“Management is About Coping with Complexity”: Concerns of Ontario Pharmacists Regarding Management of the Process of Adapting to Changes in the Scope of Pharmacy Practice

by

Beatriz Teixeira

A thesis submitted in conformity with the requirements for the Master’s Degree in Pharmaceutical Sciences
Department of Pharmaceutical Sciences
University of Toronto

© Copyright by Beatriz Teixeira 2016
“Management is About Coping with Complexity”: Concerns of Ontario Pharmacists Regarding Management of the Process of Adapting to Changes in the Scope of Pharmacy Practice

Beatriz Teixeira

Master’s Degree in Pharmaceutical Sciences

Department of Pharmaceutical Sciences
University of Toronto

2016

Abstract

Increasing evidence suggests that community pharmacists in Ontario are underutilized health care professionals, especially with respect to medication management and prescribing for patients (Pojskic, McKeigan, Boon & Austin, 2014). In December 2009, Ontario’s provincial government expanded the scope of pharmacy practice (Ontario Pharmacists Association [OPA], 2014b) to improve access to health care for Ontarians (Ontario Ministry of Health and Long Term Care, 2015). Subsequently, pharmacists have been called upon by professional organizations to adopt a patient-centered role. However, many pharmacists in Ontario are encountering challenges to fully adopting the new scope of practice. Using Kotter’s (1995; Kotter & Cohen, 2002) framework of change management, this research aims to identify and describe enablers of and barriers to the process of change in community practice. The findings of this research can further support leaders (regulators, academics, employers, etc.) in the profession to support pharmacists through the change process.

Keywords: community pharmacist, change management, pharmacy practice, medication management, patient-centered practice, professional identity.
Acknowledgements

Firstly, I would like to express my deepest gratitude to my advisor Dr. Zubin Austin for his patience, incentive, and continuous support of my M.Sc. study and related research. His profound knowledge in educational research in the health professions provided me with excellent guidance for completing my research and for writing this thesis. I could not imagine having a better advisor and mentor for this M.Sc. study, which aims to contribute to enhancing the provision of patient care by pharmacists.

I would also like to thank the advisory committee for my thesis: Dr. Alison Thompson and Dr. Peter Pennefather, for their insightful comments and encouragement, but also for challenging me to continuously refine my research project.

My sincere thanks goes also to Ms. Heather Sanguins, instructor at the University of Toronto Writing Centre, who provided me with valuable support and insight in editing my research thesis.

I thank all the community pharmacists who voluntarily participated in this research study, sharing their perspectives on the changes happening to the scope of pharmacy practice in Ontario. I am grateful for their contributions, which can enlighten pathways to fully transition pharmacists into patient-centered clinical practice.

Last but not the least, I would like to thank my family: my parents for all their love and encouragement and for inspiring me through life to continuously pursue intellectual development; my husband for his constant friendship and incentive throughout my M.Sc. program; and my brothers’ support and incentive throughout the writing of this thesis. I especially thank my daughter Julia for giving me strength to believe that with determination and hard work, I can do anything. I thank my grandparents for their sweetness and love, and particularly my grandfather, who was a great pharmacist and human being, for being the professional role model that I aspire to become.
# Table of Contents

List of Tables ................................................................................................................................ vii

List of Appendices ....................................................................................................................... viii

Chapter 1 Introduction .................................................................................................................... 1

  Problem Statement ..................................................................................................................... 1

  Background ................................................................................................................................ 2

  Objective .................................................................................................................................... 5

Chapter 2 Literature Review ........................................................................................................... 7

  Experience of Change in Pharmacy Practice ........................................................................... 10

Chapter 3 Change Management Theories ..................................................................................... 17

Chapter 4 Research Methods ........................................................................................................ 28

  Methodology ............................................................................................................................ 28

    Method ...................................................................................................................................... 29

    Recruitment and Interviews .............................................................................................. 30

    Data Collection .................................................................................................................. 31

    Data Analysis .................................................................................................................... 31

Chapter 5 Results and Discussion ................................................................................................. 33

  Kotter’s Principles #1 and #6: Establishing a Sense of Urgency; Planning for and Creating
  Short-Term Wins (Managing Time and Resources) ................................................................. 34

    Time Constraints .................................................................................................................... 34

    Workload ............................................................................................................................ 35

    Remuneration ..................................................................................................................... 39

    Pharmacy Technicians ...................................................................................................... 41

    Health Care Accessibility .................................................................................................... 43

  Kotter’s Principle #2: Forming a Powerful Guiding Coalition (Professional Cohesion) ........ 44

  Kotter’s Principle # 5: Empowering Others to Act on the Vision (Business Model of
  Pharmacies) .............................................................................................................................. 46
List of Tables

Table 1: Pharmacists’ Expanded Scope of Practice in Canada…………………………………124

Table 2: Comparison of Change Management Models…………………………………………125

Table 3: Pharmacists’ Occupational Profile………………………………………………….128
List of Appendices

Appendix 1: Pharmacists Expanded Scope of Practice in Canada........................................124
Appendix 2: Comparison of Change Management Models..............................................125
Appendix 3: Research Interview Guide........................................................................126
Appendix 4: Pharmacists’ Occupational Profile..............................................................128
Appendix 5: Additional Interview Quotes......................................................................129
Chapter 1
Introduction

Problem Statement

Community pharmacists in Ontario are health care professionals who compound and dispense medication to patients at the pharmacy, as well as counsel patients regarding health management and medication use. However, increasing evidence suggests that pharmacists are underutilized health care professionals, especially with respect to medication management and prescribing for the patient (Pojskic et al., 2014). Pharmacy education in Canada has evolved to establish the basis for expanding the scope of pharmacy practice to include a patient-centered role for pharmacists (Austin & Ensom, 2008). However, a study undertaken in Ontario reported that people who are assisted by pharmacists usually see themselves as clients or customers rather than patients (Verbeek 2004 as cited in Austin, Gregory, & Martin 2006). Moreover, another study suggests that pharmacists lack a professional identity and a clear definition of their role on which to build responsibility and to advance clinical practice (Frankel & Austin, 2013).

In December 2009, with the support of the Ontario Pharmacists Association (OPA), Ontario’s provincial government approved Bill 179, which introduced changes in laws and regulations governing the profession that expanded the scope of pharmacy practice (Ontario Pharmacists Association [OPA], 2014b). In this new regulatory landscape, pharmacists have been called upon by professional organizations to adopt a patient-centered role in order to achieve the vision put forth for their profession: “delivering optimal drug therapy outcomes for Canadians” (Blueprint for Pharmacy, 2015). Despite the support of the provincial government and professional organizations, many pharmacists in Ontario are finding challenges to fully adopting the new scope of practice.

As an industrial pharmacist with an academic background in corporate management, the principal investigator of this study was interested in understanding if change management theories might be useful in elucidating some of the existing hurdles within community pharmacy in implementing new ways of pharmacy practice. The researcher’s professional experience has
been in pharmaceutical industries, working internationally in clinical research and regulatory affairs. One of the researcher’s objectives was to explore the thoughts and experiences of practising pharmacists in Ontario and to further understand how these pharmacists feel in terms of their roles and responsibilities with regard to the patients they see.

This research aims to identify and describe enablers of and barriers to the process of change in community practice and, in particular, the process through which pharmacists’ self-identified roles and responsibilities are evolving. Kotter’s (1995; Kotter & Cohen, 2002) change management theories provide a framework for understanding and implementing change in complex organizations and systems. The current research used Kotter’s (1995; Kotter & Cohen, 2002) framework of change management to explore how pharmacists are adapting or responding to changes in their professional practice. These research findings can further encourage leaders (regulators, academics, employers, etc.) in the profession to support pharmacists through the change process.

**Background**

Pharmacists assist patients with medication management as part of the process of dispensing drug products prescribed by physicians. The Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists, the Association of Faculties of Pharmacy of Canada, and the Institute for Safe Medication Practices Canada collaboratively defined medication management as the patient-centered care that improves safety, effectiveness, and appropriateness of medication treatment (Blueprint for Pharmacy, 2013). These two activities (dispensing drug products and medication management) are complementary and interdependent. The dispensing practice is strictly controlled in order to increase the accuracy of the dispensing process and to ensure that patients receive the correct medications. Evaluating and ensuring the correctness/appropriateness of medications requires sophisticated problem solving, analytical, interpersonal, and communication skills, and a strong, scientifically-oriented knowledge of medications and their appropriate use. Assisting patients with medication management has always played a part in pharmacists’ work, but now pharmacists are being encouraged to make this task central to their practice.
Changes have been made to laws and regulations governing the pharmacy profession in Ontario with the intent of advancing pharmacy practice and consequently improving access to health care (Ontario Ministry of Health and Long Term Care, 2015). On December 15th, 2009, Bill 179 received royal assent to expand the scope of practice for pharmacists (OPA, 2014b). Bill 179 authorizes pharmacists to perform several clinical procedures in their pharmacies, including renewing or adapting prescriptions, prescribing certain drugs for smoking cessation, providing annual influenza vaccines, administering drugs by injection or inhalation, and performing procedures on tissues below the skin (OPA, 2014b). Bill 179 also expanded the scope of practice of other health care professionals; nurses and pharmacy technicians are now authorized to dispense medications (Williams, 2014), sharing the responsibilities and benefits of this activity with pharmacists. Under the provisions of Bill 179, pharmacy technicians could assume many of the technical aspects of the dispensing process, allowing pharmacists to dedicate time to perform other clinical/patient-centered care duties in the pharmacy (Lynas, 2011). Nevertheless, pharmacists still are accountable for the therapeutic/clinical appropriateness of all prescriptions dispensed in the pharmacy (Canadian Pharmacists Association [CPhA], 2014). The medication dispensing process still requires close collaboration and effective teamwork between the pharmacist and the pharmacy technician, as they do have complementary responsibilities for therapeutic appropriateness and technical accuracy, respectively. As a result, dissociating these two activities completely is a challenge that limits the ability of the pharmacy technician to relieve the pharmacists’ time, which could be dedicated to patient care.

Further changes to the professional regulations reduced payments received by pharmacies in Ontario. The Ontario Drug System Reform came into effect on May 15, 2010 and was implemented gradually over the following two years (VanderElst, 2010). The Ontario Drug Benefit Act has been modified to include significant reduction of prices of generic drug products in Ontario for both public and private sectors (VanderElst, 2010). According to these new regulations, the price paid by the government for pharmacies to supply generic products to patients covered by the Ontario Drug programs was set at 25% of the cost of the brand name product (VanderElst, 2010). The private sector was also forced to cap the generic product price. Initially prices were reduced to 50% of the drug benefit price; then in 2011, prices were reduced
to 35%, and finally, in 2012, prices were reduced to 25% of the drug benefit price (VanderElst, 2010).

Professional allowances, which are payments received by pharmacies from pharmaceutical manufacturers to cover patient care initiatives, were banned from the public sector. Professional allowances gradually were reduced and finally were banned in the private sector (VanderElst, 2010). Allowances were paid to cover the financial gap that existed between the cost and amount paid by the government for pharmacies to dispense medication (Rosenthal, Austin, & Tsuyuki, 2012). In 2012, Rosenthal’s data suggested that the reduction of professional allowances would potentially have an impact on pharmacy operations (p. 36).

One hypothesis of this research study is that pharmacies have to reengineer, that is, restructure, their businesses to adopt a leaner (more efficient) model. Such a model would directly connect activities to revenues, including increasing operations in the activities that have the highest financial return to the business. Despite recent changes in remuneration practices, volume-driven dispensing of drug products is still seen by many pharmacy owners as being more stable and lucrative than providing patient-centered clinical services in a pharmacy. The Blueprint for Pharmacy (2009) recommended that the business model of pharmacies needs to be viable in order to sustain implementation of patient-centered clinical services in community pharmacies and that additional budgeting should be planned for change management, technology, and communications costs.

Nevertheless, these regulatory changes brought a wide array of clinical services for patients in the pharmacy by enabling and remunerating the pharmacist for the delivery of patient-centered care, not simply the dispensing of medications. The new regulations and financial realities of the practice have rapidly changed the professional landscape of pharmacists, requiring pharmacists to quickly learn new skills on the job. In 2014, the OPA stated that “the new scope of pharmacy practice, which authorizes pharmacists to perform a range of clinical services in the pharmacy, will provide patients with improved access to a more complete suite of health care services.” It has been publicly recognized in Ontario, however, that the adoption of clinical services has
happened gradually and that sometimes these services may not be adopted completely by pharmacies (Silversides & Tierney, 2013).

The qualitative research study of Rosenthal et al. (2012) analyzed the opinions of pharmacists that are available in the internet’s public domain regarding Schedule 5 of Ontario’s Bill 16. Among other changes, Schedule 5 of Ontario’s Bill 16 removed professional allowances paid by generic manufacturers to pharmacies. The analysis of Rosenthal et al. (2012) revealed four themes: “the desire to maintain the status quo of practice, a focus on the business of pharmacy, pharmacy stakeholders’ perceptions of the government’s attitude towards the profession, and changes to patient services” (p. 38). Rosenthal et al. (2012) found that patient-centered care was a seldom-addressed theme in the opinions of pharmacists about the new regulatory landscape of their profession (p. 38). These findings suggest that a gap exists between the regulations that govern pharmacy practice and the perspectives and beliefs of pharmacists regarding their roles and responsibilities in community pharmacy (Rosenthal et al., 2012).

