Collaborations Between Pharmacists and Physicians: Steps for Building More Effective Working Relationships

Monograph 19

A Continuing Education Series sponsored by an educational grant from MERCK
Dear Colleague:

The role of the pharmacist in the United States health care system needs to be focused on the delivery of pharmaceutical care—improving the quality of medication use. To assist pharmacists in developing the skills necessary to do this, the American Pharmaceutical Association, with the support of Merck & Co., Inc., has developed the Dynamics of Pharmaceutical Care: Enriching Patients’ Health continuing education series.

The Dynamics of Pharmaceutical Care: Enriching Patients’ Health series is built upon the foundation of the former Value Added Services series.

As this monograph describes, an empathetic and trusting pharmacist–patient relationship is now widely recognized as a cornerstone of pharmaceutical care. Far less appreciated, however, is the importance of the pharmacist–patient relationship in successful marketing of pharmacy-based clinical services. This relationship-centered approach to marketing represents a major shift from traditional marketing philosophy, which emphasizes a more impersonal approach to transactions between organizations and customers. This monograph describes how to use relationship marketing to create and maintain a network of productive relationships with selected groups of patients and other partners to expand the delivery of pharmacy-based services.

Our goal for this ongoing series is to illustrate the basics of pharmaceutical care delivery and provide pharmacists with concrete guidance in developing professionally rewarding practices focused on improving patient outcomes.

Sincerely,

John A. Gans, PharmD  
Executive Vice President  
American Pharmaceutical Association

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Director, Pharmacy Affairs  
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Collaborations Between Pharmacists and Physicians: Steps for Building More Effective Working Relationships

For pharmacists, the first step toward establishing collaborative practice agreements is to build strong working relationships with physicians.

By Randal P. McDonough and William R. Doucette

Program Preview

The need to improve patient care by coordinating the activities of various health care providers has become a topic of increasing interest in the health care community. Practitioners from each discipline can use their specialized training and skills to make significant contributions to patient care. Pharmacists, for example, can provide the team with expertise needed to improve a patient's drug therapy and self-care skills. However, to optimize this contribution, they need to learn to work in a collaborative manner as members of an interdisciplinary team.

Over the past few years, pharmacists have begun entering into collaborative practice agreements (CPAs) as a way to integrate their services with those of physicians. Although CPAs are important to the successful integration of pharmacists' and physicians' practices, signing a CPA represents a late stage in these practitioners' working relationship—a stage most pharmacists have not yet reached. Although more than half of the 50 states have some statute or regulation addressing collaborative drug therapy management, few pharmacists are actually engaged in these collaborations.

Before pharmacists can attain the level in which a CPA is possible, they must form successful working relationships with physicians. In this article we describe a model of the stages of building collaborative working relationships (CWRS), provide pharmacists with suggestions to reach each stage, and illustrate the model with an example of a CWR among pharmacists and physicians in a community setting.

Benefits of Improved Collaboration

Currently, several trends in society and health care point to the need for increased collaboration among pharmacists and physicians: the presence of considerable drug-related morbidity and mortality; rapid advancements and innovations in medicine and pharmaceuticals; the growth of managed care, causing the movement of patients from inpatient to ambulatory settings; and the need for pharmaceutical care for an aging population. While each factor calls for closer pharmacist–physician collaboration, efforts to convince physicians to fully utilize pharmacists' skills to help manage patients' drug therapy have had only limited success.

In practice settings where pharmacists have been successfully integrated into drug therapy management processes, patient outcomes have improved. Most cited examples of this come from teaching hospitals, Veterans Administration medical centers, or university-based programs; few examples exist of pharmacists collaborating with physicians in community practice settings. For this reason, a systematic model of collaboration among pharmacists and physicians is needed.

Learning Objectives

After reading this article, the pharmacist should be able to:

▲ Identify the five stages in the development of a collaborative working relationship with a physician.

▲ Describe the influence of participant, context, and exchange characteristics on pharmacist–physician working relationships.

▲ Identify common obstacles to collaboration among practitioners.

▲ Cite strategies that can help pharmacists move from professional awareness (Stage 0) to commitment to the collaborative working relationship (Stage 4).

▲ Describe the benefits of participating in a collaborative practice agreement after a collaborative working relationship has been tested and established.
However, the pharmacy literature provides little guidance on how pharmacists can develop CWRs with physicians.

