Development of the Pharmacist-Physician Relationship: Perceptions of Program Directors and Trainees in the Faculties of Pharmacy and Medicine in Quebec, Canada

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Objectives. The purpose of this study was to describe how the pharmacist-family physician relationship is perceived by program directors and residents of the faculties of pharmacy and medicine in Quebec, Canada.

Methods. A qualitative research methodology was used to describe the perception of program directors and trainees in the faculties of pharmacy and medicine in Quebec, Canada. Semi-structured interviews of key informants were conducted, focus groups were held, and thematic analysis of official documents was performed.

Results. Learning activities are underdeveloped and there is a lack of role models encountered by pharmacy and family medicine residents with respect to this professional relationship. Hence, the content of the training programs in these 2 disciplines falls short of the expectations of the professional associations.

Conclusions. Special attention should be given to early integration of objectives, learning activities, and the evaluation of the pharmacist-physician relationship into professional training programs. Accreditation agencies should be encouraged to promote such standards.

Keywords: Pharmacist-physician relationship, practice patterns, qualitative research methodology

INTRODUCTION

Pharmacists must develop good relationships with patients and other professionals. Several important North American professional associations have clearly indicated the importance of the pharmacist-physician relationship and their willingness to promote it through university teaching. The American Council on Pharmaceutical Education as well as the Canadian Council for Accreditation of Pharmacy Programs have also included communication skills in their Accreditation Standards and Guidelines.

In Quebec (Canada), as a result of periodic changes to the drug insurance plan (RAMQ), pharmacists, especially those practicing in the community, are called on to play a greater role in the health care system. The expanded role of the community pharmacist, in response to increased demands by patients and physicians, also means that more thought is given to the way in which pharmacists and family physicians are trained in communication and interprofessional relationships. Therefore, factors that could compromise the development of new professional partnerships must be more closely identified.

The province of Quebec offers an especially interesting context in which to study interprofessional relationships. In 1998, the Quebec government became the first to recognize the increased role of pharmacists within its drug insurance plan. Through a central computer system, this new plan linked information on the remuneration and delivery of services by physicians, information on the consumption of health services and drugs by individual plan members, and information on...
the dispensing activities of pharmacists. Under an agreement between the Ministère de la Santé et des Services Sociaux (Quebec Department of Health Services and Social Services) and the Association québécoise des pharmaciens propriétaires (AQPP or the Quebec Association of Pharmacy Owners), pharmacists are remunerated for providing written pharmaceutical opinions to physicians with respect to patientspecific drug therapy. Prior to 1999, data from the RAMQ and the AQPP revealed that pharmacist underused this means of communication and remuneration. However, data from 2000-2001 demonstrated an increase in pharmaceutical opinions transmitted to physicians and reimbursement by the provincial health ministry. This can be explained by an increase in beneficiaries of the RAMQ as well as an increase in the number of pharmacists choosing to use this means of communication.

Professional associations have issued many guidelines on partnerships and the teaching of pharmacist-physician relationships. Many articles have been written about the challenges of these relationships in professional practice. However, to our knowledge, there has been very little research on the pharmacist-physician relationship within residency programs. Studies addressing pharmacist-family physician relationships have primarily assessed the impact of pharmacists on physicians prescribing patterns. In theory, faculties of pharmacy and medicine must teach their students how to establish harmonious interpersonal relationships with other professions in order to offer optimal health care. A recent American national survey showed that pharmacist-physician interaction is one of the topics covered in communication courses in colleges of pharmacy. However, research specifically examining pharmacist-physician relationships as taught in university programs is not available.

The purpose of this study is to describe the perceptions of program directors and trainees in the faculties of pharmacy and medicine with respect to the pharmacist-family physician relationship and to explore the manner in which this relationship is taught in these programs in Quebec, Canada.

METHODS

In the scientific community, there is a widely recognized need to match the nature of the research question to the appropriate methodological approach. The qualitative approach is appropriate when a detailed and holistic understanding of a social phenomenon is central to the researchers’ concerns. The research question relevant to a qualitative methodology often addresses how individuals perceive a situation that has not been extensively explored before. Therefore, due to the nature of the research question, the complexity of the theme, and the importance placed on the perceptions of participants, a qualitative approach was chosen.