Rosenthal et al. (2012) have suggested that the uptake of pharmacists’ new scope of practice can be increased if leaders in their profession take into consideration how pharmacists feel, think, and adapt to changes in practice prior to implementing these changes. Currently, although pharmacists are expected to work as health care providers, looking after the interests and well-being of patients, pharmacists are employed by pharmacy owners and managers, whose priority is to look after the interests of the business. A gap exists between the two sets of priorities. Nevertheless, pharmacies can contribute to changes in the practice if managers and owners support the suite of health services that can be provided by pharmacists. In addition, professional organizations can better lead the implementation of changes in practice if those changes are aligned with pharmacists’ willingness and capability to adopt them.

**Objective**

The primary objectives of this study are to explore and describe the impact of rapid changes in the pharmacy profession on community pharmacists and to understand the strategies that community pharmacists have been using to adapt to this evolving professional environment.
Using the widely-cited Kotter change management model (1995; Kotter & Cohen, 2002), this study aims to explore the views, feelings, and behaviors of pharmacists concerning current changes in the pharmacy profession, as well as to describe how pharmacists are adapting to changes in practice.
Chapter 2
Literature Review

Medical organizations’ key informants and policy documents have expressed opposition to what is commonly termed “pharmacists ‘prescriptive authority’” (Pojskic et al., 2014, p. 346). Despite this opposition, however, the Ontario government is expanding pharmacists’ scope of practice. Prescriptive authority is one of many changes included in the professional regulations that has increased pharmacists’ role in patient care. Furthermore, implementation of an expanded role is not limited to pharmacists in Ontario. All provinces across Canada are considering, or have made changes to, pharmacists’ scope of practice (see Appendix 1) (Pojskic et al., 2014).

In the community pharmacy realm, there has been a long-standing ambiguity in the professional orientation between health care and business roles (Perepelkin & Dobson, 2009). Research findings point to several challenges in changing to a patient-centered practice in pharmacy. Many challenges have been reported with regard to optimizing duties and workforces in pharmacies in the context of pharmacists’ expanded role (MarketView Research Inc., 2008). In 2008, a study conducted with community pharmacists working in Hamilton, Ontario found barriers to conducting MedsCheck in the pharmacy. Lack of time was cited as the main barrier, followed by workflow issues in the pharmacy (Dolovich, Gagnon, McAiney, Sparrow, & Burns, 2008). In the context of the new scope of practice, pharmacists have accumulated duties. They continue to support the business of pharmacy by dispensing medication in addition to a clinical patient-care role in the pharmacy.

Professional associations such as the OPA (2014a) and the Ontario College of Pharmacists (OCP) (2014) have offered continuing education to support pharmacists in transitioning to a patient-centered role. Continuing professional development programs also have emerged from Ontario universities in recognition of the importance of, and need for, the ongoing development of pharmacists’ professional competencies (Austin & Ensom, 2008). Nevertheless, competency may not be the only barrier for pharmacists in adopting a patient-centered practice. Alberta, the first province in Canada to approve a complete scope of prescribing authority, requires extensive training and education for pharmacists to prescribe (Makowsky, Guirguis, Hughes, Sadowski, &
Yuksel, 2013). At the same time, pharmacists have reported many important reasons to support exercising their prescriptive authority: optimization of a patient’s treatment when the doctor is not available, increased sense of professionalism as a health care provider, increased job satisfaction, required knowledge, liability, and workload (Makowsky et al., 2013). Knowledge was one of several influential factors in pharmacists’ decision to exercise their prescriptive authority.

In 2010, Rosenthal identified the following cultural traits of the pharmacy profession as challenges to patient-centered practice: lack of confidence, fear of new responsibilities, paralysis in the face of ambiguity, need for approval, and risk aversion. These cultural traits result in pharmacists avoiding accountability over patients’ outcomes (Rosenthal, Austin, & Tsuyuki, 2010). Another study suggested that pharmacists view themselves mainly as dispensers of medication rather than as health care professionals (Rosenthal, Breault, Austin, & Tsuyuki, 2011). According to Frankel and Austin (2013), significant cultural traits in the pharmacy profession, such as lack of confidence in clinical decision making and in taking up further responsibility, are hampering the evolution of pharmacy practice to a patient-centered model. Other research findings point to obstacles associated with the social legitimacy of the profession, including an overlapping role and responsibility with physicians, a business mindset that harms the professional image of community pharmacists as health care providers, and development of technology capable of performing pharmacists’ dispensing and compounding duties (Beales & Austin, 2006).

Nevertheless, pharmacists continued to move from a product-oriented role to a patient-centered health care practice, considering society’s greater awareness of patient safety and the public health focus on rational use of limited health resources, as well the greater need to define health care professionals’ accountability in patients’ health outcomes (Austin & Ensom, 2008, p. 1). Pharmacists are undergoing a paradigm shift when moving from a product-focused/business-oriented role to a patient-focused/health care oriented practice. According to Austin, Gregory, and Martin (2006), the use of terms like patient, client, customer, or consumer in pharmacy practice brings with it different interpretations of pharmacists’ roles and responsibilities, as well
as varying perceptions of pharmacists’ autonomy and hierarchy, which can have a significant impact on pharmacists’ relationships with the people they serve. A study undertaken in Ontario suggested that, “in general, people who are served by the pharmacist do not see themselves as patients, but instead consider themselves to be customers or clients” (Verbeek, 2004, pp. 8–13 as cited in Austin et al., 2006, p. 536). At the same time, the majority of pharmacists in North America and Western Europe consider the nature of their work in retail not to be “for the patient,” but rather “for profit,” attending to consumers, clients, or customers (Brown, 1995, pp. 34–35 as cited in Austin et al., 2006, p. 535). Austin et al. (2006) stated that characterizing the relationship between pharmacists and “those they serve” is an important step to ensuring that the profession appropriately meets the health needs of the society.

In 2013, Frankel and colleagues interviewed 18 pharmacists practising in Toronto, Ontario to identify and explore barriers to pharmacists’ confidence and responsibility in clinical practice (Frankel & Austin, 2013). Frankel and Austin (2013) suggested that pharmacists lack confidence in their clinical decisions when they lack a clear definition of their own professional role. A clear and well-defined professional role would allow pharmacists to build on their confidence in conducting advanced clinical practice (Frankel & Austin, 2013, p. 160). The ongoing changes to pharmacists’ scope of practice may contribute to uncertainties around roles and responsibilities in the pharmacy and around pharmacists’ position in health care.

Furthermore, changes in regulation that capped the prices of drug products (VanderElst, 2010) also reduced the revenue of pharmacies. This reduction in revenue possibly led to cuts in pharmacies’ staff and to fewer jobs for pharmacists. The reduced number of assistants and technicians working in pharmacies potentially had an impact on the time that pharmacists had available to dedicate to patient care. In addition, pharmacists’ duties and responsibilities have increased with the expanded scope. Perhaps pharmacists have been required to transition into new practice standards with limited time and resources, juggling between assisting patients and dispensing medication in the pharmacy. However, robust evidence from randomized trials shows that pharmacists’ involvement in managing several chronic diseases can improve the outcomes of these diseases and provide benefits to patients’ health (Tannenbaum & Tsuyuki, 2013). For
instance, in the United States of America (U.S.A.), there is increasing acknowledgement of pharmacists’ expertise in drug products to the society (Doucette et al., 2012).

**Experience of Change in Pharmacy Practice**

A review of the literature was performed to examine the experience of change in pharmacy. This review focused on two types of studies: studies with empirical data collection that explored pharmacists’ adaptation to new roles and responsibilities, and experiential accounts that carried with them contextual analysis and the authors’ opinions of the experience of change in the pharmacy profession.

Roberts, Benrimoj, Chen, Williams, and Aslani (2006) performed a narrative review of the literature to analyze facilitators of the adoption of cognitive services in the pharmacy profession. Cognitive services can be described as the application of pharmacists’ know-how and their experience to provide patient-centered clinical services in the pharmacy. Roberts et al. (2006) reviewed both empirical and conceptual literature that was screened through well-defined search criteria using terms related to change management in the pharmacy profession. Some interesting concepts were identified in the conceptual literature, (Roberts et al., 2006). For instance, Maddux et al. (2000) envisioned elements that could encourage change in community practice: the opportunity to have positive impact on patient health outcomes, use of technology and technicians, increased demand for drug information from consumers and health professionals, new opportunities for creating tailored drug therapies as pharmacogenomics develops, and the expansion of practice roles in community settings (Maddux, et al., 2000 as cited in Roberts et al., 2006). Rovers, Currie, McDonough, & Sobotka (1998) proposed internal and external factors that can positively influence the implementation of pharmaceutical assistance in pharmacies (Rovers et al., 1998 as cited in Roberts et al., 2006). The internal factors cited were positive staff attitudes, incentives for motivation, pharmacy design and workflow, and promotion of a professional health environment (Roberts et al., 2006). The external factors identified were supportive regulations, support from professional groups, training, formation of networks, and examples from leading practitioners (Roberts et al., 2006). McDonough, Pithan, Doucette, and Brownlee (1998) have suggested that cognitive services need appropriate marketing to change
public opinion in relation to pharmacists’ role in the pharmacy (McDonough et al., 1998 as cited in Roberts et al., 2006). McDonough et al. (1998) argued that promoting a product is essentially different than promoting a health service, which requires building confidence and knowledge of prescribers, patients, and other stakeholders with regard to the benefits of the role of pharmacists performing cognitive services. Perepelkin and Dobson (2009) supplemented this idea by suggesting that it is necessary to promote pharmacists in a regular and constant way; this comes as the result of the public’s ambiguous interpretations of the role of the pharmacist, which vary between seeing pharmacists as health care professionals and business professionals. The latter interpretation damages pharmacists’ image as health care professionals.

From the empirical literature, Nelson, Zelnio & Beno (1984) conducted a research study with eleven focus groups (n = 81) to explore why, despite pharmacists’ willingness to move into a patient-oriented clinical role, in the majority of times, this was improbable to happen (Nelson et al., 1984 as cited in Roberts et al., 2006). Since pharmacists were not engaged in delivering any clinical services, a series of measures to facilitate this engagement was suggested, including training and education, knowledge and experience, advertising, demand, manpower, revenue generation, improved pharmacist and physician attitudes and relationships, favourable pharmacy atmosphere, communication skills, access to patient information, proven benefits, legislation, and computers (Nelson et al., 1984 as cited in Roberts et al., 2006). Ruston (2001) issued a questionnaire to 731 pharmacists in Great Britain to explore pharmacist-associated and business-associated features that influence the adoption of cognitive services in pharmacy practice (Ruston, 2001 as cited in Roberts et al., 2006). Relationships were identified between the duties of pharmacists, the business of pharmacy, and pharmacists’ characteristics as professionals (Roberts et al., 2006). Obstacles to the implementation of cognitive services were identified and initiatives to assist the adoption of cognitive services were suggested, including autonomy, education, local networks, and external support (Roberts et al., 2006).

Other studies focused on the pharmacy as a service provider rather than on the pharmacist as a health care professional. One study pointed to factors influencing the delivery of health care services: professional reward, compliance with legal and contractual requirements of payers, and
financial reward (Miller & Ortmeier, 1995 as cited in Roberts et al., 2006). Doucette and Jambulingam (1999) suggested that the entrepreneurial nature of community pharmacy could facilitate the delivery of health care services in the pharmacy (as cited in Roberts et al., 2006, p. 166).

Odedina, Segal, and Hepler (1995) compared 10 pharmacists who provided cognitive services with 10 pharmacists who did not provide these services in the pharmacy. Using open-ended questions, the providers were asked what the facilitators were and non-providers were asked what the barriers were to providing cognitive services in the pharmacy (Odedina et al., 1995). Odedina et al. (1995) concluded that barriers and facilitators were very alike and could be classified under eight themes: physical layout of the pharmacy, qualified support personnel, practice orientation (service orientated versus profit-driven), patient expectation, co-operation of doctors, computer support, patient medical information, and pharmacists’ competence (as cited in Roberts et al., 2006). Similarly, Doucette & Koch (2000) compared two pharmacies that had incorporated changes with two pharmacies that had not changed their practice by using an organizational change perspective (as cited in Roberts et al., 2006).

Important differences were found between these two groups of pharmacies in several areas: links with pharmacy associations and colleagues, adequacy of staff skills, leadership skills of the owner, addressing of constraints, and complexity of the change involved (Roberts et al., 2006). Bell, McElnay, and Hughes (2000) ran in-depth interviews with 20 community pharmacists to explore factors that influenced these pharmacists’ attitudes towards the provision of pharmaceutical care (as cited in Roberts et al., 2006). These factors included having a private counselling area, having access to medication records, interacting with other pharmacists, and having a good relationship with the local doctor (Bell et al., 2000 as cited in Roberts et al., 2006). Barriers to pharmaceutical care also were identified, and the following suggestions were made to overcome these barriers: support from government or professional bodies, increased staff, and additional training (Bell et al., 2000 as cited in Roberts et al., 2006).