Although collaboration among health care practitioners is a relatively new concept for pharmacy, the nursing literature contains numerous articles on this topic.35–48 One model, based on organizational theory, describes collaboration as “high-level co-cooperativeness and assertiveness to solve problems where there are common interests and the stakes are high.”49 Baggs and Schmitz46 developed this concept further in their study of collaboration among residents and nurses in a medical intensive care unit. They identified several antecedent conditions needed to develop collaboration: the residents and nurses had to be in close proximity, they needed time to interact, they had to possess the appropriate clinical knowledge, and they had to be receptive to collaboration. Furthermore, the residents and nurses needed to have an interest in other practitioners’ professional responsibilities, to actively discuss patient care issues, to demonstrate respect for one another, and to have trust in each other’s competence. Obstacles that may prevent nurse–physician collaboration are listed in Table 1.45 Active, effective collaboration can occur when practitioners resolve these problems and integrate their services.42,43,45

Other investigators have identified these essential components for practitioner collaboration: effective communication, sharing of patient care responsibilities, and viewing other practitioners’ patient care services as equally valuable and complementary.12,26 This list is similar to the antecedent conditions described by Baggs and Schmitz.45

Effective collaboration requires all providers to commit to the relationship for the purpose of improving patient care. In fact, CWRs can translate into improved patient outcomes, a goal that is integral to the philosophy of pharmaceutical care. With pharmacist–physician collaboration, drug therapy monitoring can be increased, patient-specific information can be exchanged in a more timely manner, and drug therapy problems can be resolved more effectively and efficiently.

Model for Pharmacist–Physician Collaborative Working Relationship

Figure 1 shows a staged approach to developing CWRs among pharmacists and physicians. We synthesized the model from models of interpersonal relationships,50 business relationships,51 and collaborative care.52,53 The progressive stages of the pharmacist–physician CWR model are: Stage 0—Professional Awareness; Stage 1—Professional Recognition; Stage 2—Exploration and Trial; Stage 3—Professional Relationship Expansion; and Stage 4—Commitment to the Collaborative Working Relationship.

Table 1. Common Obstacles to Interprofessional Collaboration Among Practitioners

- Boundary or turf concerns
- Communications breakdown
- Power issues
- Lack of trust in another practitioner’s competence
- Practice sites distant from one another

Source: Reference 50.

The progressive shading of the boxes in the model as shown in Figure 1 represents the increasing collaboration among the pharmacists and physicians and signifies greater motivation to maintain the relationship.58 Contributions by all parties increase as the relationship progresses. As interdependence increases, the relationship strengthens and becomes more durable.

Interactions among pharmacists and physicians are viewed as exchanges. At Stage 0, exchange is minimal and interactions are of a discrete nature. Examples of discrete interactions among pharmacists and physicians include pharmacists phoning in refill requests, alerting physicians to possible adverse drug reactions, or discussing a drug therapy problem identified during the dispensing process. Such interactions tend to be of short duration and conducted without much thought of developing a relationship or identifying new strategies to improve the patient care process.

During Stage 1, the efforts to establish a relationship are mostly unilateral and the pharmacist is the primary instigator. For example, as pharmacists develop new services, they may call on physicians to ask for referrals to their practice. At this stage, pharmacists see the relationship as necessary for the success of their new clinical service, whereas physicians may not see the value of the service or the need to establish a direct working relationship with the pharmacist.

As the relationship progresses through the stages, efforts to maintain it become more bilateral. Once pharmacists reach Stage 4, commitment to the CWR has been achieved, all those involved have an interest in sustaining the relationship, communication is bilateral, and mutual trust and respect have been established.

Characteristics that affect the development of a CWR are shown in Table 2. The first set characterizes the participants’ personal and professional backgrounds. The second set characterizes the context of the practitioners’ practices, including environment and systems. The third set characterizes the nature and extent of exchanges occurring among pharmacists and physicians.
Participant Characteristics

Each practitioner possesses a set of individual characteristics that affect his or her willingness to accept the changes and risks involved in developing a collaboration (see Table 3). One group of individual characteristics is demographics, such as education and age. For example, younger practitioners whose education included interdisciplinary experiences may be more receptive to pharmacist-physician collaboration.59 In contrast, some older physicians have shown less support for expanding the role pharmacists play in providing clinical services.59

A practitioner’s medical specialty, familiarity with others’ professional abilities, and confidence in the benefits of collaboration may affect his or her engagement in a pharmacist-physician relationship. A physician who specializes in a particular area of medicine may have limited knowledge about conditions outside of his or her specialty that would make collaboration with a pharmacist more attractive. Alternatively, a physician’s familiarity with and respect for a pharmacist’s abilities could support his or her willingness to accept a pharmacist’s input.57,58 Also, a practitioner’s confidence that taking an interdisciplinary approach will improve patient care would bode well for his or her participation in a CWR. Pharmacists can use this information when they are deciding which physicians are likely to be good candidates for a CWR. Identifying key physicians, listing their participant characteristics, and learning more about their practices can help pharmacists plan for future meetings with these practitioners.