Source and Collection of Data

This study was conducted from January 1998 to May 1999. Data collection was based on triangulation of data from 3 sources, which constitutes a valid criterion of scientific validity in qualitative research. Our first source of data consisted of individual interviews with 4 family medicine program directors in Quebec (3 men and 1 woman) (Université Laval, Université de Montréal, Université de Sherbrooke, and McGill University) and with 2 pharmacy program directors in Quebec (1 man and 1 woman) (Université Laval and Université de Montréal). These individual interviews (over the phone or face-to-face) were semistructured and recorded on audiotape. The original interview questionnaire, was sent to participants before the interviews took place. It dealt with objectives and learning activities regarding the pharmacist-physician relationship in their program, the evaluation of interprofessional communication skill, the relevance of this training, the factors that undermined or reinforced this training, and plans in this area. All of the participants were invited to provide additional comments if necessary. These 6 interviews, which each lasted an average of 60 minutes, were led by one of the researchers (LC or MR).

Our second source of data consisted of official documents that described the objectives, learning activities, and evaluation methods of each of the programs. At the end of the interview, each program director was asked to send the team of researchers any documents related to the teaching of the pharmacist-physician in his or her program. Two family medicine program directors and 2 pharmacy program directors provided written documents.

Our third source of data consisted of focus groups that included graduates of family medicine and pharmacy programs. The program directors who participated in individual interviews identified graduates from their respective programs. (one family medicine program did not participate in this stage of the research).

Five homogenous focus groups (training and university) were created from the individuals who were willing to participate in the project (2 pharmacy groups and 3 family medicine groups). Homogeneity was targeted in order to describe the event in depth. An interview grid was used to guide the discussion, which explored the
following themes: experiences and satisfaction with training in the pharmacist-physician relationship, characteristics of a good pharmacist-physician relationship, factors that undermine or reinforce this relationship, and suggestions for improving interprofessional relationships in their respective programs. Each of the focus groups was led by one of the researchers (LC, MR, or FL) who also recorded the meeting. Altogether, 23 family medicine residents (8 men and 15 women) and 24 pharmacy residents (5 men and 19 women) participated in 1 of the 5 focus groups (which lasted an average of 2 hours). To be eligible, pharmacy residents had to be in the final trimester of their Master’s degree in pharmacy, and family medicine residents had to be in the final trimester of their residency program. Residents had to agree to participate in a focus group and consent to an audiotaped recording of the session.

Data Analysis

Each of the individual and group interviews was first transcribed verbatim. Then, for each of the questions asked during the interview, thematic analysis was performed to identify the main themes raised by participants, and to categorize them following the steps recognized for this type of analysis17 with the assistance of NUDIST software. Each researcher independently analyzed and encoded the transcriptions. The researchers’ coding was compared and discussed between the 3 researchers (triangulation). Wherever there was a difference of opinion among researchers as to the categorization of data, the final decision was reached by consensus. Using a grid that specified the elements they were seeking (clear objectives for learning the pharmacist-family physician relationship or interdisciplinarity, learning activities, and evaluation of the extent to which the relationship objectives had been reached), 2 of the researchers (LC and MR) also analyzed the content of the official documents produced by the various programs. This study was approved by the Université Laval Research Ethics Committee.

RESULTS

All program directors (2 in pharmacy and 4 in family medicine) participated in individual interviews. Furthermore, 5 focus groups were created (2 pharmacy groups and 3 family medicine groups).

Views of the Program Directors

All of the family medicine program directors in Quebec reported that their programs had general training objectives for learning about cooperation between family physicians and other professionals. In fact, objectives such as, “working effectively with other health care professionals,” or “working as part of a multidisciplinary team,” appeared in the written documents that we consulted. However, no objective specifically targeted cooperation or the relationship between family physicians and pharmacists or any other health care professionals. See Appendix 1 for illustrative quotations.

Unlike the family medicine program directors, pharmacy program directors reported objectives for learning about interprofessional relationships that were more detailed and more clearly defined than those found for the family medicine programs. Objectives such as “participating in the training of other health care professionals,” “developing skills in cooperation and communication,” and “demonstrating the ability to work as part of a team,” were reported by the pharmacy program directors and appeared in the documents that they provided. Even though these objectives refer to all health care professionals, the directors admitted that they were chiefly intended for the pharmacist-physician relationship.

Learning Activities. In family medicine, there were no training activities that specifically targeted interdisciplinary cooperation. Contact between residents of these programs and other health care professionals varied from one training setting to another and each training centre was autonomous in its choice of training activities, which lead to different training situations. In some settings, pharmacists worked in health care units such as geriatrics, intensive care, and palliative care. This provided residents with an awareness of the pharmacist’s role, and awareness was raised if the residents had specific opportunities to work with pharmacists.