Doucette et al. (2012) surveyed 478 actively practicing pharmacists to assess their entrepreneurial orientation, resource adequacy, and pharmacy staffing, which influenced changes
in pharmacy practice. The main changes to pharmacy practice that happened in the two years preceding the surveys were the pharmacy’s documentation system, the pharmacists’ skills and knowledge, pharmacy technicians’ responsibility, and documentation of patients’ information. Relieving pharmacists from technical obligations and having access to patients’ medical information facilitated the development and maintenance of clinical services in the pharmacy (Doucette et al., 2012). Nevertheless, pharmacists could make better use of business opportunities by updating their knowledge of new professional skills and participating in professional gatherings (Doucette et al., 2012). Doucette et al. (2012) also cited financial and operation support, as well as skills and knowledge, as requirements to sustain change in pharmacy practice. Doucette et al. (2012) recognized that having access to patients’ medical information is not enough to sustain practice change if other infrastructure is not in place, including having a good documentation and billing system and having adequate space to consult with patients in the pharmacy.

In Australia, Feletto, Lui, Armour, and Saini (2013) investigated pharmacists’ perceptions of their readiness for change before and after the Pharmacy Asthma Management Service (PAMS) had been implemented in pharmacies. The study of Feletto et al. (2013) used a research-based change management tool—the Pharmacy Change Readiness Wheel (PCRW)—to better understand its impact on the implementation of the PAMS management service. Feletto et al. (2013) found that the following factors related to the pharmacy, to pharmacists, and to the external environment had an impact on the implementation of PAMS: professional support, a set of mechanisms to facilitate/carry the implementation process, remuneration for enhancing practice, individual pharmacy’s vision about their respective future practice, and pharmacists’ motivation and competence to embrace change (p. 34). The study of Feletto et al. (2013) highlighted the complexity of practice change and indicated that there may be a gap between pharmacists’ feeling prepared and motivated to change their practice and actually implementing these changes (p. 34). Feletto et al. (2013) have suggested that internal, external, and individual aspects relating to the process of changing pharmacy practice need to be managed properly to facilitate the implementation of new services performed by pharmacists (p. 34).
In Canada, pharmacists are increasingly being required to shift their practice from a product focus to a patient focus as a result of the need for accessible health care services (Guirguis, Johnson, & Emberley, 2014). Nevertheless, most people who are assisted by community pharmacists feel that they are customers, rather than patients, of the pharmacy and that their pharmacist is providing information solely about their medication rather than delivering clinical care (Guirguis et al., 2014). At the same time, engaging with patients requires that pharmacists develop skills and a new comprehension of their relationship with the patient (Guirguis et al., 2014). Guirguis et al. (2014) developed an evidence-based model called “Connect and CARE” to assist pharmacists in engaging with patients in a health care practice. The evidence-based strategies suggested were developing rapport, setting an agenda, and checking for patient understanding (Guirguis et al., 2014). The model considers that pharmacists are required to develop their cognitive skills and to dedicate time towards patient-centered practice (Guirguis et al., 2014). The data collected suggested that patients appreciated connecting with their pharmacist and also that pharmacists often were hesitant to mention other health care services to patients in the pharmacy (Guirguis et al., 2014). The pharmacists’ concern was that patients would perceive their action as an effort to sell health care services in order to generate financial gains (Guirguis et al., 2014).

In Ontario, change in pharmacy practice has not been easy (Grindrod, Sanghera, Rahmaan, Roy, & Tritt, 2013). Since Bill 102—the Transparent Drug System for Patients Act—was enacted in 2006, pharmacists have been affected by the reduction of generic drug prices and the discontinuation of rebates, which had been an important source of revenue for pharmacies (Grindrod et al., 2013). At the same time, the new regulations legitimized the role of pharmacists in delivering patient care by introducing the MedsCheck program, which compensates pharmacists for performing medication reviews at the pharmacy (Grindrod et al., 2013). The program was expanded to include pharmaceutical opinions, and compensation for performing MedsCheck was also increased (Grindrod et al., 2013). Nevertheless, pharmacists found it challenging to perform MedsCheck during their available time in view of their other duties in the pharmacy (Grindrod et al., 2013). In the study performed by Grindrod et al. (2013), pharmacy graduates shared their opinions on the provision of MedsCheck in Ontario. Some factors
influencing the success of MedsCheck were identified by the pharmacy graduates, including the following: long-term relationships with pharmacists is essential for improving treatment outcomes; time constraints impede the provision of MedsCheck because of its complexity and lengthy nature; patient awareness and interest regarding MedsCheck is not ideal; availability of private space for consultations is limited; documentation requirements create a burden while performing MedsCheck; and there are other challenges associated with communicating with health care professionals (Grindrod et al., 2013).

Pojskic, MacKeigan, Boon, Ellison, & Breslin (2011) surveyed 848 Ontario family physicians to explore physicians’ willingness to cooperate with pharmacists in the management of drug therapy. Thirty-six percent of doctors responded to the survey. The survey was developed using a trans-theoretical model of behavioural change (Pojskic et al., 2011). This study found that precision of patients’ medication records was viewed as the most important advantage to pharmacist-physician cooperation, and the absence of patient information, such as laboratory results and diagnoses, was viewed as one of the biggest disadvantages to pharmacist-physician cooperation (Pojskic et al., 2011). Despite these findings, evidence from this study suggested little cooperation existed between pharmacists and physicians in relation to drug therapy management (Pojskic et al., 2011).

In 2008, Tsuyuki and Schindel drew on the change management and leadership disciplines to explore the complexity of transitioning pharmacists into patient-oriented practice. They argued that it is necessary to recognize both the sophisticated nature of professional change and the role that leadership plays in implementing such change, and that both are central to understanding the evolution of the pharmacy profession (Tsuyuki & Schindel, 2008, p. 175). Tsuyuki and Schindel (2008) chose the change management model proposed by John Kotter (1995; Kotter & Cohen, 2002), a professor at Harvard Business School and an expert in change management, to frame the analysis of their own professional experiences through research in community pharmacy. The current research project expands on the study carried out by Tsuyuki and Schindel (2008) and borrows the same change management model proposed by Kotter (1995; Kotter & Cohen, 2002) to explore its applicability in implementing a new scope of pharmacy practice in Ontario.
The work of Tsuyuki and Schindel (2008) demonstrated, in theory, how this management framework could be used to support change in pharmacy practice. Tsuyuki and Schindel (2008) suggest that the change process is composed of several elements, and that it is vulnerable to errors during its implementation, such as errors in the organization of the change process, as well as problems in leadership and in the progression of activities, which can damage the change process.

This research aims to gain insight into the applicability of change management theory to the pharmacy profession, which has its own corporate culture formed and reinforced by pharmacists’ views, beliefs, and behaviors, and where professional self-identity is formed through socialization, education, and practice-based experiences. This research reports on the perspective of community pharmacists regarding barriers and enablers of aspired changes in practice, in light of Kotter’s (1995; Kotter & Cohen, 2002) model of change management.
Chapter 3
Change Management Theories

In organizational terms, the pharmacy profession is undergoing a radical change. Radical change or “frame bending” includes shifting courses of action to completely different directions with the goal of transforming an organization (Pryor, Taneja, Humphreys, Anderson, & Singleton, 2008). Businesses should seek radical changes that deeply modify the foundation of an industry’s competitiveness to sustain operational capacity throughout time (Doucette et al., 2012). The addition of patient-oriented health services to the dispensing role of pharmacists is a good illustration of a radical change (Doucette et al., 2012), due to the pace and complexity of changes required to happen within the profession in a short timeframe. The shift in pharmacy practice from dispensing to a service-oriented model demands reorganization of resources, which address tangible and intangible elements including money, physical space, equipment, and human resources, as well as the know-how and expertise of pharmacists (Doucette et al., 2012).

Pharmacy practice beyond dispensing of medication can be defined as pharmaceutical care (Moullin, Sabater-Hernández, Fernandez-Llimos, & Benrimoj, 2013). Pharmaceutical care was expanded to encompass a service-oriented definition, which includes services related to the administration of medication to patients, delivered by pharmacists using their knowledge to promote a safe and effective medication treatment. (Moullin et al., 2013) According to Moullin et al. (2013), a professional pharmacy service can be described as initiatives performed by a pharmacist or other health practitioner in the pharmacy using their health care expertise directly or indirectly (through another practitioner) with their patients, to ameliorate health care procedures. The definition of professional pharmacy service proposed by Moullin and colleagues includes the objective of improving results associated to patient’s health and increasing the overall quality of health care. Therefore, for the purpose of this research, the terms “pharmaceutical care” will be used interchangeably with “service-oriented model of patient care.”

Managing change is crucial to securing a successful implementation of new ways of practice. This research considered the pharmacy profession as an organization with common beliefs, attitudes, and intentions. In this sense, changes to the ways pharmacists practice their duties and
manage changes in behavior are important pieces of the successful implementation of new ways of practice. Individuals must be willing to change and have the resources and time available to successfully transition into new roles and responsibilities. This research project required a change management model applicable to implementing changes in corporations that could be applied to the pharmacy profession as an organization. The goal was to identify areas of improvement and gaps that exist in the process of transitioning pharmacists into a patient-oriented health care practice.

Change management can be defined as a methodical way of using expertise, apparatus, and other means to optimize the gains of implementing a change (Metre, 2009). Change management theories can also be applicable to managing an ongoing procedure with the intent to upgrade it to a better-performing activity (Metre, 2009). Successful change management results in efficient long term or permanent change (Metre, 2009). Managing change can be described as planning, organizing, directing, and controlling initiatives and efforts to implement change (Gill, 2003), as well as managing individuals affected by the change with the objective of reducing risk as the current operations are kept functional (Kotter, 1995). Management promotes expected results in an organized manner to keep things functioning effectively (Gill, 2003). Therefore, when implementing change, focus should be maintained on measurable results in order to monitor the progress of the change process (Metre, 2009). Progressively, change management is viewed as an ongoing activity within for-profit organizations to ameliorate business performance (Metre, 2009).

Several change management models have been used to effectively implement changes in organizations. Addressing the nature of changes affecting organizations is crucial to achieving successful transformation. Change management models can be organized according to the type of changes they address. Some examples of the changes with which organizations deal constantly include culture and process changes, affective and behavioral changes, structural transformations, and environmental changes (Pryor, Taneja, Humphreys, Anderson, & Singleton, 2008). Changes happening in organizations are usually multifaceted and, as a result, are classified in several of these categories of change. Currently, change management models are
facing challenges resulting from the nature and pace of changes happening to organizations at this time. Changes have become more elaborate, with less time available to implement them (Pryor et al., 2008).

In order to understand and select the most suitable model for exploring pharmacists’ opinions and adaptation to changes in their scope of practice, a summary of key change management models used to achieve effective implementation of changes in organizational behavior was prepared. The summary includes process-oriented change models that focus on modifying culture and social organization by applying methods based on behavioural sciences (Burke, 1994, p. 54, as cited in Siegal et al., 1996, p. 56).

Lewin’s model (1945, as cited in Siegal et al., 1996) advocates unfreezing the present, moving from the present, and refreezing for effective, long-term change management. Lewin’s model advocates the need to unfreeze present behavior (Siegal et al., 1996) to deconstruct and move from present to future with the required people and processes in order to solidify changes (Pryor et al., 2008). Unfreezing present behavior can be interpreted as giving a series of coaching sessions to a group within the organization to bring awareness of the need for change (Siegal et al., 1996). Moving from present to future signifies acting or undertaking measures to change individual behaviour to bring about process-oriented changes (Siegal et al., 1996). Refreezing is the third step, which advocates solidifying changes in behaviour to avoid falling back into old ways of practice (Siegal et al., 1996).

Lewin’s (1945) model can be very useful as a starting point in analyzing a past event, understanding it, and preparing contingencies for future events (Pryor et al., 2008). This model can be used for planned/expected events, such as in preparation for natural disasters like hurricanes and earthquakes (Pryor et al., 2008). Nevertheless, Lewin’s model is less useful for unplanned events, in which an organization has no previous experience going through such an event (Pryor et al., 2008). Lewin’s model is also limited in situations of fast-paced changes, where there is no time for planning and where planning and acting need to happen simultaneously (Pryor et al., 2008). In the case of changes facing community pharmacists in Ontario, unpredicted sudden changes of conduct were imposed on these professionals by
regulations, and changes were made effective immediately by the Ontario government. In addition, the pressing need to sustain profitability of pharmacies required pharmacists to adapt to new ways of practice and additional duties, leaving little time for planning and adapting to this new professional realm.