Context Characteristics

Context characteristics also influence the growth of collaboration (see Table 4). Context comprises features of the participants’ practices and the setting where they interact. The features of a health care practice include commonly performed patient care activities, resources present (e.g., personnel, finances, facilities, contracts), patient mix, and organizational structure.59,60 These factors influence practitioners’ perceptions of the costs and benefits of establishing a CWR. For example, a primary care physician in a rural setting may perceive some benefits of establishing a CWR with the local
Table 3. **PARTICIPANT CHARACTERISTICS THAT AFFECT COLLABORATIVE WORKING RELATIONSHIPS**

1. Demographics of the practitioner

   Education: Practitioners whose training included an interdisciplinary approach to patient care are more likely to collaborate with other practitioners.

   Age: Older practitioners, especially those who have not had training in the interdisciplinary approach to patient care, may show lower support for collaboration with other practitioners.

2. Specialist versus primary care practitioners: Primary care practitioners may have more opportunities to interact with other team members and form collaborative working relationships. However, specialists are often accustomed to working with other providers, since their education and training reinforces this concept (e.g., endocrinologists working with nurses, dietitians, and pharmacists to care for patients with diabetes).

3. Familiarity with other practitioners: Practitioners who have worked on teams in the past may be more willing to participate in future collaborations after they have assessed the competence of a particular practitioner.

4. Practitioner confidence: Practitioners who believe that an interdisciplinary approach to patient care is best may be more willing to collaborate with other practitioners.

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Table 4. **CONTEXT CHARACTERISTICS THAT AFFECT COLLABORATIVE WORKING RELATIONSHIPS**

1. Practice features

   Patient mix: The types of patients who receive care from the pharmacist and the physician can influence the development of collaborative working relationships. Patient groups with greater needs are more likely to benefit from collaborative care.

   Practice type: This includes group practices versus single-provider practices. Providers in single-provider practices do not have the same professional support as providers in group practices and may be more willing to form collaborations with pharmacists.

2. Proximity of practices: Practitioners in close proximity to one another have more opportunity to interact and form collaborations.

3. Volume of interaction: The more interaction between providers, the more likely they will develop professional relationships that have the potential for becoming collaborative.

4. System relationship: Collaboration is more likely to occur if pharmacists and physicians are part of a common health care system that supports collaboration. For example, clinical pharmacists within the Veterans Administration system are integrated members of the health care team who provide a variety of primary care services (e.g., anticoagulation, lipid management, diabetes education.)

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pharmacist since both practitioners share the same patient pool, may improve patient care by sharing patient information, and have less formal organizational structures that foster open communication. In contrast, a specialist in a metropolitan area may have a less diverse patient mix and his or her patients may patronize a variety of pharmacy practices. In cities, practitioners' organizational structures and channels of communication may be more formal, with limited opportunities for meeting other practitioners face-to-face.

The proximity of the practitioners—geographically, organizationally, and socially—is another important context characteristic. In settings where pharmacists and physicians are in close proximity (e.g., a family practice clinic), opportunities to interact increase because they may share a common building, be part of the same management group, and attend common business and social functions. These circumstances may increase the number of interactions in which practitioners experience each other's approach to patient care, increasing their comfort level with each others' clinical competence.

Another context characteristic is the health care system. When practitioners are in the same system (e.g., a health maintenance organization), collaboration can be facilitated or hindered through organizational structure, rules, and role setting.
Exchange Characteristics

The third set of features that influence the development of pharmacist–physician CWRs is exchange characteristics (see Table 3). Here, exchange is not limited to monetary transactions, but can also encompass social interactions. Pharmacists and physicians exchange information, permission, and responsibility for patient care. The nature of such exchange can range from discrete to relational. Discrete exchange is characterized by separate, unrelated transactions, in which the identity of the exchange partner is of little consideration. Under discrete exchange, the net benefit of each transaction is considered. In contrast to the impersonal nature of discrete exchange, the identity of the exchange partner is of vital interest to the parties involved in relational exchange, which focuses on a relationship with a particular party. Also, in relational exchanges, the parties behave as though the net benefits will balance over the long term, rather than on a transaction-by-transaction basis.