The pharmacy programs had various training activities to introduce pharmacy students to the pharmacist-physician relationship. Factors that influenced medication prescribing, the physician’s pharmaceutical opinion, and interview techniques are integral parts of the curriculum. For example, compulsory courses in communication include training sessions on telephone conversations with physicians. Courses such as “Pharmaceutical care” and “Pharmaceutical approach” focus on problem-solving and indirectly touch on the challenges of pharmacist-physician interaction. Like the directors of family medicine programs, directors of pharmacy programs identified instruction and time spent in a clinical setting as the main source of information about the pharmacist-physician relationship.

Factors that Hinder or Promote Learning. The directors of the family medicine programs identified several factors likely to make it easier for residents to learn about the pharmacist-physician relationship: clear
objectives that are written into the training program, supervisors who act as role models, and increased contact with hospital and community pharmacists who can communicate the importance of their role to physicians. Conversely, these program directors reported that excessive training and work activities, the lack of role models, restricted budgets, the reduction in the number of hours during which pharmacists were available, an overemphasis on hospital training, and misconceptions about roles were obstacles to learning about this relationship. They mainly talked about the relevance of this learning in the context of possible projects for the future, which are described later on in this paper.

The pharmacy program directors felt that it was necessary and relevant to teach about the pharmacist-family physician relationship because they saw these 2 groups of professionals frequently working together. They felt that this instruction should start at the beginning of the pharmacy program and be pursued into continuing education. They reported that the presence of role models in the clinical setting was the most important factor in learning about this relationship.

The pharmacy program directors reported that students’ lack of confidence, their submissive attitudes towards physicians, the aggressive attitudes of some physicians, and a lack of time were major obstacles to students’ learning about the pharmacist-physician relationship.

**Evaluation of the Pharmacist-Physician Relationship.** According to the directors of the family medicine programs, the pharmacist-family physician relationship was not evaluated because it was not specifically taught in family medicine. They reported that the ability to work with other professionals was one of the evaluation criteria for rotations, but that this evaluation was not systematically performed. The pharmacy program directors reported that they found it difficult to evaluate what their students had learned about the pharmacist-physician relationship. Evaluation was mainly through role-play in courses that taught this theme or during clinical teaching. These program directors felt that training in a clinical setting was the best time to evaluate this relationship, although this skill was not systematically evaluated in the pharmacy program either.

**Future Academic Plans.** Although the family medicine program directors did not have specific plans to improve the teaching and evaluation of the pharmacist-physician relationship in their programs, they felt that residents should learn to work more effectively with community pharmacists and be better able to observe their supervisors interacting with community pharmacists.

Neither pharmacy program in Quebec has plans to improve the teaching and evaluation of this skill. The program directors feel that a return to joint didactic teaching and early exposure for students in both pharmacy and medicine programs would enable them to increase their knowledge of the other program.

**Views of the Family Medicine and Pharmacy Residents**

**Experiences and Satisfaction.** The family medicine residents described the pharmacist-physician relationship (primarily in the hospital setting) as an experience that was usually positive. Residents reported that they had only occasional contact with the pharmacists except in geriatrics, palliative care, and oncology services, during which they had almost daily contact with the pharmacist. When a resident was working in a unit in which the pharmacist was a member of the care team, the pharmacist was a colleague and a specialist in medications. The pharmacist answered questions about medications, was available even at night, identified drug interactions, made suggestions for treatment, reviewed the initial medication, and was a source of information on the price of medications. Generally, family medicine residents reported that they were very satisfied with the information they received from the pharmacist, as well as the pharmacist’s availability and support (see Appendix 2 for illustrative quotations).

Pharmacy residents, on the other hand, were much less enthusiastic about their experiences and were less satisfied with the pharmacist-physician relationship during their training. According to several residents, the perception was that physicians felt threatened by the pharmacist’s suggestions, did not understand the pharmacist’s role, and became less receptive depending on their age and specialty.

In addition, pharmacy residents, just like family medicine residents, spent little time in each care unit. This reduced the likelihood of pharmacy residents developing long-term, stable working relationships with physicians. The lack of pharmacists who can act as role models in the care units also interfered with learning about the pharmacist-physician relationship for both medical residents and residents in pharmacy. Lastly, pharmacy residents reported that knowing about the other professional fosters a good pharmacist-physician relationship. They felt that their experiences were positive when they had the time to develop a professional relationship. And when the main objective of the pharmacist-physician relationship was the patient’s well be-
ing, the relationship was even more agreeable and productive.