Schein (1980, 1985, 1992, as cited in Pryor et al., 2008) extends on Lewin’s three-stage model by describing different approaches to unfreezing an organizational status. Schein argues that it is important to show individuals within an organization the gap between the current state and the desired one. It is also important to motivate people to embrace changes by assuring them that changing their conduct will not cause them any humiliation, punishment, or lack of self-esteem (Pryor et al., 2008). Schein advocates three stages of creating the ideal acceptance and enthusiasm for change (Siegal et al., 1996): (1) raising awareness of the need for change, which, in turn, will encourage individuals to incorporate change; (2) raising guilt and anxiety regarding a dysfunctional situation and the aspired reality; and (3) creating a perception of safety within an environment of change. Schein (1980, 1985, 1992, as cited in Pryor et al., 2008) defines cognitive restructuring as the psychological process by which people perceive their environment and act on those thoughts and perceptions. Cognitive restructuring is most dominant in the second step of Schein’s (1980) model. This shifting in perception of the world and acting upon new ideas can be achieved by an individual’s recognition of a new role model, such as a mentor, boss, or teacher, who can provide new ways of interpreting a certain situation (Siegal et al., 1996). In the third step of Schein’s model, “refreezing” means solidifying new behavior in such a manner that it will fit comfortably with individuals’ perceptions of themselves and will be well integrated with their social realm (Siegal et al., 1996). According to Schein (1980), cognitive restructuring will lead to freezing of changes by allowing individuals to feel comfortable with changes to their work and to feel aligned with their social environment within the system in which they work. Schein’s model addresses some of the barriers to changing people’s behavior in order to achieve successful change management. In the final analysis, the contribution of Lewin and Schein was to provide the first recognition of how to change an organizational culture, but neither model offered concrete strategies for accomplishing change on a practical level.
Shields (1999) proposed a five-step model (as cited in Pryor et al., 2008) that reduced this gap:

1) Define the desired business results and change plans
2) Create capability as well as capability to change
3) Design innovative solutions
4) Develop and deploy solutions
5) Reinforce and sustain business benefits to implement change in an organization (p. 11).

Shields (1999) argues that critical steps need to be properly connected for change to be successful. These steps require management of human resources to coordinate with business process innovations (Pryor et al., 2008). Shields also suggested that preliminary consideration of the human and cultural components of the organization are necessary in evaluating the change effort to ensure that the change initiative will be successful (1999, as cited in Pryor et al., 2008). Nevertheless, Shields’s model did not include a step to prepare teams for changes in the organization and to support individuals through the implementation process (Pryor et al., 2008). Shields’s model also failed to include communication as a central component to creating cooperation and willingness for implementation of changes (Pryor et al., 2008).

Jick’s 10-step model of change management is strategic in guiding the change process within organizations (1991, as cited in Metre, 2009, p. 9). This model also serves as a guide for assessing an evolving change process. The 10 steps of Jick’s (1991) model are:

1) Analyze the organization and the need for change: This step involves evaluating the organization and its requirements for change.
2) Create a shared vision and common direction to motivate change initiatives among members of the organization.
3) Separate current change efforts from past initiatives.
4) Create a sense of urgency regarding the shared vision and the current initiatives to achieve this vision.
5) Support a strong leader role: Encourage and support leaders to secure the participation of those involved in the change process and their proficiency to execute desired changes.
6) Line up political sponsorship: Obtain the agreement and support of senior management and other influential leaders that can assist in the progression of the change effort.

7) Craft an implementation plan.

8) Develop enabling structures and remove any foreseen obstacles that might hinder the progress of the change initiative.

9) Communicate, involve people, and be honest.

10) Reinforce and institutionalize change (p. 10).

Jick’s 10-step model of change management is better suited for the strategic phase of a change process (1991, as cited in Pryor et al., 2008). Therefore, it can be used as a guide to start the change process or to appraise ongoing change happening in an organization (Pryor et al., 2008). This model can demonstrate that change is a continuous process and that enquiries to evaluate the process should be constant; it demonstrates as well that these queries coincide throughout the steps of the change process (Pryor et al., 2008).

Kotter’s (1995; Kotter & Cohen, 2002) model, described by Metre (2009), proposed the following eight steps to achieve successful, long-term change management within organizations:

1) Developing a sense of urgency (Kotter, 1995): Kotter’s perspective was that urgency motivated people by developing a perception of reality regarding change initiatives’ purpose and goals (Metre, 2009). Kotter highlighted the importance of emotional commitment of individuals to the change efforts.

2) Building a guiding team (Kotter, 1995): In this stage of the change process, Kotter was interested in the conjunction of strengths and skills of leaders and managers that could influence individuals to accept and agree with the change effort.

3) Creating a vision (Kotter, 1995): Once leadership was developed, Kotter’s third step was to develop a common vision for all involved in the change effort. Kotter believed that a common vision would serve as a guide for the change effort, helping to develop tactics on ways to execute each step of the change process.

4) Communicating for buy-in (Kotter, 1995): Kotter’s fourth step advocates communicating extensively the common vision to ensure commitment of the individuals involved in the
change. This communication was the responsibility of influential leaders from several areas of the organization.

5) Enabling action (Kotter, 1995): The fifth step involves promoting action by empowering individuals involved in the change process. This step can be achieved by preparing for problems ahead of time and removing barriers, as well as systems and processes, which cripple the change process.

6) Creating short-term wins (Kotter, 1995): Kotter’s proposal was to divide the change process into several smaller phases for management purposes, each of which could have measurable outcomes (Metre, 2009) that could reflect the progression of the change process.

7) Consolidating improvements (Kotter, 1995): This step focused on systems, processes, policies, and procedures that undermine the vision (Metre, 2009). Contracting, promoting, and training people to be advocates of the vision to members of the organization is important at this stage in the change process (Metre, 2009).

8) Institutionalizing new approaches (Kotter, 1995): The final stage involved connecting in a clear manner individuals’ new approaches and ways of working to the progression of the organization’s objectives towards the aspired future state (Metre, 2009).

Jick’s (1991, as cited in Pryor et al., 2008) and Kotter’s (1995; Kotter & Cohen, 2002) models are similar and present common elements for successful change management. It is interesting to note that these elements are listed in different orders in these models. Kotter’s model presents the step of creating a sense of urgency first in the change process. Also, Kotter’s model does not address previous analysis of the need for change, as Jick’s model suggests. Separating past initiatives from current change effort is also not in Kotter’s model, as it explores more deeply the here and now and moving forward, rather than analyzing the past. Kotter’s model also details how to reinforce change by implementing short-term wins. In the case of this research study, the pharmacy profession has, for a long time, been subject to changes in practice that have been partially successful. There have been numerous initiatives to move pharmacists to patient-centered practice. It would be impractical to look at the past given the fragmented scenario of changes to pharmacy practice in Ontario. Kotter’s (1995; Kotter & Cohen, 2002) model also seems to resonate better with the current reality within the profession, where the sense of
urgency to change has already been established through several channels, such as government, pharmacy associations, pharmacists, pharmacy owners, etc. At the same time, this research aims to contribute to the long-term changes in the profession to a more patient-centered practice. Therefore, finding ways to reinforce change by creating incentives or “wins” is one of the possible contributions of this research study.

Mento, Jones, and Dirndorfer’s model (2002) recommends the following 12 steps to successfully implement change in an organization:

1) The idea and its context: Identifying the need for change, such as a new product or innovation. Mento and colleagues (2002, p. 49) cited Senge’s (1990) definition and discussion of creative tension as a process for generating new ideas that arise from intrinsic energy of creativity, rather than extrinsic energy of solving an existing problem. Intrinsic energy comes from the vision and generates improvements in the process, and it also increases momentum during its course, given that the motivation for implementing change is the improvement of a current situation. Extrinsic energy focuses on the fixing of a problem and diminishes as the problem becomes less serious.

2) Define the change initiative: Planning the course of change and resources necessary. Define the people involved in the change initiative and their roles and responsibilities.

3) Evaluate the climate of change: Learning about the organization’s context, its advantages, and its disadvantages. This analysis will assist in creating a change management plan. Identifying lessons learned is a good practice at this stage to learn about the forces of resistance within the organization.

4) Develop a change plan: This plan should include objectives and roles for the people involved in the change, from higher management to executers, from customers to service providers, etc. Framing the plan towards each role’s capability and comfort level can contribute to the adoption of changes to processes. Planning to implement changes in organizations is finding a balance between the authority needed to ensure discipline in following the plan and the persuasion of people involved in the change effort to agree with the initiative.
5) Find and cultivate a sponsor: This step relates to Kotter’s (1995) idea of developing a guiding coalition and Jick’s (1991) idea of lining up political sponsorship by defining the influential leaders in the organization, an implementation plan, and a monitor of progress.

6) Prepare your target audience: Resistance is to be expected in any social context when change is introduced, regardless of whether the change is positive or negative. The tendency of individuals to preserve the status quo results in questioning and skepticism before they can accept change. Kotter and Schlesinger (1979, as cited in Mento et al., 2002) suggested using tools such as focus groups and surveys to identify resistance within companies.

7) Creating the cultural fit and making the change last: This step states the importance of aligning the cultural traits of an organization to the implementation of changes in this organization. The culture of organizations determines ways of practice, which can undermine change initiatives if the two are not “in sync.”

8) Develop and choose a change leader team: Choosing the best leader to push for the change process. A leader is needed who can motivate people to adopt the change and, at the same time, consistently recognize the value and compensate those who make the effort to adapt to the change.

9) Create small wins for motivation: This step closely follows Kotter’s (1995) idea of creating short term wins to recognize the effort of people working towards the change initiative. These short term wins can go a long way in opening dialogue with the people involved in the change process, which can stimulate the exchange of different points of view regarding the change initiative.

10) Constantly and strategically communicate the change: This step is borrowed from Jick’s (1991) step nine: “communicate, involve people and be honest (p. 55).” This step of Mento and colleagues’ model (2002) emphasizes the importance of constant communication with the recipients of change in order to maintain momentum of the change process. This step also states the importance of the manner of communicating the change effort at the beginning of the process, to increase the acceptance and encourage people to “buy in” to the idea of change.

11) Measure progress of the change effort: This step recommends measuring evolution of the change process by creating measurable results such as milestones and benchmarks.
12) Integrate lessons learned: This step requires reflecting upon the change process and learning lessons from lived experiences. Documenting experiences such as cultural norms, informal leaders, and work rules, as well as politics involving members of the organization, can provide a very useful guide for teams during future change initiatives.

Mento and colleagues’ (2002) model was developed from research of other change models and experiences from the 1990s (Pryor et al., 2008). Mento and colleagues’ model differed from the other models, because it included a step to oversee and rate the ongoing change process (Pryor et al., 2008).

Both Jick’s (1991) and Mento and colleagues’ (2002) models presented a step to deal with leadership conduct and to reinforce stable and enduring leadership skills (Pryor et al., 2008). Kotter (1996) and Shields (1999) gave more emphasis to the development and persuasion of the individuals directly responsible for acquiring and performing the change (as cited in Pryor et al., 2008, p. 11). Ultimately, motivation to change practice in the pharmacy profession must come from individual pharmacists. This study focuses on the view and opinions of pharmacists regarding changes to their professional practice, being both the recipients and implementers of change. Kotter’s (1995; Kotter & Cohen, 2002) model seems more adequate to frame the data collection and analysis of this research study.

These change management models have common characteristics. They all indicate a procedure to identify the reason and need for change (Pryor et al., 2008). At the same time, all models suggested that leadership is necessary to create the willingness and cooperation of individuals within the organization to promote the change (Pryor et al., 2008). Most models suggested developing a vision to drive the organization from the current situation to a new, aspired future reality or context (Pryor et al., 2008). Several models promoted the idea of incentivizing small improvements to support an environment of ongoing, progressive change (Pryor et al., 2008). Nevertheless, change management models present different elements of how to implement changes to an organization. Some models have been deemed more appropriate than others, depending on the organization’s environment, infrastructure, and stage in the change process.
Kotter’s (1995; Kotter & Cohen, 2002) change management model was chosen for this research study because of its strong behavioral component that addresses change management in deeply entrenched cultures of organizations, such as the pharmacy profession. Kotter’s model for implementing change management is composed of three consecutive phases: promoting an environment for change, involving and creating capabilities in the entire organization to adopt the change, and solidifying and maintaining the change in the long term (Campbell, 2008, p. 23). Pharmacists’ location in this involve-adopt-maintain spectrum with respect to the uptake of a clinical role in the pharmacy has not yet been established. Kotter’s (1995; Kotter & Cohen, 2002) model highlighted the importance of leadership, order, and pace in changing organizational behaviour. Kotter’s model provided not only a guide to changing how people perform their work but also a model for convincing people that changing the way they do things was worth their effort and time. Currently, change is constant, and organizations that will survive in the long term need to effectively adapt to, learn, and act quickly in the progression and in face of challenges to implement changes (Pryor et al., 2008).

Please see Appendix 2 for a comparison of the change management models.
Chapter 4
Research Methods

Methodology

Qualitative methods were considered appropriate for data collection and analysis for this study. It was used to gain understanding of participants’ perspectives of their lived experiences in their natural settings, which, in turn, could impact their behavior in practising health care (Huston & Rowan, 1998).

A constructivist paradigm was used to inform this qualitative research study to examine the perspective of pharmacists regarding changes to their scope of practice. The constructivist theory argues that individuals actively construct their understanding and knowledge through lived experiences when interacting with their social environment (Thomas, Menon, Boruff, Rodriguez, & Ahmed, 2014). Therefore, individuals’ own sets of values and beliefs can influence knowledge translation into practice (Thomas et al., 2014). In health care, not all scientific knowledge is brought into clinical practice (Thomas et al., 2014). According to Thomas et al. (2014), constructivism is used in health research to recognize and indicate gaps between the existing scientific knowledge and the actual health care practice that is delivered to patients. One of the assumptions of this research study is that the social realities of community pharmacists can shape their professional culture, which, in turn, can influence how they assimilate new ways of practice and deliver patient-centered care.