Exchange characteristics include attraction, communication, power and justice, norm development, expectation assessment, performance assessment, and conflict resolution. Physicians who perceive greater value from a pharmacist's contributions are more likely to find an expanded role for pharmacists attractive. Several aspects of communication can affect relationship development: bidirectionality, method of communication, frequency, and content or message. Bidirectionality refers to the extent that two-way communication occurs. Such communication should support movement toward a CWR. Also, the use of a communications medium that allows person-to-person discussion of patient issues should facilitate collaboration. For example, face-to-face visits provide opportunities for pharmacists and physicians to become comfortable with one another and start to develop relationships based on trust and respect. In contrast, if practitioners never have the opportunity to see each other and communicate only by telephone or fax, they may never become comfortable enough with each other to establish true CWRs. The frequency of the message refers to the number of times pharmacists meet or have extended discussions with physicians about patient care. Lastly, in regard to content, the message should remain clear and concise, focusing on patient care and the benefits of the collaboration for physicians and their practices.

Power and justice relate to the ability to influence another and to the fairness of the relative costs and benefits of the exchanges. Power can derive from various sources, including authority, ability to reward or coerce, and expertise. Given physicians' legal authority to prescribe medications, they typically possess more power than pharmacists. However, pharmacists can use their expertise to gain some countervailing power. The more balanced the power between the pharmacist and physician is, the more likely they are to progress to a CWR.

Norms develop to govern any social exchange. Social norms are regular behavior patterns or expectations about how someone should behave. Norms of exchange can develop over time as people interact. For example, physicians may be resistant to pharmacists' recommendations, particularly if they have not previously experienced this service. However, as they become more comfortable with the competence of pharmacists and gain trust in their recommendations, physicians can become more accepting of pharmacists' inputs. The formation of relational norms, such as reciprocity and solidarity, can support collaboration among pharmacists and physicians. Conversely, firmly established norms

Table 5.

<table>
<thead>
<tr>
<th>Exchange Characteristics That Affect Collaborative Working Relationships</th>
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<tr>
<td>1. Attraction: Certain characteristics or circumstances may cause providers to be professionally attracted to each other.</td>
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<td>2. Openness and bidirectionality of communication: Providers who communicate with each other in an open manner are more likely to form collaborative working relationships.</td>
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<tr>
<td>3. Power and justice: This characteristic refers to the ability of one provider to influence another and the fairness of the exchange (costs and benefits).</td>
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<tr>
<td>4. Norm development: Norms develop over time as providers become more comfortable with each other professionally.</td>
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<td>5. Expectation development: As providers begin to exchange information, they will begin to form expectations about the other's abilities and competence.</td>
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<td>6. Performance assessment: As expectations develop, providers will begin to assess the performance of others.</td>
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<td>7. Conflict and its resolution: This refers to one provider's belief that another is preventing him or her from achieving his or her goals. Resolving conflicts through open discussion allows the relationship to strengthen.</td>
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against pharmacist-physician collaboration could act as obstacles to cooperation. For example, if a CWR has never been established in a certain area or within a particular practice, then resistance from potential participants may be more likely.

As pharmacists and physicians begin to exchange information, each provider assesses the other's performance. These assessments help the providers recognize each other's value, build mutual trust, and develop satisfaction with the relationship.22,23 The net benefits of each exchange among partners combine to add value to the professional collaboration. Similarly, if expectations are confirmed, then satisfaction with exchange partners may result.74 The continued meeting of expectations also can contribute to the development of trust.75

Many working relationships involve conflict at some point. Here, conflict refers to one party's belief that another is preventing him or her from achieving his or her goals. For example, a physician may believe that expanding the role pharmacists play in patient care will prevent the physician from providing the best care to his or her patients. The presence of conflict, however, can offer parties an opportunity to strengthen their relationship. When confronted with conflict in a working relationship with a physician, a pharmacist should communicate directly with the physician. If possible, a cooperative conflict resolution strategy, such as joint problem solving, can be used. That is, both parties should work to resolve the conflict.

Participant, context, and exchange characteristics all affect the likelihood that pharmacists and physicians will develop a CWR. Some characteristics are active in all stages of a pharmacist-physician relationship, whereas others are influential only in certain stages. These characteristics determine whether practitioners can establish a deepening interdependence and, ultimately, collaboration.

Collaborative Working Relationship

Model: Stages

To fully explain the CWR model, we will describe the model's stages and illustrate each stage with an example from practice.

Stage 0—Professional Awareness

Most pharmacists have already reached the stage of professional awareness with physicians. Typically, this includes engaging in interactions of a discrete nature, such as dispensing prescriptions that are faxed or telephoned in to the pharmacy, identifying adverse drug interactions, and answering drug information questions. Many pharmacists have limited their interactions with physicians to such activities and do not regularly discuss whether a drug is therapeutically optimal for the patient. During the awareness stage, pharmacists may be satisfied with this status quo and have no plans to develop CWRs with physicians. Practitioners in both groups consider these basic exchanges professionally safe, routine, and defined by perceived expectations.76 Although pharmacists must be confident in these exchanges, they do not have to be satisfied with this level of interdependence.

