Idea Paper

Pharmacists' social authority to transform community pharmacy practice

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Abstract

Leaders in the profession of pharmacy have articulated a vision of pharmacists as providers of patient-centered care (PCC) services and the Doctor of Pharmacy was established as the required practice degree to achieve this vision. Pharmacist-provided PCC services have been shown to reduce medication costs and improve patient compliance with therapies. While community pharmacists are capable of, and are ideally placed for, providing PCC services, in fact they devote most of their time to prescription dispensing rather than direct patient care. As professionals, community pharmacists are charged with protecting society by providing expert services to help consumers manage risks associated with drug therapies. Historically pharmacists fulfilled this responsibility by accurately dispensing prescription medications, verifying doses, and allergy checking. This limited view of pharmacy practice is insufficient in light of the modern view of pharmacists as providers of PCC. The consumers' view of community pharmacy as a profession represents a barrier to transforming the basis of community pharmacy from product distribution to providing PCC services. Community pharmacists are conferred with social authority to dictate the manner in which their professional services are provided. Pharmacists can therefore facilitate the transition to PCC as the primary function of community pharmacy by exercising their social authority to engage consumers in their roles in the new patient-pharmacist relationship. Each pharmacist must decide to provide PCC services. Suggestions for initiating PCC services in community pharmacy are offered.

Introduction

For more than fifty years, a debate whether the fields of pharmacy constitute a profession has appeared in the pharmacy literature.[1-8] This debate is currently sustained by continuing efforts to transform the basis of community pharmacy practice from product distribution to patient-centered care (PCC) services. Pharmacy leaders have articulated a vision of pharmacists as providers of PCC services and established a *Doctor of Pharmacy* as the required practice degree to implement this vision[9].

PCC is defined "an approach that adopts [the] perspective of patients–what matters to them, what affects them either positively or negatively, and their experience of illness," and more specifically as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."[10,11] Pharmaceutical care, defined as "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality

of life," is an expression of PCC in the context of pharmacy services.[12] Pharmacist-provided PCC services generally include collecting, maintaining, and evaluating patient-specific health information and the direct consultation with patients and their other healthcare providers to implement, monitor, and revise care plans according to patient outcomes.[13-15] These functions are consistent with the IOM recommendations to empower pharmacists to participate in collaborative drug therapy management services and to empower patients in their own healthcare.[11] Despite some limitations in study design, the Asheville Project and the Diabetes Ten City Challenge have demonstrated the benefits of pharmacist-provided PCC in decreasing healthcare costs and improving patient outcomes.[16,17]

Most pharmacists practice in a community setting. Consumers received more than 3.6 billion prescriptions from community pharmacies in 2009.[18,19] While community pharmacists are capable of, and are ideally placed for, providing PCC services, in fact they devote most of their time to prescription dispensing rather than direct patient care.[18] A consortium of pharmacy organizations responded to this challenge with Project Destiny, a program to develop a patient-centered practice model for community pharmacy. The Project Destiny Business Plan contains analyses of the

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opportunities and barriers for the transition of community pharmacists into providers of PCC services. Any realistic practice model must be economically viable, and the document is appropriately focused on securing reimbursement for pharmacists' professional services.[20] Barriers to implementing a new professional practice model are not all economic, however. Society must participate in altering the roles of both pharmacist and medication consumer before patient care can become the primary role of community pharmacists. Further significant progress toward professional transformation requires that community pharmacy engage its necessary partner: the patient.

The transition of pharmacists to providers of PCC services requires a different patient-pharmacist relationship than that maintained by the current community pharmacy model. Because this new relationship demands new behaviors and modes of thinking by both pharmacists and patients, the desired transition represents a culture change. Ironically, the most obvious barrier to the transition, i.e. the pharmacist's responsibility for prescription dispensing, is an essential tool to facilitate the transition. Community pharmacists are conferred with social authority to dictate the manner in which their professional services are provided. Pharmacists can therefore facilitate the desired culture change by exercising their social authority over pharmacy services to engage consumers in their roles in the new patient-pharmacist relationship.