**Characteristics of a good Pharmacist-Physician Relationship.** Family medicine residents defined a good pharmacist-physician relationship as accessible, mutually respectful, open, and one in which both parties acknowledge the other's expertise. Pharmacy residents described a good relationship with a physician as egalitarian and complementary, and marked by mutual trust. They would like physicians to stop seeing pharmacists as a threat and be more open-minded.

**Learning Activities.** Where learning objectives are concerned, pharmacy residents would like the emphasis to be placed on communication and negotiation skills that can be used to influence prescribing practices, for example, how to ask a question, how to be assertive, how to get what you want. The expectations of family medicine residents were practical as well; they would like pharmacists to teach them about prescription preparation, the principles of pharmacokinetics, and new medications. They would also like a better understanding of what pharmacists can provide them professionally. As for learning methods, some pharmacy residents reported that they learned about this relationship on their own, through trial and error. But others believe in the importance of training activities, the most useful of which would be contact with clinicians who are role models during their rotations. But they deplored the fact that exposure to role models varied so widely from one rotation to another. The family medicine residents reported that they had learned this relationship by observing how their supervisors interacted with pharmacists, even though opportunities to observe role models in action were infrequent. The family medicine residents also reported that the ongoing presence of a pharmacist in the care unit was very conducive to learning about this relationship.

**Factors that Hinder or Promote Learning.** Factors that promoted learning this skill were the same in both disciplines: knowing each other, participating in joint training, having the presence of role models, and sensing the possibility of developing an ongoing relationship with the other professional, implying that he or she is close by and available. The common obstacle for both professions is, without question, misconceptions about their respective roles. Other obstacles included lack of availability, lack of information about the patient, and lack of time. Both groups reported that their clinical supervisors did not seem particularly interested in formal instruction about this relationship:

Pharmacy residents reported that it was easier to develop a good relationship with younger physicians and that team work in a hospital setting encouraged interdisciplinary communication. Pharmacy residents also reported that physicians have a good relationship with them when the physician has a specific need for pharmacological expertise, but that physicians are not very receptive when the opposite is true.

**DISCUSSION**

Studies addressing the pharmacist-family physician relationship within residency programs have mostly assessed the impact of pharmacists on physicians prescribing patterns. This is the first study of the pharmacist-physician relationship in training programs in Quebec. Despite the importance placed on this relationship by professional medical and pharmacy organizations, it appears from this exploratory study that there are no specific objectives about this relationship in these programs. Therefore, it was not easy for respondents to identify learning activities that focused on developing this relationship. Furthermore, none of the programs had defined an evaluation process (formative or summative) specifically for this relationship. At the time of our study, there were no formal joint learning activities or collaborative projects. However, pharmacy programs seem to target the pharmacist-physician relationship more specifically than family medicine programs. They also seem more proactive in trying to develop learning activities specifically on this theme. This can be explained by the directors of pharmacy programs feeling that it is in their interest to give priority to this learning in order to strategically position the discipline in the health care network and contribute to better delivery of care to the public. The family medicine program directors possibly place value on learning skills other than the pharmacist-physician relationship. Historically, the discipline of family medicine has defined itself on the basis of relationship, but that of the physician and the patient rather than that between health professionals. Presently, there is a great deal of pressure on these programs to incorporate new skills into their curricula (for example, involving the patient in the decision-making process, and to give these new skills the same weight as biomedical skills. Moreover, plans are underway to establish family medicine groups across the province, with an emphasis on integrating nurse clinicians into family physician groups. These groups will be responsible for a well-defined roster of patients. Consequently, the physician-nurse relationship is possibly a more significant concern for stakeholders and public decision-makers than the pharmacist-physician relationship. Interestingly, models of collaborative care that would cover the
study of relationship between more than one health care discipline and include the patient are yet to be developed. Last, there are only 2 pharmacy programs in the province and an acute shortage of pharmacists is already acknowledged. Therefore, it is also possible that the small number of pharmacist in training programs in the province contributes to a lack of collaboration between both professions in the academic programs.

Family medicine program directors acknowledged their lack of understanding of the role and skills of newly trained pharmacists. The pharmacy profession has itself undergone profound changes in recent years. Instruction in new skills for supporting decision making by physicians and patients, and in the delivery of care to patients and the community may contribute to this lack of understanding on the part of physicians.