Pharmacists who want to expand their services must develop CWRs with physicians that go beyond discrete exchanges. One approach is to look upon each interaction as an opportunity to expand the relationship.76 Pharmacists can begin to position themselves for this role expansion by displaying confidence in their capabilities and preparing for the next stage—professional recognition.7

Example

Our example involves collaboration between a community pharmacy and a neurology practice located in the same city. The community pharmacy is an independent practice that provides clinical services and disease state management programs. The pharmacy is centrally located in the city approximately 1 to 2 miles from the neurologists' offices. Before the initiation of a CWR, communications between the providers was of a discrete nature, meaning the pharmacist-physician relationship was at Stage 0 (professional awareness). For example, a pharmacist would call a neurologist when refills were needed, drug interactions occurred, or a patient was complaining of an adverse effect related to the medication. However, the pharmacists were interested in developing a community-based anticoagulation service.

Stage 1—Professional Recognition

Pharmacists should expect to engage in unbalanced exchanges with physicians when initiating the professional recognition stage. In the beginning, efforts to increase the frequency and quality of interactions with physicians tend to be unilateral, with the pharmacists prompting the exchanges. Pharmacists in this stage should work to make physicians aware of the resources they can provide to the physicians' practices (see Table 6). The value of the relationship comes from the synergy between the physician and pharmacist, which allows both to gain from the partnership. Through a series of positive exchanges with a pharmacist, a physician can start to build a foundation of trust and a growing commitment to the relationship.

To promote the relationship, a pharmacist may begin to regularly provide helpful information (e.g., patient medication histories, adherence information) to the physician. The physician may come to expect this value-added service and distinguish the pharmacist who provides it from others. In order to develop the foundation for a CWR, it is important to realize that each exchange is interpreted in terms of the relationship's history and anticipated future.75 Thus, at this point, the practitioners begin to consider the costs and benefits of continued exchange.

The dominant exchange characteristics in Stage 1 are attraction, communication, and power and justice.
Enhancing the pharmacist’s attractiveness or usefulness to the physician is essential for development of professional recognition. Pharmacists may accomplish this by identifying an area of need for patients and physicians in their practice setting and developing expertise in that area. Pharmacists can propose a service that will benefit their patients as well as targeted physicians. Pharmacists should be able to describe how the services they provide can add value to physicians' practices in order for physicians to acknowledge the usefulness of pharmacists to the health care team.

Communication is a common thread that weaves through the entire CWR model. Without adequate communication, the exchanges among pharmacists and physicians may be misperceived, which can lead to conflicts. For example, some physicians may fear that a pharmacist’s plans may be to create an independent practice and segment the delivery of services to patients. By communicating specific objectives of the service and requesting feedback from physicians, pharmacists can establish the flow of communication.

Power and justice are exchange characteristics that determine the exchanging parties’ abilities to achieve their intended goals. At this stage, the balance of power is tilted in favor of physicians. Physicians who have not collaborated with pharmacists in the past may see little reason to do so at this point. In essence, pharmacists are more dependent on this collaboration than are physicians. To shift the balance of power, pharmacists must put forth extra effort to communicate to physicians the benefits that the pharmacy service can provide to patients and physicians.

Justice is achieved when the new service benefits patients, as well as physicians and pharmacists. All practitioners should be in agreement that the goal of collaboration is to improve patients’ health. Exercising justice implies voluntary compliance by practitioners and supportive behaviors for the promotion of mutual goals involving patient care. Recognition of these mutual goals allows for the exploration and trial stage.

Example

In the CWR example introduced previously, the neurologists were unaware of the anticoagulation service being developed by the community pharmacy. They were equally unaware of the pharmacists’ clinical competence to perform this service. The neurologists were chosen because they were adjusting warfarin doses on their own, had expressed an interest in becoming involved with an anticoagulation clinic and were open to discussing an expanded role for the pharmacists. One of the pharmacists began to call on key physicians (“thought leaders”) and administrators from the medical group who were willing to discuss collaboration with a community pharmacy.

At the initial meeting, these physicians expressed an interest in the anticoagulation program but asked for more evidence of such a program’s feasibility and a description of how information would be communicated among providers. A series of meetings took place over a 2- to 3-month period during which the pharmacist put together literature about pharmacy-managed anticoagulation clinics as well as an initial protocol. With each meeting, interest increased and other key individuals were brought in to assess the service. While interest was mutual, the pharmacist was fully responsible for the meeting agenda and materials (i.e., unilateral effort). After enough interest was generated, the medical director of the neurologists' medical group agreed to meet with the pharmacist and a vice president of the local hospital where the neurologists’ practice was located.