The Evolution of Community Pharmacy

The generally accepted model of pharmacist-provided PCC is based on clinical pharmacy services as practiced in large hospitals and clinic settings.[13-15,20] Hospital pharmacists initiated clinical pharmacy services (drug information, pharmacokinetic dosing, pharmacists serving on patient care teams) in the 1960's to address unmet needs in the medication use process.[21] These services expanded in large hospitals throughout the 1970s and 1980's. Pharmacist-intensive services were facilitated by pharmacy departments' use of trained technicians as well as prepackaged and pre-labeled unit-dose medications in the dispensing process to increase pharmacists' availability for direct patient care. The evidence that clinical pharmacy services improved patient outcomes and reduced healthcare costs formed the basis for the Hepler and Strand model of pharmaceutical care.[12] Pharmacy school curricula were revised to include training in patient-centered care and the patient-focused PharmD was eventually adopted as the required practice degree.

In contrast to the recent, purposeful establishment of clinical pharmacy practice, modern community pharmacy is the result of a century-long evolutionary path. Pharmacy at the turn of the 20th Century was equal parts skilled craft and retail business. Most prescriptions were compounded. Pharmacists also sold patent medicines and various tonics as part of their sideline businesses to supplement prescription sales. The public health movement during the early 1900's provided a stimulus for initializing the professionalization of pharmacy. Pharmacists began to apply their knowledge on health matters to "inform parents and victims of the unsuspected ravages of diseases which in their ignorance they believe to be of little importance."[22]

Counter prescribing, the practice of a pharmacist suggesting and selling medications to treat a patient without a physician's order, was common in 1900. Pharmacists were essentially diagnosing, prescribing, and dispensing within the pharmacy. Physicians were wary of counter prescribing as an intrusion into their control over therapeutic decision-making. Pressure from physicians and like-minded pharmacists brought an end to counter prescribing by 1940.[23] Pharmacists generally accepted responsibility for preparing and distributing medications ordered by physicians; thereby, in a sense, assuming a subservient professional status in the healthcare system. They embraced the role of drug compounding expert and resource for physicians.

Mass production and the introduction of new drugs in the post-WWII years caused a rapid increase in the dispensing of manufactured products. By the mid-1950's, the declining importance of compounding in the community drug store precipitated a search for new roles for pharmacists in the healthcare system. Eugene White, Robert Swain, Donald Francke, and other leaders in the profession saw an opportunity to utilize pharmacists as drug experts who could educate physicians on the growing number of drugs being introduced to the market and ensure the appropriate use of drugs by consumers.[3,8,24,25] Educational requirements expanded over time to better prepare pharmacy graduates for their changing roles. Some community pharmacists attempted to formalize patient counseling as a professional service with an attendant professional fee as early as 1957.[7] Although unsuccessful, this initiative foretold changes within the community pharmacy structure to address unmet needs in medication use.[26]

The 1952 Durham-Humphrey amendment to the 1938 Federal Food, Drug, and Cosmetic Act further defined the future of community pharmacy by establishing prescription and non-prescription drugs classes.[27] Under this law, prescription drugs were only to be sold to consumers by a licensed pharmacist upon order from a licensed physician. The community pharmacist was thus defined as custodian of drug products and charged primarily with protecting the

safety of the consumer by regulating distribution of these drug products. Meanwhile, the APhA Code of Ethics of 1952 prohibited pharmacists from discussing drug therapies with patients.[28] Community pharmacists worked pursuant to a physician's order on behalf of a patient, but not directly with the patient. American consumer culture evolved to embrace drug products as commodities and pharmacists as highly trained purveyors of medicines. Therefore, while the number of prescription medications was rapidly expanding, American consumers were being socialized to expect their pharmacist to dispense medications but to not become involved in the medication use process, nor in their overall healthcare. Pharmacists' responsibility for dispensing, which remains the cornerstone of community pharmacy today, represents both a barrier and an opportunity for community pharmacists as they transition to providers of PCC services.

Community Pharmacists as Professionals

Professional and *professionalism* have been defined in various ways. In a recent review of professionalism, Wilkinson, Wade and Knock identify five primary elements that are present in various definitions and interpretations of medical professionalism:

   i.   Adherence to ethical practice principles
   ii. Effective interactions with patients and with people who are important to those patients
   iii. Effective interactions with other people working within the health system
   iv. Reliability
   v.   Commitment to autonomous maintenance and continuous improvement of competence[29]

Historically, sociologists found professions as self-policing, i.e. establishing practitioner oversight to ensure that these elements are maintained and consistently offered to the external community.[30,31] However, most of these functions have been assumed by "professional boards of certification" operating in individual states.[32] Characteristics such as those proposed by Wilkinson, *et. al* are useful to understand behaviors expected of a professional, but they do not illuminate the nature of a patient-pharmacist relationship, which we believe is essential to pharmacist's professional roles. Professionalism for community pharmacists involves more than the acquisition of knowledge and skills to conform to a checklist of procedures.