This study explores and increases our understanding of pharmacists’ perceptions of their own profession in light of recent changes in pharmacy practice. The principal investigator looked at changes in positions, responsibilities, and experiences of pharmacists as members of the health care system, following the introduction of various significant changes to practice. Understanding pharmacists’ experiences in clinical practice and their response to these changes may contribute to more effective implementation of health services in pharmacies. Thomas et al. (2014) proposed that obstacles and facilitators of practice change in health care can be explored through the lens of social constructivist theory. Building on this idea, this research suggests that using
social constructivism to explore pharmacists’ experience, views, and feelings in adopting patient-centered practice can assist in identifying the challenges of pharmacists and the strategies they use in delivering high-quality health services in the pharmacy.

Change management theories were deemed appropriate to frame this research and analyze the data gathered concerning the changing scenario of community pharmacy practice. Some change management theories address practice change as a function of people’s behavior. Kotter’s (1995; Kotter & Cohen, 2002) change management theories were used as the theoretical framework for this research study. Kotter’s theories were chosen because, as is discussed in Chapter 2, Tsuyuki and Schindel (2008) proposed their use in a community pharmacy environment in a theoretical manner. This seminal article was widely read and circulated within the pharmacy community, given the stature of its authors as clinical, academic, and thought leaders within the profession of pharmacy. Since its publication, the Tsuyuki and Schindel (2008) paper has been widely read, widely cited, and extensively discussed within the professional community. Given its dominance in the field of pharmacy, Kotter’s (1995; Kotter & Cohen, 2002) model was identified as a valuable lens through which to conduct an examination of practice change. This study tests the utility of Kotter’s theories in studying actual lived experiences of pharmacists.

Methods appropriate to qualitative research were used to collect, interpret, and analyze data for this research study. Qualitative research is essential to knowledge development in the health care disciplines (Morisson, 1994), as it helps to construct and define meaning from peoples’ social experiences in their natural settings; it considers their opinions and understanding of their own social realm (Pope & Mays, 1995, pp. 42–45).

**Method**

This study used several methods applied to research in health professions in order to explore, understand, and interpret meaning from pharmacists’ testimonials regarding changes in practice occurring in community pharmacy. The protocol for this research study was approved by the University of Toronto Research Ethics Board before the interviews were conducted.
Recruitment and Interviews

Qualitative data can be acquired by using several methods, with interviews being one of the most common (DiCicco-Bloom & Crabtree, 2006). Interviewing is generally used when the research aims to elicit meaning and interpretations by stimulating participants to share their lived experiences (DiCicco-Bloom & Crabtree, 2006). In-depth interviews are used in health research to recreate people’s impressions and interpretations of an occurrence relating to the delivery of health care (DiCicco-Bloom & Crabtree, 2006). Therefore, interviews were chosen as the best method to capture pharmacists’ perspectives of their role, position, and responsibilities as health care professionals in the face of current changes to their scope of practice. Interviews were the most suitable method for capturing pharmacists’ experiences working in community pharmacies in the context of the pharmacy as a place for health care delivery.

In depth, semi-structured interviews were conducted with community pharmacists who were licensed to practise in Ontario. This research sought to elicit pharmacists’ opinions regarding their new scope of practice. These interviews allowed the researcher to delve into the perspective of pharmacists,—first to capture their views and then to interpret meanings formed in the social context of community pharmacy.

The inclusion criteria for this study included English speaking, licensed community pharmacists in the province of Ontario. Exclusion criteria for participation in this study included pharmacists working in hospitals, academia, and pharmaceutical industries. Given the logistical difficulties associated with study recruitment, purposeful sampling was identified as appropriate for this exploratory research. Pharmacists who were interviewed for this study were known to the researcher and her supervisor, recommended by colleagues, or recruited on the fly in professional settings. Pharmacists were contacted through phone, by email, or in person, and they were invited to participate in the research study. A recruitment letter outlining the details of the research was provided to pharmacists. Once the pharmacists verbally agreed to participate, a confidentiality agreement and consent form was signed by the principal investigator and the participants. Purposeful sampling of participants was undertaken, because it was important to collect the opinions of community pharmacists who were engaged in the change process and
were willing to speak about their lived experience on the job. Nevertheless, the study participants varied widely in their years of experience, ages, and positions within community pharmacy. The participants also had various experiences on the job that required different skills to practice.

**Data Collection**

Interviews were conducted and recorded in-person or over the phone, using Skype technology whenever possible. Interviews lasted between 30–45 minutes, and the researcher followed an interview guide that listed open-ended questions about how pharmacists were adapting and responding to changes in their professional practice. The researcher used Kotter’s (1995; Kotter & Cohen, 2002) eight-step model for change management to frame the interview guide for this research study. The interview guide was created by considering how this eight-step model of change management related to the experiences of pharmacists in changing their practice (see Appendix 3: Research Interview Guide).

The interviews began by asking pharmacists to describe their practice, the patients they see, and their colleagues and other health care professionals with whom they interact with on a daily basis. The interviews continued by asking what made the pharmacists feel proud about their profession. The interview then addressed the topic of change in practice, asking pharmacists about recent changes and their impact on their daily practice. Lastly, pharmacists were asked who they believed to be the leaders in the pharmacy profession.

The interviews were carried out until thematic saturation was reached. For the purpose of this study, saturation was defined as the moment in data analysis in which new codes no longer emerged from the research data, consequently defining the coding scheme.

**Data Analysis**

In-depth analysis of pharmacists’ lived experience in community pharmacy was deemed appropriate for this research study in order to discuss sensitive issues related to professional identity and underlying concerns regarding responsibility, purpose, and financial compensation within the profession.
Content analysis was chosen because it is widely used in health research to examine data collected from a specific event considering people’s interpretations of it (Krippendorff, 1989). According to Green and Thorogood (2009), the objective of conventional content analysis is to identify important aspects of an interviewee’s narrative to depict an occurrence or event. This study’s aim was to explore and understand pharmacists’ accounts through their reported views and feelings regarding their lived experiences in adapting to a new scope of practice.

Data was analyzed through coding. Coding is used to explore and interpret qualitative data derived from interviews (Saldana, 2008). Coding is a method of connecting data to an idea and further relating the idea back to the entire data applicable to that idea (Richards & Morse, 2007, p. 137, as cited in Saldana, 2008, p. 8). Therefore, inductive coding was performed to the transcripts of interviews in this research study. Codes were grouped into categories (Hsieh & Shannon, 2005). Codes were sequentially categorized according to their relation to one of Kotter’s eight principles of change management. This theoretical framework was used to interpret participants’ comments in light of the stated research objectives. Field notes were maintained as part of this research analysis.
Chapter 5
Results and Discussion

A total of 12 community pharmacists, all of whom were licensed and practising in Ontario, Canada at the time of the interviews, were recruited for this study. Pharmacists were interviewed using open-ended questions designed to elicit their views and to understand how they are adapting to the changes currently occurring in their practice (please refer to Appendix 3: Research Interview Guide).

Pharmacists performing different roles in community pharmacy, such as managers, owners, and pharmacy employees, were interviewed for this study (see Appendix 4 for pharmacists’ occupational profiles). These professionals had varying years of experience, as well as differing roles and responsibilities in the workplace. The pharmacists performed a mix of clinical services in the pharmacy, including running smoking cessation clinics, administering flu shots, performing MedsCheck, and counseling patients during treatment for drug addiction. All participants worked in different community pharmacies. Some participants were involved with academia as students or professors at the University of Toronto. Others were involved with professional associations or worked in home care as part of multi-professional health care teams. The interviews in this study were transcribed verbatim by the principal investigator after all interviews were completed.

Interviews were coded inductively and framed by Kotter’s (1995; Kotter & Cohen, 2002) eight-step model of change management. The application of change management theory to the pharmacy profession in this context was important to better understand the experiences of pharmacists during this time of rapid evolution in the profession. Community pharmacy has its own corporate and professional culture, which is formed and reinforced by pharmacists’ views, beliefs, and behaviours, and where professional self-identity is formed through socialization, education, and practice-based experiences (Livigni, 1994 as cited in Rosenthal, Tsao, Tsuyuki, & Marra, 2015; Austin & Ensom, 2008; Austin, 2014; Beales & Austin, 2006). The objective of this analysis was to identify elements in community pharmacists’ experiences that reflected how changes were being incorporated by community pharmacists and to identify any relationships
that might exist between the implementation of changes in community pharmacy and Kotter’s (1995; Kotter & Cohen, 2002) model of change management. Codes emerged from analysis of the interview transcripts in light of Kotter’s model. Codes were categorized according to their relation to one of Kotter’s eight principles of change management. This theoretical framework (Kotter, 1995; Kotter & Cohen, 2002) was used to interpret participants’ comments in view of the research objectives. Interview transcripts were transcribed by the researcher. The transcriptions were analyzed to gain an understanding of participants’ viewpoints. These transcriptions also were reviewed by a second reader to verify coding and categorization. The theoretical framework (Kotter, 1993; Kotter & Cohen, 2002) provided eight categories against which to compare the transcriptions, and the research analysis resulted in the following categories: Managing Time and Resources, Professional Cohesion, Business Model of Pharmacies, Communication, Policies, Professional Development, Paradigm Shift, and Sense of Professionalism. Words and short phrases relating to these categories were identified. These categories provided a structure in which to describe the study results that are presented in this chapter.

Kotter’s Principles #1 and #6: Establishing a Sense of Urgency; Planning for and Creating Short-Term Wins (Managing Time and Resources)

Time Constraints

The pharmacists who were interviewed for this study cited challenges associated with having enough time available to implement the new scope of practice at many levels of pharmacy operations. Pharmacists expressed their frustration in trying to attend to patients and provide new scope of practice services while still having to fill many prescriptions and to manage complex drug distribution systems. As the following quotes demonstrate, the participants also mentioned that pharmacies were typically understaffed, which did not allow pharmacists to dedicate sufficient time, energy, or attention to patient care.
“I think the biggest challenge with anything that we do in pharmacy now is the time perspective.” (P3, paragraph 24)

“I really enjoy the patient interaction so... filling lots of prescriptions is frustrating sometimes, and we don’t have the time... as much time as I would like actually to be able to spend with patients. It’s frustrating if there is a line of people who are building up because I’m working myself, so it’s understaffed, so therefore you can’t really spend as much time as you would like and there were changes that were made... There definitely needs to be better staffing so that the pharmacists can truly participate in working closely with patients like we are trained to be able to do.” (P5, paragraph 24)

Workload

In order to have time available to provide clinical services, one major challenge is managing the workload in the pharmacy. For instance, pharmacists reported that their available time in the pharmacy is divided among too many responsibilities and obligations, such as dispensing medication, supervising technicians, managing inventory, and performing other administrative tasks that are required as part of the business aspect of pharmacy operations. Therefore, time is taken away from assisting patients and providing expanded scope of practice services. According to most study participants, pharmacies did not invest sufficiently in staff to support patient-care services. Pharmacies hired an inadequate number of assistants, technicians, and even pharmacists, who would otherwise be able to divide the workload and to restructure the operational activities of the business to allow more time to be dedicated to patient care. (Please refer to Appendix 5.a for more quotes related to this topic.)

“I think the biggest challenge [in current daily pharmacy practice] is just lack of pharmacy support in terms of personnel. The pressure is to fill as many prescriptions as you can. If you give a
greater time, patients are impatient: ‘what do you mean it takes 20 minutes to put a label on to…?’ They want it now, and the management wants you to fill it now, so it doesn’t leave you time to provide the type of professional services that pharmacists can provide. For me, that is the challenge. How do you do that? How do you bring in more consult-type services? How do you run clinics in the pharmacy? I would love to see diabetes clinic or asthma clinic or something like that running in a pharmacy, but how do you make that happen, you know?” (P5, paragraph 30)

Currently, pharmacists’ time is divided amongst too many duties in community practice. For example, pharmacists are expected to simultaneously dispense medication, provide patient care, and deal with other administrative duties within the pharmacy. As noted by many study participants, employers, regulators, and policy makers could have considered whether it was reasonable to expect pharmacists to perform multiple administrative tasks in the pharmacy in addition to providing patient-centered practice.

“Probably the challenge like everywhere that comes up is the time limitation. In a very busy pharmacy setting, dealing with the multiple things that are going on all at once, and having time to ... handle a situation the way you really want to handle it can be a little challenging when you have got multiple people waiting and you are trying to track down a doctor, or you are trying to, you know, clarify something, or ... touch base with the doctor about drug interaction, or ... clarify something that they’ve left off the prescription, ... it kind of slows the process down and then having time to actually spend ... with the patient as you like ... some people need a little more time to fairly understand what we are trying to explain ... and sometimes it can be very challenging when
you have got many people waiting in the environment we are currently in.” (P7, paragraph 14)

In the past, pharmacists in Alberta identified that time is needed to dedicate to patients in order to deliver clinical services in community pharmacy (Rosenthal et al., 2011, p. 364). Patients can benefit from working with pharmacists to accurately assess their health conditions and the adequacy of their treatments. According to some of the pharmacists who participated in this study, making adjustments to patients’ treatments requires detailed analysis of the interaction and side effects of all of their medications. In addition, these pharmacists have expressed the view that some patients’ situations are more complicated than others’, depending on the medications they have been prescribed.