The neurologist assessed the clinical quality of the protocol and tested the pharmacist’s clinical decision-making abilities by asking him questions about cases from her practice concerning the dangers of warfarin. As each case was presented, the pharmacist provided his clinical recommendation and explained what information he would provide to the patient. The pharmacist addressed the neurologist’s concerns about the dangers of warfarin and agreed to put together a protocol for vitamin K use in patients who are over-anticoagulated. The neurologist agreed to take the clinic proposal to her partners, and another meeting was scheduled to further discuss the collaboration.

At the subsequent meeting, the neurologist and pharmacist worked out the details of how the neurology office and the pharmacy would communicate. Forms were developed (see Figures 2 and 3), a protocol was refined, and an agreement was made to try the service. A shortcoming of the arrangement was that no timeframe was discussed, leaving commencement of patient referrals to the anticoagulation service unplanned. In fact, for the first 2 months after this
agreement, no referrals were made. This prompted the pharmacist to meet with the neurologist to start the referral process and move on to Stage 2 of the collaboration process.

**Stage 2—Exploration and Trial**

During this stage, practitioners gauge and test their compatibility, expectations, trustworthiness, and commitment to the relationship. Pharmacists continue to be the initiators as physicians consider their obligations as well as the benefits and risks of collaboration. The stakes of the exchange can impact the extent, duration, and nature of the exploration and trial stage. For example, physicians may decide to refer a patient to the pharmacy to test the pharmacists' skills and competence. The quality of care that the pharmacists give to the patient will be evaluated by the physicians to determine if it is worthwhile to continue the relationship by referring more patients (see Table 7).

Norms and expectations continue to develop during the exploration stage. Norm development can help to define the purpose and boundaries of the relationship. The presence of norms of exchange helps to identify the appropriate use of power and to establish which practitioner should have responsibility for specific patient care activities. Providing excellent care and establishing services that meet patients' and physicians' needs allow pharmacists to establish norms that did not exist during previous physician–pharmacist interactions, thus moving the relationship beyond exploration and trial.

Each exchange during the exploration and trial stage will help the practitioners refine their expectations regarding others' behavior. This development of expectations can either increase or decrease the value physicians and pharmacists place on the working relationship. If physicians feel their patients did not receive the expected care from pharmacists or if misinformation was given, then expectations could be lowered. Commitment is limited during this stage, thus making the relationship fragile and easily dissolved.
crucial for the pharmacist to communicate a patient’s progress directly to the physician in order to minimize the potential for miscommunication.

In the exploration stage, physicians place trust in the pharmacists’ capabilities. When the pharmacists’ care behavior meets or exceeds the physicians’ expectations, the relationship can expand. The trust, value, and satisfaction necessary to support the expansion of the professional relationship can develop over time with continued provision of outstanding care.

Example

With the anticoagulation service arrangement in place, the neurologists had not made any referrals during the first 2 months after agreeing to use this service. Consequently, the pharmacist scheduled another meeting with the head neurologist to discuss service implementation and patient referrals. The main problem cited by the neurologist was that neither she nor her colleagues remembered to refer patients as they presented to their practice. A new strategy in which nurses in the neurologists’ office would identify appropriate patients and start the referral process was discussed, and the neurologist agreed to refer a patient within the next 2 weeks.

Toward the end of the second week, a patient was referred from the neurology practice to the pharmacy-managed anticoagulation service. The patient had the appropriate paperwork, which included the goal international normalized ratio (INR) and the indication for the anticoagulation. The service was performed, the dose was adjusted, and the patient care information was faxed to the neurology office. The case of this first patient was more complicated than the pharmacists had expected, and she had been referred because of the neurologist’s frustration with her admitted nonadherence to therapy and diet. The patient’s INRs fluctuated over a wide range. The pharmacists worked with the patient and were able to stabilize her INRs over a 6- to 8-week period. In accordance with the practice agreement, reports of dosage adjustments and patient interventions were faxed to the referring physician after each patient visit. Due to the success achieved with the first patient, another patient was referred to the pharmacy for treatment within a week.

Stage 3—Professional Relationship Expansion

Seeing a continued increase in benefits from the exploration and trial stage can lead practitioners to increase interdependence and expand professional relationships (see Table 8). Key exchange characteristics of this stage include communication, norm development, performance assessment, and conflict resolution.
Communication becomes more bilateral when both parties are involved in fine-tuning the relationship through performance assessments. The exchange efforts are still unbalanced, with pharmacists needing to continually communicate the benefits previous patients have received from pharmacists' services.