Pharmacists practice within the confines of well-defined social relationships with physicians and medication consumers, so professionalism must be considered in the context of this social structure. In this light, a more relevant view of professionalism is provided by Evetts.[33] Rather than defining characteristics or motivational aspects of professionalism, Evetts asserts that professional authority derives from a social structure established in collaboration with society. Professions are established, at least in part, to assist society in dealing with risks.[33] Evetts specifically identifies pharmacy's claim to professionalism as the societal grant of control over a specialized area of "knowledge-work."[33,34] The founding of a profession represents a *quid pro quo*. Society grants control over a specified area of knowledge-work because its members understand and believe in the necessity of the professionals' work and because laypersons are unable to do the work for themselves. In exchange for the grant of control over pharmacy-based knowledge-work, a professional pharmacist is obligated to use his/her expert knowledge to assist patients in managing the risks associated with drug therapy.

As part of the grant of control over specific knowledge-work, professions are conferred authority by society to determine the manner in which professional services are provided. Historically, the pharmacy profession's primary societal charge has been to protect consumers by the purposeful transfer of medication custody. To this is added a value that is based upon the expression of professional knowledge-work, and the power to add that value lies in professionalism. *Social authority for pharmacists is the power to add value to dispensed medications.* Pharmacists, therefore, have social authority to impose reasonable conditions on the transfer of prescription medications to a consumer in order to best protect the consumer's health.

The Evetts interpretation of professionalism clarifies the challenges facing the pharmacy profession as it strives to implement PCC as pharmacists' primary function. Community pharmacy differs from other healthcare professions, including hospital-based clinical pharmacy, in that consumers do not view community pharmacists primarily as providers of PCC services. Rather, the consumer enters a community pharmacy as part of his/her responsibility in the patient-physician relationship, i.e. the physician orders the patient to acquire prescription medication from a pharmacist and to use the medication as instructed to improve their health. Community pharmacy services are commoditized in terms of the consumer's out of pocket expense (e.g. $4 generic prescriptions, free antibiotics, cash incentives for transferring prescriptions from a different pharmacy), speed with which medications are dispensed, and convenience to the consumer (e.g. pharmacies as department stores, drive-through windows, 24-hour accessibility). Consumers view the community pharmacy as a retail outlet for drug products, not

as a venue for receiving professional PCC services. Community pharmacy requires revision of the societal grant defining responsibilities for pharmacy-based knowledge-work to emphasize pharmacist-delivered PCC services for the purpose of maximizing patient health. In more practical terms, *consumers of community pharmacy services must make the transition from customer* to *patient*.

A consumer becomes a patient *via* acceptance of a *sick role*. The sick role, formalized by Talcott Parsons in 1951 and further elaborated by Parsons and others, legitimizes an ill person in the healthcare social system.[35-37]Within this system, a patient presents him/herself to healthcare professionals as "wanting to get well" and submits to their social authority to obtain counsel, assess risks, and manage specific products to achieve wellness. The professional has the responsibility to be accessible to the patient and to apply his/her specialized expertise to achieve the optimal therapeutic outcomes for the patient. When the sick role and professional roles come together a professional bond is formed.

This conception of the sick role is appropriate for acute illness (e.g. minor infection) where the patient is expected to return to health from the current illness. A model of *patienthood*, a staple of medical sociology, is better applied to patients with chronic illness (e.g. hypertension or diabetes).[38-40] In both structures, an ill person is labeled as a patient by a physician. Patient-centeredness requires sensitivity to the effects of diagnoses on patients' self-image. A person labeled as patient for an acute illness can accommodate the label within their self-concept because health, or "normalcy," will soon return. On the other hand, a person labeled as patient for chronic illness must reorganize his/her self-concept to accommodate a new social definition of "normal." Pharmacists initiating PCC may find it easier to approach patients with an acute label than patients with a chronic illness label. Although the latter may, indeed, benefit more from pharmacy services.[41]

The relative balance of social authority determines the course of any professional interaction. The physician holds the greatest authority in the US healthcare system. Patient-centered healthcare services (e.g. diagnostic testing, treatment by other healthcare professionals) are generally only made available to the patient pursuant to a physician's order, i.e. specific instructions to an allied health professional to provide services on the patient's behalf. While a patient has significant autonomy to select the providers of these services, consumers must submit to the authority of a physician in the patient-physician relationship to enter the healthcare system. A physician's order is required for the patient to receive services. The physician's order binds the patient to the sick role.