All of the program directors (medicine and pharmacy) identified several obstacles to learning about the pharmacist-physician relationship. On an organizational level, both disciplines reported a lack of time. All health sciences programs are facing an exponential increase in the number of skills that must be taught, not only in terms of knowledge, but also attitudes and attitudes. The prioritization of learning objectives always involves a cost, that is to say, the feeling that another objective has to be dropped. In Canada, there is already talk of increasing the family medicine program from 2 to 3 years.

Family medicine program directors tended to identify organizational barriers (lack of money, limited availability of the pharmacists, etc) whereas pharmacy program directors tended to identify attitudinal barriers: lack of confidence on the part of their residents and aggressive attitudes on the part of physicians. We believe that this is a result of the residents’ lack of exposure to role models on the care team who can assert themselves with confidence. Family medicine residents, on the other hand, usually work with confident role models.

Our results are congruent with those of a local study on practicing pharmacists and physicians. This study specifically targeted pharmacist-physician communication in the context of compliance with treatment. Physicians and pharmacists identified the importance of trust, recognition of skills, and a relationship based on the patient’s needs as the keys to a successful pharmacist-physician relationship. More frequent contact between the groups (discussion groups, joint continuing education) and the implementation of communication tools are among the proposed solutions. What our research adds is the observation that these attitudes are already present at the end of professional training before the pharmacist or the physician enters practice. This could have implications for the academic settings, such as taking a leadership role in the training of health care collaborative teams and not health care professionals.

The literature on the pharmacist-physician relationship describes the difficulties experienced by family physicians and pharmacists within the context of practicing their profession. However, the existing literature addressing communication skills training within residency programs does not focus on this relationship. Our research, based upon 3 different sources of information, adds to the scarce literature about pharmacist-physician relationships in training programs.

The limitations of this study must be considered. With the qualitative methodology used, it is not possible to apply the results either to other training settings or to current practitioners. With respect to the small number of participants, there are no guidelines for sample size in qualitative inquiries. Sample size is dependant on the research question, the purpose of the inquiry, and what can be done with available time and resources. Indeed, qualitative methodology is recognized for its ability to provide an in depth understanding of a complex phenomenon by taking into account the context in which it occurs. It allows for the re-creation of a social microcosm in which the researcher can identify the participants’ values, attitudes, and behaviour. Qualitative methodology makes it possible to generate hypotheses for future research and to contribute to a larger body of scientific knowledge in the field.

Another limitation of this study was the lack of member checking; many researchers using qualitative methodology have their final report re-read by participants to validate their results. This step was not undertaken because of lack of time and resources. Lastly, 2 of the researchers came from the disciplines being studied. While they attempted to maintain an objective approach throughout the entire study, their involvement in data collection possibly influenced participants and their own interpretation of the data. However, with the human and financial resources available to us, it was not possible for the third researcher to conduct all of the individual and group interviews. Besides, intense discussion about the nature of knowledge and how it is produced reminds us that, for some researchers, there is no truth out there that we can measure accurately and what we study is influenced by our unique way of knowing. For others, there is a truth out there that can be measured or at least estimated. Where one’s opinion lays depends on the paradigm he/she adopts. Despite these limitations, we
firmly believe that the results reflect ways in which the pharmacist-physician relationship is currently taught and learned in 3 of the 4 family medicine programs and in both pharmacy programs in Quebec, and can inform future research in the field.

**CONCLUSIONS**

There is scientific evidence to support that there is a need for greater interaction between pharmacists and physicians. However, this study shows that there are no specific objectives about developing this relationship within the curriculum of pharmacy and family medicine programs in Quebec. Therefore, identifying learning activities pertaining to this relationship was difficult for respondents. None of the programs has defined an evaluation process (formative or summative) specifically for this relationship. Consequently, there should be more emphasis on earlier integration of these objectives, learning activities, and the evaluation of these activities into professional training programs. These results provide essential information for accrediting and reviewing training programs in medicine and pharmacy. The main implication of this study is for both training programs to elaborate specific objectives and consequently learning activities, including joint projects. In terms of further research into the pharmacist-physician relationship, future studies of medical and pharmacy residents should use other methodological approaches and be conducted in other cultural contexts.

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Appendix 1. Points of View* Expressed by the Program Directors of Pharmacy and Family Medicine Programs in Quebec, Canada, Concerning Pharmacist-Physician Relationships

**Point of View of Program Directors**

On learning objectives

In family medicine:

“We do not have any specific family physician/pharmacist objectives. There are objectives for cooperation with other health care professionals in general, as well as with clerical staff, but these are really very general objectives.”