Performance assessment involves physicians evaluating the quality of care provided by the pharmacists. Such assessment helps to shape the future expectations and affects the development of trust and influence in the collaboration. Changes in expectations and norms may emerge from feedback during performance assessment. Expectations continue to evolve as physicians and pharmacists establish the range and depth of their interdependence. The goal is to maintain or increase the quality of the exchange so that the professional relationship can continue to expand.

Conflicts should be expected when progressing through the expansion stage. During successful resolution of conflict, the expectations for the relationship may be renegotiated. Conflict resolution is more likely to be constructive when pharmacists have achieved a balance of power with physicians and all parties are oriented toward maximizing benefits for their patients. The increase in interdependence and trust built through past exchanges allows for development of a stronger relationship—one that can withstand these conflicts. The investment in the collaborative effort also strengthens the commitment to its continuation and makes dissolution of the working relationship more costly.

Pharmacists must adapt and be willing to accept both positive and negative evaluations from physicians to continue developing the relationship. The amount of influence physicians believe pharmacists should possess during patient care may be redefined, thus establishing new norms. The key is to ensure that the relationship continues on a positive and productive course as the situation evolves. Norms, expectations, and conflict are active through the expansion stage and eventually lead to formation of a CWR by deepening the interdependent interests of the physicians and pharmacists.

Example

The relationship between the neurology group and the community pharmacy practice we cite as our example is currently at Stage 3. Although an increasing number of patients have been referred to the pharmacy, the majority of the neurologists' patients who need anticoagulation therapy monitoring have not been referred. Additionally, several neurologists in the physician group still have not used this anticoagulation service. Those who have referred patients, however, have expressed gratitude for and satisfaction with the service.

Currently, the pharmacists make dosage adjustments and provide patient education. In return, the physicians provide the pharmacy with a prescription for services (certificate of medical necessity), the patient's diagnosis (ICD-9 code), and any other pertinent clinical information necessary for providing patient care. The pharmacists fax the INR results and dosage adjustments to referring physicians after each patient visit. Pharmacy reports provide other pertinent information (e.g., the percentage of time patients are within the targeted INR range), and the forms have been updated and refined to
improve the patient care process. The neurologists have come to expect timely information and reliable clinical recommendations from the pharmacists. Conflicts have been minimized because of the communication among the practitioners. The neurologists who use the service have given the pharmacists full responsibility for dosage adjustments.

Stage 4—Commitment to the Collaborative Working Relationship

The prominent exchange characteristics for Stage 4 are the same as those for Stage 3. Collaboration is more likely to occur when physicians view the risk to their own practice as low and the value added as high. Scanzoni\(^2\) stated that for commitment in a relationship to exist, at the very least, all of the following elements must be present: relatively high input levels by the parties, relatively lengthy duration, and relatively great consistency. Reaching commitment will be more likely if the exchange efforts by and relative power among members of the pharmacist–physician team are somewhat equitable. Physicians will rely on the knowledge and skill that pharmacists have displayed during the development of the CWR. Pharmacists will rely on the clinical information physicians provide to them as they help to manage patients’ drug therapy. The time required to obtain commitment to collaboration can vary considerably because of participant and context characteristics (e.g., practitioner type, practice setting, professional experience). Face-to-face meetings, clinical recommendations, and feedback to pharmacists will help to move the relationship through the various stages.

Once commitment to a CWR is achieved, practitioners still need to attend to the relationship. Face-to-face meetings to discuss patients, practice issues, and other concerns should be regularly scheduled. If conflict does occur, then an open discussion among the practitioners should be scheduled promptly to resolve the issue. Both pharmacists and physicians should identify strategies to improve the joint care process to ensure optimal patient outcomes. Also, staff from both practices should be informed of the relationship so that they become involved in the collaborative process.

Example

As discussed previously, the CWR we took as our example is currently in Stage 3. However, some of the neurologists have moved to Stage 4 by agreeing to a formalized CPA, reflecting their satisfaction with the pharmacist’s anticoagulation services (see Figures 2 and 3). A formalized CPA offers several benefits. First, some third party payers may reimburse pharmacists for cognitive services when this agreement is in place. Second, many patients are more comfortable with an expanded role for pharmacists if their physicians are referring them to the anticoagulation clinic. Third, a CPA provides a legal foundation for the professional relationship among pharmacists and physicians. Lastly, CPA provides a model that can be expanded to include other clinical services available at the pharmacy clinic and additional referrals from other physicians.

Plans are underway for the pharmacists to meet with the entire group of neurologists to share the results of the program and secure their agreement to use the service for their patients on warfarin therapy. Communication with those neurologists not using the service will be increased and an emphasis will be placed on performance and outcomes of the service.