Hospital- and clinic-based pharmacists have significant social authority over patients as a result of the physician-patient relationship. The success of pharmacist-provided PCC in these settings is largely due to the physicians' delegation of authority to pharmacists for the purpose of providing drug-related patient care. This delegation is formalized in hospital organizational policies and collaborative practice agreements and is binding on the sick patient. A patient submits to the social authority of both their physician and pharmacist as part of the sick role.

The sick role does not extend the physician's social authority to the community pharmacist to the same degree, however. A prescription in the hand of a non-hospitalized patient is not interpreted as an order for the pharmacist and patient to enter into a professional PCC process. Consumers generally do not consider themselves patients in the community pharmacy, nor do they view filling prescriptions as a professional interaction akin to visiting a physician. Rather, the prescription is an order to transfer medications from the custody of the pharmacist to the consumer. Knowledge-work, in the consumers' view of community pharmacy as a profession, is associated with dose verification, accurate dispensing, allergy checking, etc. Consumers possess a similar level of social authority to that of community pharmacists in that they select a pharmacy to patronize (within insurance plan limits) and control the extent of their interaction with pharmacists. They may avoid personal contact with pharmacists and receive their medications *via* mail order or a drive-through window. Non-hospitalized consumers are thus patients to their physicians and customers to their pharmacists. Consequently, the pharmacy profession must accept the responsibility to facilitate the consumer's transformation from customer to patient.

Redefining the Patient-Pharmacist Relationship
Stimulating a professional relationship between pharmacist and patient begins at the community level because consumers must perceive pharmacists as necessary experts within the healthcare system. Pharmacists may achieve recognition in the community by participating in public health efforts.[42] The American Society of Health-System Pharmacists formalized a policy, initially stated in 1980 by the American Public Health Association, that pharmacists have responsibilities to actively participate and promote public health efforts.[43,44] These responsibilities include specific population-based care, health education, development of public health policy, and research and training specific to public health goals of disease prevention and the health needs of the national population. Furthermore, Smith and Olin believe pharmacists should advocate healthy lifestyles at the community level.[45] They take formalized pharmacy

education to task for not preparing graduate pharmacists to address the health risks represented by their customers' poor diet, sedentary lifestyle, obesity, tobacco consumption and excessive alcohol use.

Public health efforts will help society understand, value, and desire pharmacists as providers of PCC services. Without the awareness generated by pharmacy's public health mission, many consumers will not know what to expect in terms of pharmacist-provided PCC services and choose to remain customers when they could be better served by acting as patients.[46-50] Renberg, Lindblad, and Tully reported that patients they interviewed did not "spontaneously" speak of the pharmaceutical care services they had already received, and did so only after prompting.[51] Worley et al. similarly found that patients were not aware of the roles pharmacists expected of them in PCC.[52] Educating consumers about their roles in the patient-pharmacist relationship is therefore another important public health goal. Consumer awareness of community pharmacists' healthcare expertise increases opportunities to engage patients in PCC.

The pharmacist's assertion of professionalism must be demonstrated by personal accountability to individual patients who present themselves for PCC services. The existing community pharmacy practice model contains the essential elements for effective delivery of PCC services: consumers and pharmacists brought together in a professional environment by a physician's order for transfer of prescription medications. The centerpiece of an effective PCC-oriented care model is the professional relationship between patients bound to the sick role and a community pharmacist committed to "providing patient care that ensures optimal mediation therapy outcomes."[9] A patient's need for prescription medications stimulates the professional relationship, medications are accurately dispensed according to best practices, and the patient and pharmacist engage in PCC processes appropriate to the individual patient's needs. This can be achieved by reassembling the components of the existing community pharmacy practice model for the purpose of supporting the pharmacist as a provider of professional PCC services.