In pharmacy:

“Clearly, pharmacists work mostly with physicians, but also with nurses. However, the objectives mainly focus on the relationship with physicians.”

On learning activities

In family medicine:

“At ----, there are clinical units with pharmacists, for example, geriatrics and intensive care. The pharmacist does the rounds; he or she is there and gives an opinion. Family medicine residents work side-by-side with the pharmacist or the pharmacy resident. They discuss the pharmacist’s recommendations, drug interactions, etc. The more they work together, the better they understand each other’s work. This is the type of cooperation they need to learn.”

In pharmacy:

“I think that interdisciplinarity is best learned in the clinic where students are part of a team comprised of physicians, nurses, and pharmacists. That’s where they best understand each other’s work.”

“We must teach the principles of a good relationship with physicians through pharmacists’ experiences, for example, role play. But it shouldn’t be limited to this. Students need to be able to observe and talk to seasoned clinicians who have a very good professional relationship with physicians and other professionals. That’s what will help the most.”

On future academic plans

In family medicine:

“Residents in family medicine who work frequently with hospital pharmacists have much less contact with community pharmacists…. We need to teach residents to get into the habit of calling the community pharmacist to follow up on patients with chronic illness, patients receiving intensive pharmacotherapy, and patients who are not complying with their treatment …But residents have to be shown how. Unfortunately, few supervisors show them how. We need to improve that.”

*“Description and quotation are essential ingredients of qualitative inquiry…Direct quotations should be included to allow the reader to enter into the situation and thoughts of the people represented in the report.”*24 (p 429-430)
Appendix 2. Points of View Expressed by Pharmacy and Family Medicine Residents in Quebec, Canada, Concerning Pharmacist-Physician Relationships

Points of View of Residents

Experiences and satisfaction with regard to the pharmacist-physician relationship

In family medicine:
“In intensive care for example, the pharmacist always gives advice on medications during rounds. It’s always very interesting because we learn a lot about the most appropriate choice of medications in a particular situation, about interactions, etc.”

“Pharmacists explain a lot to us and are always readily available, even at night.”

In pharmacy:
“There are supervisors in medicine who think they know everything and that we are only there to answer their questions…It’s unusual for them to ask us for help…Once we say, for example, that maybe they should change a medication, they say that they are the doctor…They think of us as drug police…In some specialities, older physicians are even less receptive. I haven’t found that they are interested in pharmacists at all, even though we are part of the team.”

Characteristics of a good pharmacist-physician relationship

In family medicine:
“You have to be able to drop your judgment, respect each other, and really understand what each person can contribute.”

“Unless both people keep an open mind, a collaborative relationship is impossible.”

In pharmacy:
“To work together, you have to give and receive on an equal basis.”

“If the trust isn’t there, nothing will happen.”

“A lot of physicians don’t understand the pharmacist’s role – we aren’t cops. They need to trust us and accept that we can help them to better treat the patient.”

Learning activities (working with a role model)

In family medicine:
“Today, I had a chance to see my supervisor phone a pharmacist because he had a patient who was arrhythmic and he wanted to check some things. If I hadn’t seen him do it, and if he hadn’t explained why he called, I would have never thought to do it. Now, I phone the pharmacist more often.”

“In family medicine, most of my supervisors did not discuss this with me. We discussed the physician-patient relationship, but not the pharmacist-physician relationship… Something would have to go wrong for us to discuss it. There were other priorities.”

In pharmacy:
“I worked with a community pharmacist. He had such a good relationship with physicians, a good way of working with them. If I have problems, I will definitely call him. He will be my role model for a long time.”
“In my pharmacy residency rotations, I never sensed that it was all that important. The fact is that my supervisors never took the time to clearly discuss it with me. I have to say that, in general, I got along well with physicians. Everyone says that it’s important, but it’s the last priority.”

Factors that hinder learning

In family medicine:
“In family medicine, most of my supervisors did not discuss this with me. We discussed the physician-patient relationship, but not the pharmacist-physician relationship… Something would have to go wrong for us to discuss it. There were other priorities.”

In pharmacy:
“In my pharmacy residency rotations, I never sensed that it was all that important. The fact is that my supervisors never took the time to clearly discuss it with me. I have to say that, in general, I got along well with physicians. Everyone says that it’s important, but it’s the last priority.”