Conclusion

As illustrated in the model (Figure 1), CWRs develop in five stages. While the CWR model is derived from theory and practical experience, it has not yet been empirically tested. Future research is needed to better understand the influences on the development of CWRs among pharmacists and physicians. Evidence from a variety of practice settings would be useful for assessing the accuracy of the model.

As the benefits of pharmacist–physician CWRs become more apparent, more pharmacists are likely to develop them. The CWR model offers a framework that can guide practitioners in this effort. Pharmacists and physicians can strengthen their professional relationships by collaborating to improve patient outcomes. More importantly, knowledge of these stages and the activities needed to progress to higher levels in the working relationship is the springboard for initiating successful CPAs.

References


Assessment Questions

Instructions: For each question, circle the letter on the answer sheet corresponding to the answer you select as being the correct one. Please review all your answers to be sure that you have circled the proper answer. There is only one correct answer to each question.

1. Factors supporting the need for an increase in collaboration among pharmacists and physicians include all of the following except:
   a. Movement of patients from ambulatory to inpatient settings.
   b. An aging population that requires more medication.
   c. Presence of considerable drug-related morbidity and mortality.
   d. Innovations in pharmacotherapy.

2. According to Baggs and Schmitt, which of the following conditions will facilitate collaboration among health care practitioners?
   a. Practitioners should be in close proximity.
   b. Practitioners need to be making time to interact.
   c. Each practitioner should possess useful knowledge for patient care.
   d. All of the above alternatives are correct.

3. All of the following obstacles to collaboration among health care practitioners have been identified in the nursing literature except:
   a. Payment for collaboration.
   b. Boundary or turf concerns.
   c. Breakdown in communication among practitioners.
   d. Power issues among practitioners.

4. The Model for Pharmacist–Physician Collaborative Working Relationship includes all of the following stages except:
   a. Professional Recognition.
   b. Profession Balance.
   c. Exploration and Trial.
   d. Professional Awareness.

5. ______ is a context characteristic that can influence the development of pharmacist–physician collaboration:
   a. Physician training.
   b. Pharmacist trust in a physician.
   c. Patient mix.
   d. Pharmacist expertise.

6. Physicians who receive more ______ from a pharmacist’s contributions are more likely to support an expanded role for pharmacists.
   a. Work.
   b. Problems.
   c. Costs.
   d. Value.

7. ______ exchange is characterized by separate, unrelated transactions in which the identity of the exchange partner is of little consideration.
   a. Relational.
   b. Complex.
   c. General.
   d. Discrete.

8. The stage in the collaborative working relationship model that is characterized by a testing of a pharmacist’s skills and competence is ______.
   a. Professional Awareness.
   b. Professional Recognition.
   c. Exploration and Trial.
   d. Professional Relationship Expansion.

9. Routinization of new patient care activities is likely to occur in which stage of the collaborative working relationship model?
   a. Commitment to the Collaborative Working Relationship.
   b. Professional Relationship Expansion.
   c. Exploration and Trial.
   d. Professional Recognition.

10. Which of the following activities is not an example of a discrete exchange?
    a. Dispensing a prescription.
    b. Identifying an adverse drug reaction.
    c. Performing dyslipidemia testing on a patient under a collaborative care agreement.
    d. Answering a patient’s routine drug information question.

11. According to Scanzoni, characteristics of commitment include all of the following except:
    a. Relatively high input levels.
    b. A power imbalance.
    c. Relatively long duration.
    d. Consistency by the parties.
12. Which of the following strategies can help pharmacists achieve professional recognition (Stage 1)?
   a. Regularly provide physicians with helpful information, such as adherence information.
   b. Identify services in the pharmacy practice that can complement the physician's practice while meeting patients' needs.
   c. Discuss specific ideas with physicians to gauge their interest.
   d. All of the above alternatives are correct.

13. At which stage in the collaborative working relationship model is the pharmacist likely to have the least power?
   a. Commitment to the Collaborative Working Relationship.
   b. Professional Recognition.
   c. Professional Relationship Expansion.
   d. Exploration and Trial.

14. Aspects of communication that can affect relationship development include the following:
   a. Content.
   b. Bidirectionality.
   c. Medium used.
   d. All of the above alternatives are correct.

15. Relatively few pharmacists participate in collaborative practice agreements (CPAs) because:
   a. Only a few states have some form of CPAs statute or regulation.
   b. Signing a CPA represents a relatively late stage in a working relationship, and many pharmacists have not yet worked through the precursor stages.
   c. Integrating pharmacists into drug therapy management has not been shown to improve patient outcomes.
   d. None of the above alternatives is correct.
Monograph 19

Collaborations Between Pharmacists and Physicians: Steps for Building More Effective Working Relationships
(ACPE I.D. # 202-000-01-190-H04)

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