The specific procedures involved in the pharmacist-provided PCC are common knowledge within the pharmacy profession.[13,15] The pharmacist must establish a relationship with each patient based on mutual trust and commitment to the patient's well being. The pharmacist must document health and medication histories, current medications, etc. to allow an objective assessment of the patient's health needs. Community pharmacists typically do not have access to a patient's medical record, so the patient's physician is

contacted for information the patient cannot provide (clinical lab data, specific diagnoses, etc.). The pharmacist solicits feedback from the patient and physician (as appropriate) regarding the patient's therapeutic progress, side effects experienced, and compliance with therapy, and recommends alterations to the therapeutic regimen as appropriate. The continuous assessment of patient progress is integral to providing PCC. In addition to providing PCC services, the pharmacist is responsible for ensuring that prescription medications are dispensed accurately and in a timely fashion.

The patient must actively participate in his/her own care beginning with a commitment of time to the process. With the pharmacist's guidance, the patient provides relevant health information, articulates his/her personal goals for drug therapy and preferences regarding therapeutic options, and provides frank and complete feedback allowing the pharmacist to monitor and evaluate efficacy of the drug therapy. The patient is responsible for adherence to the treatment plan prepared by the pharmacist for the specific patient.

Continuous monitoring of patient responses to therapy contrasts basic prescription counseling from the more intensive PCC process. Pharmacists must apply effective communication skills and probe patients' attitudes toward the medication use, subjective perceptions of health or illness, fears and concerns about therapy, etc. Such conversation allows pharmacists to apply professional judgment to promote optimal outcomes for their patients and to genuinely integrate the patient in the PCC process. Some situations may warrant the pharmacist's calling a patient at home to monitor drug therapies between patient visits to the pharmacy. Pharmacists' routine monitoring of patients, rather than medications, promotes closer professional relationships and active engagement by patients in the PCC process.

The pharmacy environment and workflow processes must be designed to facilitate PCC services. Mutual trust is a cornerstone of the patient-pharmacist relationship. A private and comfortable space in the pharmacy is necessary to promote effective patient-pharmacist interactions. The pharmacy must employ appropriately trained support staff (technicians, cashiers) to accept and reliably perform the non-professional aspects of pharmacy operations while the pharmacist is engaged in professional activities. The pharmacy must have a suitable patient record system to support the pharmacist's PCC mission.

There are costs associated with the patient status, including investments in time and intellect in the PCC process,

increased dependence on healthcare professionals, and self-image as an un-well person (even considering modern ideas about wellness). Therefore, pharmacists must clearly demonstrate the benefits of PCC services to the patient. The economic and therapeutic benefits of pharmacist-provided PCC services have been shown in large-scale studies.[16,17] Experience from a variety of community pharmacies (chain and independent) and ambulatory clinics indicates that patients tend to be more adherent to and satisfied with their drug therapies when they receive PCC services from their community pharmacist.[17,53,54] Pharmacists can also discuss the impact of each patient's engagement in PCC on their own therapeutic progress. Patient empowerment, the acquisition of sufficient knowledge and accurate self-awareness to make successful choices to attain health-related goals, frequently is understood as a prerequisite to patients entering a professional relationship with a healthcare provider.[51,55] Patient empowerment may also develop as a result of the professional relationship.[53]

Pharmacists benefit from engaging patients in PCC. Pharmacists who provide PCC services enjoy the admiration of the patients and collaboration as colleagues with physicians who valued their collaboration.[53,54,56] Patient care promotes pharmacist job satisfaction by instilling a sense of professional autonomy and empowerment.[57,58]

Employers are responsible for implementing workflows and creating a culture where patient care is the organization's highest priority. While we cannot comment on reimbursement strategies, offering pharmacist-provided patient care services can help a pharmacy (or pharmacy chain) differentiate itself from the competition and contribute to the strength of a brand. Patient satisfaction with professional services can increase customer loyalty to the pharmacy. Improved patient adherence with drug therapy drives prescription refills and extends to filling new prescriptions. Allowing pharmacists to provide PCC services makes more efficient use of the pharmacy resources and improves opportunities for pharmacists to interact with physicians and other third parties as necessary to better serve patients. Pharmacy costs are reduced as pharmacists experience greater job satisfaction and decreased job turnover associated with providing patient care.[57,59]

Suggestions for implementation

Pharmacists transform customers into patients by creating the cultural expectation that PCC services are an integral part of receiving prescription medications. Community pharmacists' social authority over prescription dispensing provides the means to create this cultural expectation. The "R_x only" designation means that consumers may only use

prescription medications under the supervision of qualified healthcare professionals. The pharmacy profession is charged with the responsibility to protect society from risks associated with drug therapy by providing expert services that laypersons are not capable of providing for themselves. *It is therefore a pharmacist's ethical duty to dispense prescription medications only to patients who have received appropriate PCC services.* Social authority is an essential tool to convince patients that pharmacist-provided PCC services are integral to the medication use process. The responsibility for prescription dispensing, the historical centerpiece of community pharmacy practice, therefore affords community pharmacists the opportunity to elevate their practice to that of a patient-centric, caring profession.