“We are in a good position, and I think the busy dispensary is actually hard to do because often times we will be looking at a summary of medications that you have on a prescription paper. So you are looking at sort of the big picture, but not necessarily the whole big picture, and I think that is why it is important to invite patients to come in and sit down with them and take time with them. I’m not talking of a five minute review at the desk, I’m talking, you know, you come in for half an hour or twenty minutes, you know, the complicated ones take at least one hour and then come with follow-up after that too right?” (P8, paragraphs 30 & 32)

In contrast, pharmacists in this study indicated that they are constantly being pulled in different directions, making it challenging for them to deliver high-quality health care services. The pharmacists who participated in this study said that they are required by managers and owners to dedicate time to dispensing medication in addition to performing health care services and associated administrative duties in the pharmacy. Pharmaceutical opinion and patient care require time to be performed for the benefit of the patient. For instance, a study by Dolovich et al. (2008) found that pharmacists reported that the main
challenge to performing MedsCheck is time (p. 341). Business owners allocate time to do what is lucrative. Accordingly, business owners allocate time to business operations in order to optimize profit.

Pharmacists in this study complained that MedsCheck sometimes is performed as a “profit generator” with no consideration for the actual benefit to the patient.

“We are racing a classic case where people do MedsChecks completely different, and I have seen people who just think it is a drug list and they get them to sign on it like it’s money owed to them, and it is probably one of the most frustrating things, because if you do it properly, even the simplest patient should take at least 10 to 15 minutes of conversation if they are on three drugs ... it’s an opportunity for you to have a conversation, there is no way [for] a healthy person on no drugs, to have a full conversation about their health can [sic] take less than 10 minutes and so when you see people doing it in less than that time, you really begin to question ... and these are usually the business owners, and I think these changes need to occur and needs to be a change within the culture of pharmacy, and that takes time unfortunately.” (P4, paragraph 16)

“I’m not so impressed with the way the chains in particular have handled the change, I think that they have decreased our professionalism across the board by forcing people to do a five-minute MedsCheck and, you know, forcing them to do so many per day, per week, you know, I think that makes for a very stressful work environment.” (P8, paragraph 72)
Remuneration

Pharmacists interviewed for this study indicated that the reduction in pharmacies’ income contributed to the time constraints that pharmacists are facing in their practice. This decrease in remuneration is related to the reductions in drug prices and other income that pharmacies formerly received from the Ontario government and other payers. As a result, pharmacies have decreased hiring of new staff. Therefore, pharmacists have to work harder, because their duties within community pharmacies have increased. This increase in duties has created difficulties for pharmacists in performing MedsCheck and other patient-centered services.

“I mean, you can do MedsCheck. You get paid for your MedsChecks. But I spoke with a lot of pharmacists, and they said that they don’t have enough time to do what they want, because they are cutting back ... you need an overlap of two pharmacists to do the MedsCheck, because if you are busy, how can you have a good discussion with a person if you are interrupted every minute to come and sign this prescription, or if there is a phone call. You can’t do it. The larger stores, like Shoppers and PharmaPlus, they are not overlapping pharmacists anymore. I mean, if they can’t afford to do that, you think the smaller pharmacies, independent pharmacies can? No.” (P10, part 2, paragraph 38)

In community pharmacy, managing pharmacists’ time is directly related to the remuneration pharmacies receive for delivering their services to the population. In the past, costs for non-dispensing health care services were partially offset by rebates and allowances paid by the pharmaceutical industry and, therefore, these services were provided to the patient without any cost to the pharmacy. Recently, however, rebates and allowances were banned by the Ontario government (VanderElst, 2010). As a result, provision of these health care services now creates an operational/business cost to the pharmacy. Remuneration for health care services must ensure financial viability from a business perspective to be provided in the pharmacy. From the perspective of pharmacy owners and managers, if health care services are not profitable
activities, they will not recognize any incentive to offer these services to patients. On the other hand, providing pharmaceutical care can build long-term relationships with patients, who will then become loyal clients and returning customers to the pharmacy. Nevertheless, it is unrealistic to expect these services to be provided regularly and with high quality without remuneration to compensate for the pharmacist’s time and other expenses related to the delivery of health care services (Morrison, 2013).

In addition, a considerable amount of pharmacists’ time and attention on the job is directed at delivering health care services through pharmaceutical care. No literature was found detailing time spent by pharmacists in a typical week focused on direct patient care. However, the American Pharmacists Association (APhA) indicates that pharmacists’ time dedicated to patient care varies due to the business model. According to the APhA, a comprehensive medication therapy review with one patient could take from 30 to 60 minutes of a pharmacist’s time (American Pharmacists Association, 2007). The pharmacists interviewed for this study identified challenges in delivering the health care services now included in pharmacists’ expanded scope of practice, such as time constraints, remuneration models, and shortages in staff in community pharmacy. These challenges were associated with pharmacists’ practice as health care providers within the business model of pharmacies.

“So I think time is the biggest barrier in terms of doing our profession services. That is definitely one. I would say the other thing is just the financial remuneration models that they have, right? I mean, we do a lot of things for free, and I think that is important in the long run to get paid for them, or else the sustainability of those kinds of free services are going to certainly dwindle right? Because the pharmacist is doing, let’s say, disease state management clinic for eight hours and, really we see 10 patients, that builds a lot of customer loyalty, and, you know, I’m sure they’ve made changes for the patient in terms of benefiting them, but if they are not getting reimbursed for it, I still then need
to find another pharmacist to cover off, you know, the day-to-day functions in terms of signing. So, I think time is one, I think the financial situation is another factor as well.” (P3, paragraph 26)

Pharmacy Technicians

Pharmacies hire pharmacy technicians to address the need for staffing in the pharmacy. Pharmacy technicians support the pharmacists’ role in patient-oriented health care. Pharmacy technicians are trained to support pharmacists in their dispensing duties. However, the pharmacists interviewed for this study mentioned the advantages and disadvantages of hiring pharmacy technicians to support their role in dispensing medication to patients. Pharmacy technicians can reduce the workload of pharmacists so that pharmacists can dedicate more time to health care services in community pharmacies. Some pharmacists believed that the technicians would increase the time that pharmacists had available to dedicate to patient care. Other pharmacists questioned how technicians could effectively relieve pharmacists from technical duties. If pharmacists remain accountable for the dispensing process, then it would still be required for pharmacists to review the technical work performed by technicians. (Please refer to Appendix 5.b for more quotes on this topic.)

“I don’t understand quite well, what is the role of the registered technician. Well, the talk that has been going around is that the registered technician will be checking off on the technical parts of the prescription, while the pharmacists will be signing off for the clinical part. I see this as a duplication of responsibility and a bit of a waste of time. I am not sure if that is the general consensus or not, but I don’t see it in black and white yet.” (P9, paragraph 28)

“We like the status-quo, so I think we need to kind of break that mould. I think one of the ways we could do that is embrace regulated technicians more, especially in the community. In the community they are highly underutilized, and if we can, you know,
kind of capitalize on them on their expertise and down, free up our time to other, you know, take part in more training, or we could take part in more direct patient care.” (P6, paragraph 90)

The support of pharmacy technicians can help pharmacists to be fully dedicated to patient-oriented health services. One pharmacist pointed out the difference in the nature of pharmacists’ role working as health care providers in comparison to their role working as drug product dispensers. This participant pointed to differences in objectives, duties, and priorities that comprise pharmacists’ work agendas and motivate their practices in these two different roles. It is important to keep these roles separate in order to avoid a conflict of interest between working for the benefit of the patient and working for the benefit of the business.

“I think utilizing the certified technicians, and even the pharmacy assistant really, you can sort of create a functional way to make that work so that the pharmacists can spend more time with the patient. I think that is really the ideal. Now that I’m getting a bit older and I have a bit more experience, I am actually thinking that it is a little bit of a dichotomy, the dispensing role and the clinical role. Sometimes the money and the clinical stuff, they are not in sync with each other. So I am starting to think, now as I’m getting a bit older, that would probably be a great idea to separate those two functions. Just because the clinical advice that you give, you want it to be seen evidence-based and for the best interest of the patient. You don’t want it to be seen as ‘I’m recommending the thing that has a comfortable margin for me.’ You don’t always want to be money driven, you know what I mean?” (P8, paragraphs 22 and 24)

Another pharmacist described the inefficiencies he faces when there are no pharmacy technicians on duty. He faces inefficiencies when trying to contact physicians on behalf of patients during
his work in community pharmacy. He also described his time as being divided among several duties and responsibilities.

“If I am working on a Sunday evening, then there is no technician, I have to take care from A to Z, calling hospitals on ‘off’ hours. Good luck if you can find a doctor. [I’m] doing all those things that might take an hour or so. Meanwhile, serving the other patients, filling prescriptions, also administering flu shots, as well as performing MedsChecks, answering phone calls, doing counselling over the phone, counselling on the floor, and so forth. The usual, nothing unusual.” (P9, paragraph 18)

Health Care Accessibility

Regardless of how pharmacists feel about their workload in community pharmacies, offering clinical services at pharmacies seems to make sense from a public health perspective, especially when considering health care accessibility for patients. According to Pojskic et al. (2014), the Ontario government and pharmacies’ professional organizations were in support of pharmacists’ prescriptive authority, and they were in agreement that it would broaden patients’ means to receive primary care. In the study by Pojskic et al. (2014), pharmacy and government informants expressed their belief that the expenditures on public health could be diminished by directing patients to pharmacists for their prescription needs.

Some services that are based on physicians’ and nurses’ practices can be made available at pharmacies. Pharmacists’ expanded scope could relieve doctors’ hours to attend to their patients, but it could also make patients less dependent on doctors’ time for procedures such as administering vaccines and treating minor ailments (Pojskic et al., 2014). However, pharmacists are still limited in their capacity to review patients’ health conditions, as they do not have access to patients’ medical histories and clinical data. For instance, pharmacists do not have access to patients’ clinical laboratory results, which are crucial in assessing patients’ health conditions and in evaluating their medication therapy.
“So I think that is a really good … just even accessibility …. we talked about immunization, any kind of prescribing, and it should take away some of the pressure off the health care system. So, if you are used to having to go to a doctor or nurse for your immunization, if you could do that in the pharmacy now, it would just free up the doctors and nurses to take care of patients at another level as opposed to immunization, which is just pretty straightforward.” (P2, part 2, paragraph 139)

“Well, I think the biggest challenge from the dispensing side is that we don’t have access to lab values, and sometimes it becomes a bit of a challenge when you request them and they are not readily provided, if at all. So it’s very difficult to assess, for example, a diabetic and their creatinine clearance if you don’t know what their serum creatinine is and if, you know, you don’t know whether anyone sees this.” (P8, paragraph 34)

Kotter’s Principle #2: Forming a Powerful Guiding Coalition (Professional Cohesion)

Much of the literature regarding the evolution of pharmacy practice has noted that pharmacists can expand their scope of practice for the benefit of patients but also to contribute to the efficiency of public health services. At the same time, the expanded scope of practice should allow pharmacists to exercise their knowledge and skills learned through many years of training in university. According to the pharmacists interviewed for this study, the profession can go further in supporting change in pharmacy practice. One pharmacist suggested that the profession needs to act collectively to defend its viewpoint with regard to changes in professional practice. Having a common goal can strengthen the profession’s ability to plan and execute changes in practice. To begin, one common goal could be to effectively negotiate with stakeholders within the community pharmacy realm and to create momentum for change within the profession.
Therefore, aligning several initiatives is important, such as promoting the pharmacist within the community and influencing decision makers to accept changes to pharmacy practice.

“I think there has to be a better push, I think there has to be advertisement for the profession, I think ... they have to do a better job on the policy standpoint, making, you know, decision-makers understand what are ‘importances’ and then coming back and saying ‘this is the difference that we have made.’ I think it is very, very important because [it] is going to take time to change the culture of pharmacy from being completely business-oriented to being clinically-oriented.” (P4, paragraph 16)

“We have to be together, and a little aside, we’ve always been sort of quiet in the background ... I felt so anyhow ... you know the physicians are out there ... protesting or whatever they are saying or, I guess maybe not so much on strike, and I think nurses ... I should say our voices have always been quieter, more quiet than other health care providers, and so it’s time that we do speak up and defend our points, what we agree with and what we don’t agree with.” (P2, part 2, paragraph 119)

On a national level, one pharmacist suggested that it would be beneficial to pharmacists if policies were harmonized across provinces. This harmonization would allow pharmacists to practice in different provinces, which would unify the profession nationally.

