 6: Phase 3 - Poster Intervention B

### IL FARMACISTA:



un punto  
di riferimento  
per la  
salute

Farmacia Cassarate,  
Lugano

Nei mesi di Aprile, Maggio e Giugno, la nostra farmacia è a vostra disposizione per offrirvi informazioni e rispondere a tutte le vostre domande riguardo a temi come:

- Artrosi
- Colesterolo
- Diabete
- Dolori
- Generici
- Ipertensione arteriosa
- Mal di schiena
- E tanti altri disturbi della vostra salute

Il farmacista potrà offrirvi consigli su come prevenire questi disturbi, o potrà aiutarvi a conoscerli per affrontarli meglio.

Potete rivolgervi al farmacista ogni volta che lo desiderate e senza appuntamento: è sempre a vostra disposizione per offrirvi il suo aiuto!

## Appendix 7: Phase 3 – Descriptive statistics

### Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	F	151	75.5	75.5	75.5
	M	49	24.5	24.5	100.0
	Total	200	100.0	100.0	

### Age

N	Valid	200
	Missing	0
Mean		50.51
Std. Error of Mean		1.194
Std. Deviation		16.887
Range		67
Minimum		17
Maximum		84

### Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary school	4	2.0	2.0	2.0
	Junior secondary school	36	18.0	18.0	20.0
	Apprenticeship	52	26.0	26.0	46.0
	High school	61	30.5	30.5	76.5
	Technikum	15	7.5	7.5	84.0
	University	28	14.0	14.0	98.0
	other	4	2.0	2.0	100.0
	Total	200	100.0	100.0	

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