Implementation of the PCC services in the community pharmacy thus begins with a proactive choice by a pharmacist to fulfill his/her professional obligations to ensure their patients' optimal medication therapy outcomes. A pharmacist committed to this goal is essential for the delivery of PCC services. Recent evidence suggests that the majority of community pharmacists prefer to spend their time in dispensing rather than patient care.[18,60] This issue has been addressed by the profession *via* the mandatory PharmD degree, as recent graduates are more inclined to providing patient care than pharmacists who have been in practice for many years.[18,60]

A pharmacist's public health mission can begin with in-store signage and advertising that emphasizes the professional services available and educates consumers on pharmacists' personal accessibility as healthcare experts, e.g. "… large enough to meet your healthcare needs and small enough to know your name." These approaches can also be used to initiate discussions about specific public health and wellness issues. Patients may be recruited into professional interaction regarding smoking cessation, maintaining a healthy body weight, the societal need to secure drugs of abuse, etc. Pharmacy websites and social media profiles dedicated to medication matters can increase the impact of public health efforts. Ending the sale of tobacco and alcohol in pharmacies would certainly increase the credibility of these messages.

A committed pharmacist can begin providing PCC services by taking the initiative to engage patients in professional discussion rather than speaking only with those who request it. One simple approach to accomplish this goal is for the pharmacist to personally convey filled prescriptions to the consumer. Customers are encouraged to make the transition to patients when their pharmacist endorses the value of PCC services by proactively initiating professional interaction with them. There is no more visible demonstration of the

pharmacist's accessibility than presenting medications to the patient and providing PCC services the patient needs to best benefit from the medications. In contrast, assigning a cashier to ask the consumer "Do you have any questions for the pharmacist?" is an undeniable statement that the pharmacist has higher priorities than providing PCC services.

Patient feedback, the primary mode by which community pharmacists monitor drug therapy, is most easily solicited when patients return to the pharmacy for medication refills. Speaking with every patient affords the opportunity for the pharmacist to regularly gather information from patients, update patients' health and medication profiles, monitor adherence with therapies, document other medications being used, etc. The future availability of universal electronic patient records will facilitate PCC services by providing the pharmacist access to current patient health data. Existing technology such as "refill reminder" telephone or email systems support the pharmacist's PCC mission by promotion a patient's medication adherence between pharmacy visits.

Some pharmacies offer medication therapy management (MTM) services on defined "clinic" schedules where a pharmacist is available to provide in-depth education on particular disease states (asthma, smoking cessation, diabetes, etc.) and actively engage the patient as a participant in their own care.[61] MTM clinics have several benefits for a pharmacist committed to providing PCC services. Patients who participate surely benefit from professional pharmacy services in improved therapeutic outcomes. Those patients who participate in MTM clinics are trained in the behaviors expected of a patient in the pharmacy, thereby contributing to the desired culture change for community pharmacy. Pharmacists who provide MTM services build professional relationships with their patients and continually hone their patient care skills. Perhaps equally important for the profession, every consumer who enters the pharmacy is exposed to professional advertising regarding the clinic offering and is introduced to the concept of community pharmacists as providers of PCC. A sustained MTM clinic program is not sufficient, however, to transform community pharmacy into a patient-centered caring profession. A pharmacist's ethical duty is to provide appropriate professional services to all patients, not only those who voluntary participate in MTM clinics. A pharmacist can begin by offering MTM clinics then use his/her experience as the basis for incorporating PCC into the routine pharmacy workflow.

A private space for consultation between the patient and pharmacist is essential to protect patient privacy and confidentiality and to underscore the importance of PCC

services. The best-intentioned pharmacist will find it impossible to engage patients in PCC if there is no assurance of patient privacy. A public counter directly adjacent to a cash register is not a conducive environment. Some stores offer the concession of segregating a continuous counter space with vertical partitions in an attempt to create the illusion of privacy for patients. While these structures are a small step in the right direction, patients may still feel reluctant to share personal information in such an environment. The physical layout of the pharmacy should be designed to provide maximum privacy for the professional interaction.