“I think there is an opportunity for CPhA to, either rally up all the provincial organizations and work with all the provincial organizations and kind of lead those provincial organizations with the scope so that there is not great disparity in what each province can do, because right now, I mean, it’s all over the place. Ontario doesn’t have minor ailments prescribing, Nova Scotia has
extensive minor ailments prescribing, and Saskatchewan has, you know, some minor ailments prescribing. It’s just all over the place, and it would be nice to see that we are all asking and pushing for the same thing as a unified front, because a pharmacist in Ontario should be able to do what pharmacist[s] in New Brunswick or PEI or BC or Alberta or, and anywhere in between, we should all be able to do the same thing.” (P7, paragraph 67)

Kotter’s Principle # 5: Empowering Others to Act on the Vision (Business Model of Pharmacies)

Business owners and managers are important decision makers in the process of implementing the new scope of practice. Several pharmacists interviewed for this study cited challenges in performing the expanded scope under the current business model in which pharmacies operate. Pharmacy owners and managers may benefit from adapting the business model of pharmacies to allow dispensing of medication to happen concomitantly with delivering a full suite of clinical services.

“We need to change the flow of the pharmacy, so that there is a pharmacist potentially that sees the patient initially and then all the technical aspects that happen after that, for example, the actual filling of the prescription. In the current model environment we have, it’s not how it works, so we need to do a better a job at figuring that out.” (P7, paragraph 53)

However, pharmacists have also mentioned that revenues have decreased and that the workload has increased in the community pharmacy setting. At the same time, the cost to operate pharmacies has increased in relation to the revenue of pharmacies, given that pharmacies have lost significant sources of income, such as rebates and allowances, and they have also lost significant margin on generic drug sale prices. Increased business costs have an impact on several issues related to the socio-economic situation of the pharmacy profession, such as fewer
jobs, lower salaries, increased workloads due to reduced staff in the pharmacy, and decreased training opportunities for pharmacists. (Please refer to Appendix 5.c for more quotes on this topic.)

“If you need to know why, I can tell you why. I was running a business, and I was the franchisee of a big store, 24 hours and all the stuff. During a different time. It was not a corporation back then. It was a private company. Back in 1993, I used to pay the pharmacists what is the ongoing rate today. How many years is that? 21 years. So, the hourly rate of a pharmacist rolled back to the 1993 rates ... this is a sad story. The new grads don’t have a clue, because they have not seen any better. They graduate from school, get the ongoing rate, and they are happy with it. Most of them have a six-digit debt in loans. They are happy to pay back the loan, end of story. They live with what they get. In reality, that is not the fact. In reality, we roll back the rate 21 years backwards, and that is not fair. Nonetheless, this is happening, when the responsibility of the pharmacist has increased tremendously. It’s no longer checking the bin, opening a jar, matching the pill, signing and then, ‘boom.’ That is no longer the issue. Now, we are talking about ‘there is an incompatibility, there is an interaction, you can’t do this, and you can’t do that.’ There is a lot into it. According to the guidelines, whether it becomes a bylaw now, where if you don’t do ‘X’ amounts of MedChecks per shift, then you are not doing well. If you don’t do call backs ‘X’ amount per shift, then you are not doing well. This is added pressure. I understand. I understand. Pressure is a part of life, but there’s got to be, there’s got to have a reward. Well, instead of having a reward, the salary rolls back. That is my answer.” (P9, paragraphs 92 & 98)
Reimbursement Scheme

Pharmacists reported concern regarding the reimbursement paid by the Ontario government to pharmacies for health care services. Pharmacists questioned whether the reimbursement scheme actually will compensate pharmacies for the pharmacists’ time when providing expanded scope of practice care. In the past, the time that pharmacists dedicated to clinical services was reimbursed through professional allowances and rebates. Now that these activities have been banned by the provincial government, pharmacy managers and owners have had to adapt their budgets to a new financial situation, which seems to be financially tighter and more reliant on government fees paid for patient-care services. Currently, the Ontario government is compensating pharmacies on a fee-for-service basis for offering health care services.

Nevertheless, pharmacists have reported that owners and managers of pharmacies still feel hesitant in adopting the pharmacists’ new scope of practice, perhaps because they feel that these services have a lower financial return than having pharmacists dispense medication to patients. In addition, customers of pharmacies do not seem fully aware of all of the services that pharmacies can provide. Many times customers are not willing to speak to a pharmacist. Some patients might feel that their treatment and health condition is something they should discuss only with their doctors. Other patients, however, might find it very convenient to have access to their pharmacist and not to have to depend solely on their doctor’s availability. This shift in pharmacists’ roles and responsibilities will require an investment of time and resources from pharmacies. For instance, community pharmacists depend significantly on technology for their practice, for example, by using computerized databases, drug-interaction checking, and generation of drug information, as well as online adjudication of insurance claims (Austin & Ensom, 2008, p. 5). Community pharmacists also count on pharmacy technicians and assistants to cover technical duties and to allow pharmacists to dedicate time to delivering patient-centered health care services (Austin & Ensom, 2008, p. 5). (Please refer to Appendix 5.d for further quotes on this topic.)

“The remuneration needs to be looked at in time, because it has to be something that is sustainable and that you are going to make a
Pharmacies are remunerated for providing health care services to patients. However, many community pharmacists are employed by pharmacies on a fixed-income basis and are expected to perform patient-centered care. Pharmacies are paid a fee for offering these services, which are only covered partially by the government for a limited percentage of the population. The question remains: Can pharmacies financially sustain patient-centered care? In other words, can pharmacies afford to pay for pharmacists’ time to dispense medications and deliver patient care? Can these two activities co-exist in terms of the need for profitability to a pharmacy? It is important to address profitability in the case of pharmacies, since these are commercial establishments that can only sustain their practice if they generate sufficient revenue to pay for their associated business costs and, in addition, generate profit.

“I think the future of pharmacy is going to be more fee-for-service, and we are definitely getting away from the dispensing fee, covering daily operations of the pharmacy expenses. I see that
more and more every day as private insurers and the government, they are pushing down the cost of the drug, which then decreases the amount of money we generate off mark-up, because 8% of $100 is $8, but 8% of $25 is only $2. So you are getting 8% mark-up. Dollar values in the pocket of businesses are less.” (P7, paragraph 71)

“The problem with the whole situation now I guess is that dispensing has always been the bread and butter, so that’s really what paid the bills. I guess in terms of cognitive services, will that pay all the bills? The short-term answer is “no”. Therefore, the dispensing function is still an important function just for the viability of the profession, I think. However, once that changes more in terms of cognitive services, maybe one day that will be more of a ... financially sound business decision to go with the pharmacist.” (P3, paragraph 16)

Addressing the economics surrounding the pharmacy profession is one of the important conditions in executing long-term changes in scope of practice.

“I have yet to see, every time I’m in a conference and people talk about the money of it, the people giving the talks at these conferences, never have an answer, and almost shy away from comments on: ‘Well, that’s for the businesses to figure out how to make it viable.’ They [the people giving talks at conferences] never really have an answer of, you know, no one seems to be doing the economics of it and at the actual, you know, pharmacy level, they just say, well, figure it out, figure it out, and that’s, you know, it’s a little late to figure out ... and we [pharmacists] have already agreed to, you know, $7.50 for something that actually costs us
Pharmacy Associations

Pharmacy associations have a role to play in safeguarding pharmacists’ interests in terms of remuneration. These associations have strong leadership positions from which to negotiate with governments and insurers on behalf of pharmacists. Therefore, pharmacy associations can represent pharmacists’ interest in recognition of their actual compensation needs with respect to fulfilling their expanded scope of practice. Conducting business viability studies could help pharmacy associations establish an approximation of the cost for pharmacies to perform patient-centered services. In this sense, the reimbursement of pharmacists should be ensured by payers in order to encourage pharmacies to offer those services to patients.

“The Ontario Pharmacists Association’s [OPA] role is, like as a pharmacist’s and a manager’s [role], not only to help us take steps down the expanded scope path and down the path of bigger and better things for the profession. They also need to firmly guard how it is remunerated by either the patient, the insurance industry, or the government. Then, they need to adopt a model. In my opinion, if the new expanded scope that you are expecting us to take on or wanting us to take on is not a self-sufficient model, if the compensation coming back does not cover the cost of doing the service, it should be a non-starter. We should not be agreeing to it. If you want us to do a service or [if] we are going to do expanded scope, then the amount of compensation being paid to us by whoever it’s being paid to [sic], whether the patient or the government or private insurance, than that needs to cover the cost of doing that service.” (P7, paragraphs 59 & 61)
“Our association sometimes agrees to compensation that doesn’t really make sense at the business level. Where other provinces are getting, for example, 12 or 15 dollars for flu injection, we are getting seven dollars and 50 cents. Obviously, their math has been done, they know what the time involvement and the cost to do that is, and the seven dollars and 50 cents cover [for] that? I am going to say, no it doesn’t, but, you know, you hope to get them [patients] through the door and [hope that] they pick up other things. In my experience as being a vaccinator this year at our pharmacy, people aren’t coming in and buying other stuff at the same time. In our practice, they are coming in for the flu shot and for the flu shot only. So, we are probably taking an overall loss on doing the flu injection.” (P7, paragraph 61)

Fee-For-Service Model

The pharmacists who participated in this study reported that the Ontario government’s reimbursement for health care services does not cover the cost of these services in the pharmacy. The provision of health services in pharmacies has a premise that is essentially different than that of the provision of health services by physicians. As businesses, community pharmacies require profits in order to exist. As such, for pharmacies, health services need to provide a minimum turnover in order to be profitable and, therefore, viable for the business.

In Ontario, most community pharmacists are employed by pharmacies and are paid for the number of hours they work. In contrast, other health care professionals, such as physicians, are paid by the provincial government in a fee-for-service model. As reported by pharmacists, the fee-for-service model is not consistent with expenses related to providing these services in pharmacies. At the same time, these fees are not paid to pharmacists, whose efforts to embrace the new scope of practice have not yet been compensated. The government, together with pharmacy associations, could incentivize the provision of these health services by developing a reimbursement scheme that is consistent with the cost of delivering these services to pharmacies.
A unique remuneration model would better compensate pharmacists to provide health care services. Perhaps such a model would need to be different from the model currently in place to pay for services provided by other health care professionals, such as physicians. Pharmacy owners likely would not be willing to engage in health care practice if they needed to pay more for, and earn less from, pharmacists’ time. At the same time, pharmacists have little incentive to engage in patient-centered practice if they will not be compensated for their time and effort.

“The manager and also being responsible for the profit of a business in the daily operations, we can’t move forward unless there has got to be some compensation coming back to the business for it. We are not non-profit pharmacies; retail pharmacies are there to make money as a business. Someone [sic] took a huge risk and went into business and wants it to be viable. There is not unlimited money that comes in that covers the cost, like some of the hospitals out there, or other government-run organizations. If we continue down this road, which I believe we need to do, there has to be some compensation model coming back for the added scope. We can’t just continue to do things and get nothing in return, because then we have extended our scope, we have added to our workload, we are providing better services at a higher level, and we are not being recognized for that. I don’t believe any profession or anybody would do that in any other profession.” (P7, paragraph 29)

The fee-for-services model currently in place to reimburse physicians for their services might not be the most appropriate or adequate model for reimbursing pharmacists for health care services delivered in the pharmacy. Establishing the same fee-for-service model to compensate for services provided at the pharmacy could encounter resistance from other health care professionals, whose perception might be that their income is being transferred to pharmacists.
“I think for me there is [sic] a few challenges I see coming up with a lot of the changes that are starting to happen because of the model that is developed in Ontario. The first is the conflict that will occur with these family doctors that are attached to these pharmacies, so, in a sense, some of these doctors view as: if I’m [pharmacist] giving prescription refill, then that patient is not going in to see them for a visit. So if the majority of that pharmacy’s revenue or the majority of that livelihood is coming from that doctor, they want to appease that doctor. Unfortunately, I see doctors who will write Crestor that the patient has been on for five years, so Crestor is like a lipid medication, and they will give them one month at a time, because they want that patient to come in every month, but that patient has been on it for three years. So if I decide to refill, I can really upset that doctor, because they get ... you know, they are based on a quantity and fee for service model which is pretty ridiculous, so the first thing is just interaction with other health care providers.” (P4, paragraph 12)

Costs associated with patient-centered practice are being evaluated by owners and managers of pharmacies, such as investments in staff to relieve the pharmacists from carrying out technical duties. As reported by a pharmacist interviewed for this study, pharmaceutical assistance for patients cannot always be performed within a short time frame. Therefore, the fee-for-service model might not work effectively to support pharmacists in offering these services at the pharmacy. Performing a viability assessment of health care services provided at pharmacies, including the costs associated with allocating pharmacists time to dedicate to patients, could assist pharmacy managers and owners in implementing health care services for patients.