The most important factor in implementing PCC services is the proactive choice by a pharmacist to engage patients and take responsibility for their medication therapy outcomes. A motivated pharmacist will have no difficulty finding advice on how to implement specific PCC services. Pharmacy journals regularly publish scholarly papers, articles on innovations and experiences in pharmacy practice, and continuing education programs intended to assist pharmacists in developing and enhancing their PCC services. Professional pharmacy organizations' websites maintain links to practice-related resources for pharmacists. Pharmacists can subscribe to weekly email digests of recent developments in practice.

Community pharmacists may perceive barriers in their workplaces that limit their professional accessibility to patients and that may preclude their offering of PCC services. Overwhelming prescription workload is commonly mentioned as preventing pharmacists from interacting with patients. The solution to this problem is to stop misapplying the pharmacist's time on filling and labeling prescription vials or communicating with insurance company representatives regarding rejected claims. Pharmacists can expand their time for providing professional services by assigning these tasks to trained technicians and by employing technology in the dispensing process. Support staff perform these duties well for other primary care providers and insurance companies, and technicians can perform them for community pharmacies. "Tech check tech" programs, where certified technicians check the work of other technicians, may be implemented in community pharmacy.[62] The professional pharmacist's need for effective support staff strongly supports the recent call for uniform national credentialing standards for pharmacy technicians.[63] Large pharmacies may be able to cross-train "front-end" clerks to assist in the pharmacy department at times of peak demand.

Pharmacists can begin providing PCC services using a phased approach: patients with the greatest perceived need (e.g. acute versus chronic disease, severity of disease state, number of concurrent medications, history of non-

adherence) may be engaged first, followed by those of progressively lower priority until the PCC service is routine for all patients. The "levels of care" concept can be applied in therapeutic collaboration with individual patients to determine the extent of PCC services required.[64] Some patients will require extensive care services over a sustained period of time, while others will require only basic education limited to an acute illness.

The patient's physician may be required periodically to provide input into the PCC process. Initially, some physicians may be reluctant to engage in this aspect of their patients' care. While it is routine for pharmacists to collaborate with physicians in hospital and clinic settings, community pharmacists typically do not share this level of collegiality with physicians. Patients can lobby their physicians on their own behalf to facilitate data sharing and therapeutic decision-making with their pharmacist. Engaging patients in interactions with their physicians may also raise the physicians' awareness of the community pharmacist-provided PCC services. Pharmacists may reinforce their PCC roles in regular interactions with physicians. While some physicians may resist pharmacist authority, research has revealed that a welcome collaboration with many physicians may occur in the context of pharmacist-provided PCC services.[53]

Employee pharmacists may need to lobby management for authorization to redesign workflows for the purpose of offering PCC services. National pharmacy chains have opened health clinics staffed by nurse practitioners and physicians assistants adjacent to their pharmacy departments.[65,66] Pharmacists employed by these pharmacies may find opportunities to integrate PCC services with the health clinic services. Pharmacists can track the costs associated with each incremental service offering as well as their patients' outcomes, adherence to therapy, prescription refill rates, the number of new and returning patients, etc. to establish the value of their own services. These data can guide workflow adjustments that further support enhanced PCC services. Management, in turn, can use the data to propose reasonable reimbursement for their pharmacists' professional pharmacy services. The quantification of services can also be used in public service announcements and in-store signage, e.g. "Our pharmacist can help you reduce your asthma attacks while lowering your medication costs."

Conclusion
Pharmacists, as professionals, are charged by society with helping consumers manage the risks associated with drug therapies. Each pharmacist must choose to fulfill his/her professional obligation by providing appropriate PCC services. Community pharmacists who choose to provide PCC must

accept the responsibility to transform their customers into patients. Pharmacists are conferred with social authority to accomplish this mission. Community pharmacists, specifically, have the authority to impose appropriate PCC services as a condition of dispensing prescription medications to their patients. PCC services may be provided within the context of the existing community pharmacy practice model by redesigning workflow processes to maximize time available for professional patient-pharmacist interaction. The proactive choice by a pharmacist to provide PCC services is the critical first step in achieving PCC as the primary function of the community pharmacy practice.

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