“I have been in meetings with people. I look at [what] they are saying: ‘You can do tons of MedsChecks for us through the renal program, and we just recommend all of our patients to go through
you and get their drugs from you. We can say: get a MedsCheck from a pharmacy. ‘We are happy to do that, but I’ve said to them, on the business side of things, because the patients that you are wanting these MedsChecks done for are very complicated patients and, you know, luckily I have pharmacists who are very caring and they don’t want to abuse the system, when they do a MedsCheck, they do a very thorough MedsCheck. They are not the pharmacist [sic] that, you know, a patient walks up to the counter and they say ‘well you know, we’ve put you on a med list for the last [sic] six months, this is what you take, this why you are taking, sign here and let me get my sixty dollars,’ and it takes [them], you know, three minutes. And I know that happens, I have been in those pharmacies where, you know, filling in and helping, and you know that is how they do their MedsChecks. In my opinion that is not the way it was designed to be done, and the pharmacists agree [it] is not the way it was designed to be done, that isn’t really going to show any clinical benefit to the patient by doing it that way, but when we do it, and it takes up to one hour and a half to two hours, that is not a business model that is sustainable.’” (P7, paragraph 107)

Changing the business model of pharmacies for them to adopt delivery of health care services as a standard practice would require resources, time, and dedication from pharmacists, pharmacy owners, and managers. According to Dr. Alison Roberts’ program (Canadian Pharmacists Association [CPhA], 2012) in Australia, some of the issues related to changing practice in community pharmacy to patient-focused health care include:

- developing an implementation plan of changes in practice and setting clear objectives with the entire pharmacy staff
- capturing and developing new team members in the pharmacy to practice health care
- establishing physical space in the pharmacy that is suitable for attending to patients
• fostering customers’ interest in the health care services offered by the pharmacy
• communicating well and relating to family physicians in the location
• securing that health care services offered at the pharmacy are financially viable
• creating other networks to sustain health care practice (Canadian Pharmacists Association [CPhA], 2012).

Nevertheless, early adopters can change patient care by developing innovative health care services to offer at pharmacies and, at the same time, developing patient loyalty to pharmacists.

“I guess to run more of these clinics, at least I know that I’m not losing money doing these clinics, but I’m actually maybe getting my pharmacist wage paid for that period of time, so it’s not much of a loss and therefore I’m more up to do this so that I get that customer service and customer attention.” (P3, paragraph 79)

“So, I think it’s the economics part of it that is really up in the air right now, because MedsChecks and what they have done right now is a good supplement, a decent supplement, but [it] is not financial sustainability. I think that by making more money, perhaps then you can really filter this money into other things, right? Other things in terms of practice, in terms of having specific clinic days, having even an hour or two a day where you can book MedsChecks … that type of thing, right? So the more money on the top end of things will trickle down to more services, but the less money on the top end, 100% of your services will tend to decline, right? Unless those services are getting reimbursed, like the cognitive services, so, it’s a two-way street.” (P3, paragraphs 87 & 89)
Kotter’s Principle #4: Communicating the Vision

The pharmacists who participated in this study indicated that effective communication is required at several levels within the community pharmacy realm. During their interviews, pharmacists frequently mentioned several communication channels that require improvement in order to support patient-centered practice.

Collaborating with Physicians

Some pharmacists told stories of their successful relationships with physicians at nearby clinics, who collaborated with them to provide pharmaceutical care to patients. Other pharmacists, however, encountered challenges in collaborating with physicians as part of a health care team. At times, physicians have been unwilling to give up health services that were under their scope of practice so that they could be performed by pharmacists, when physicians have been remunerated for these services. Nevertheless, pharmacists have the competence and skills to perform these services, and, moreover, pharmacists often would be more readily accessible to patients than physicians. Pharmacists can relieve doctors’ workloads by seeing patients who are waiting for treatment. In this way, pharmacists can make a significant difference in relieving the load on the already overloaded public health care system.

“Yes, I do believe that in some practices, there are [sic] a fantastic cooperation, a good liaison, a good rapport between pharmacists and doctors. But in most of the others, there isn’t. First of all, this injection thing of immunization has been looked at as being a disaster for doctors, and they hated us from day one, because their gut feeling was that we were invading their territory and taking away their business. Nonetheless, to add insult to injury, they found out that pharmacists can now prescribe an extension for a month or two, until they [the doctors] come back from vacations. So, what is next? So, they are very iffy. They need to be reassured, and this is not coming from the pharmacists’ community. It has to
come from a neutral side. Whether it be the Ministry of Health, I don’t know. It’s got to be a neutral party to give this reassurance, that ‘you know what? Nobody is here to step on your toes. We are here to help out and we are here for the health and benefit of the patient at the end of the day.” (P9, paragraph 76)

Pharmacists and physicians, as well as patients, can benefit from working in collaboration for the benefit of patients. Physicians could refer patients to pharmacies to obtain their prescribed medications. Pharmacists could better support patients by assisting them with their treatment, working in partnership with physicians to relieve the time that physicians must dedicate to patient care.

“In terms of physicians, we have a walk-in clinic, and our family practice there is about five doctors in there, and our relationship with them is very good, and we do a lot of interaction with them on a daily basis. Interactions can be just, you know, verifying and clarifying prescriptions. More in-depth interactions would be recommending changes in drug therapy and things like that.” (P6, paragraph 8)

Currently, there are challenges regarding optimal communication with physicians. Some of the hurdles identified by study participants in communicating effectively with physicians included physicians’ availability to speak to pharmacists on a regular basis, thus causing delays in addressing changes to patients’ treatment, and unreadable prescriptions causing delays in the pharmacy and loss of productivity in patient care. Pharmacists lose time to dedicate to patient care when they have to clarify prescriptions that lack clear information and that contain dosage regimens that are not available in the pharmacy. One pharmacist interviewed for this study expressed his frustration with physicians who do not provide complete information on their prescriptions, requiring clarification and increasing the workload for both the pharmacist and the physician.
“In terms of interactions with doctors now, it’s more or less an interaction via fax, which is not my favorite method of talking to a doctor, and communicating something that the patient has communicated, because the doctor might not even see that document, because the secretary gives it to him. He signs it. Ok, and that’s it. You can miss a lot of things via fax. Sometimes it takes longer for the doctor to get back, yes. So, that aspect, I don’t like as much. There is a lot of paperwork. It would be much easier if I could pick up the phone like we used to do, get the doctor on the phone, ask him a quick question and ‘blah, blah, blah.’ Everyone is happy, no paperwork. You could call the doctor and he would pick up the phone ... Not now, no way. The secretary doesn’t want to take a little note. She says, ‘fax me the question.’ That, to me, is ridiculous. She could take the note and ask the doctor to call me back. Why must I have to type it and fax all this?”

(P10, part 1, paragraphs 4, 6, & 8)

“No matter how much we spoke about that in mutual meetings with doctors ... I mean, please take the time to write your name, and please take the time to write your license number, when you know it is a narcotic. You know, I know, everybody knows it is a narcotic. For narcotics, controlled, as well as targeted substances Rx, the prescriber has to write his/her CPSO number along with the health card number of the patient ... it’s that simple!! It saves myself hours, and I say hours on a Sunday evening, on a Saturday evening, talking hours on the phone, trying to move around from department to department. Oh, it’s a left wing, it’s a D wing. It’s this and that. Sometimes it happens to be an intern that nobody knows who that is. In the middle of all that, the patient is frustrated, I lost track of my productivity because I spend an hour
on the phone, and God knows what happened to the rest of the people. This is very frustrating. Whereas, only a small little thing that would take two seconds would have solved the problem. The second challenge is when I see doctors writing strengths, going by the book. They open the book and say ‘169mg QID for 10 days.’ I mean, give me a break. I understand you go by the body weight and you multiply by the daily dose. I can understand that, but you have to come up with something feasible. We are talking about somebody who doesn’t have a scale at home or a pipette to measure that kind of thing.” (P9, paragraphs 44 & 46)

Nevertheless, some pharmacists have established long-term working relationships with physicians working at nearby clinics. These pharmacists build relationships with physicians to the benefit of patients. Physicians and pharmacists speak together regularly about their patients. Pharmacists dispense medication prescribed to patients by their physicians and counsel these patients about their drug therapy. Pharmacists are also available to provide support to physicians regarding drug products and their effects during patients’ drug therapy.

“We have long-standing physicians there, so, you know, they quite often do call us for advice or some drug information. I find, just because we have that rapport and that trusting relationship we have with them, so, yes they do call us, certainly, if they have any questions regarding, you know, the patients’ medication or which one to prescribe at times if they are a little bit unclear, especially with new drugs and so forth.” (P3, paragraph 10)

Professional Recognition

Despite the challenges of communicating with physicians, all of the pharmacists interviewed in this study were interested in taking on a more active role in patient care. Regardless of the business-oriented roles and duties they assumed in community practice, these pharmacists have
always identified themselves with the health care provider role. The pharmacy profession can achieve recognition of their role in patient care by providing patients an extended and differentiated suite of health care services.

Developing patients’ perceptions that certain conditions can be treated at the pharmacy can lead to patients’ recognition of the competence of pharmacists as health care professionals. Many people are not aware of what pharmacists can do for them in terms of health care. Moreover, people may hear that pharmacists can perform certain health care services, but they cannot find these services in every pharmacy, making it difficult for all patients to use these services. This lack of consistency in health care services offered at pharmacies can possibly influence patients to revert back to the physician to receive their needed care. Lastly, there is still a perception that pharmacists are professionals working for the business of pharmacy, whose priority is not the health of patients but rather selling drug products to customers.

“We are perceived, at this point in time, as being just a pill counter. That is dangerous and a very big injustice there. I couldn’t lie. We went into a price war where we ended up being perceived as a bunch of merchants. This is not right, because people say to themselves, ‘I can have it cheaper at Store X,’” or whatever. I don’t want to mention names, now it’s irrelevant. I am just giving you an example. So the fact is that this prescription, instead of being health oriented, health care oriented, is not perceived among the population from that angle at all. We still perceive it as, ‘how much are you going to charge me?’ That’s the kind of thing. So, yes, there are many people and many excellent pharmacists who are really doing [sic] a leadership role where they practice. But the word of mouth is not getting that out.” (P9, paragraph 60)

There are two important determinants of establishing recognition and value concerning what pharmacists can do for patients. The first is having health services in the pharmacy covered by
public and private insurers. Patients covered by public and private insurers can appreciate the convenience of getting more aspects of their health checked at their local pharmacy. Pharmacy owners and managers will take an interest in offering these services for a fee. Secondly, financially compensating pharmacists is one way to incentive these professionals to acquire skills and take the leap to dedicating themselves to patient-centered clinical care.

Currently, some of these services can only be accessed at a doctor’s office. The pharmacists interviewed in this study indicated they can provide the patient with greater access to several health care services. In addition, innovative health care services can be developed in the pharmacy, which are complementary to the health care received by patients from other health care professionals. For example, review of medications, extension of prescriptions, and evaluation of medication interactions are some of the basic services that pharmacists can provide to patients. Also, there are several educational services that pharmacists can provide to the community to educate patients about their health and treatments. Smoking cessation clinics and diabetic clinics are just two such educational initiatives that could be provided to patients by pharmacists.

Pharmacists who are operating a business have incentives to develop new ways of practice and to create unique health promotion services for patients. In terms of health care quality and access, there might be a potential advantage from pharmacists working within a business: clear and direct incentives for pharmacists to continue improving services provided to the patient. The government can take advantage of this business leverage to create a high-quality suite of health care services that can be delivered to patients through pharmacies. The disadvantages that a business-oriented practice can bring to health care practice, such as pharmacists being tied up with dispensing drug products to optimize profits, can be minimized by a business leverage to improve health care practice in favour of the patient, who is the ultimate customer of pharmacies.

**Competition**

Competition exists for both public and private service providers. Research shows how doctors’, pharmacists’, and other health care professionals’ roles overlap, and these professionals are in a
constant tug-of-war to be entitled to a certain scope of practice (Pojskic et al., 2014, p. 349). However, there is increasing evidence showing that patients’ needs are greater than physicians’ capabilities to deliver health care (Tannenbaum & Tsuyuki, 2013). Interprofessional power disputes should not stand in the way of improving patient care. Patients could benefit greatly if the government channelled this competition among pharmacists, physicians, and other health care practitioners to foster improvement of health care services and to increase access to these services instead of limiting certain health care practices to specific categories of professionals. Pharmacists have the ability to work from within a financially self-sustaining, private health care setting, which seeks to improve the quality of services to increase profitability and to contribute to the growth of the business of pharmacies. Ease of access to high quality services might be the unique differentiator of what the pharmacy professional can deliver in a publicly funded health care system.

“Well, it’s just an idea that I want to throw on the table. If we can come up with a bunch of volunteers that are willing to sit around the table with the community of doctors, I mean physicians, it would be very beneficial, because we can build bridges, not by lip servicing, but by real facts. We keep saying ‘let’s work for this together,’ ‘we belong to the same health care family,’ but that is lip servicing, it is not put into practice. You know what I mean? So that is what it comes down to. We need this kind of get-together thing to reassure them that we are not there to step on their toes, that’s one. We are here to work together to facilitate things.” (P9, paragraph 108)

Communication with Patients

Many aspects of communication with patients also can be improved. Patients’ access to health care services can be enlarged if patients learn what the pharmacist can do for them. Many patients are unaware of the existence of health care services in the pharmacy. Moreover, they may be unaware of the pharmacists’ competency and skills to offer these services.
“I don’t think patients understand the capabilities of pharmacists completely, especially neighbourhoods that come from different backgrounds from other countries, so you notice differences, that some patients from some countries, pharmacists are held in a higher level, and in other countries pharmacists are just dispensers, whether prescription isn’t important.” (P4, paragraph 12)

As health care professionals, pharmacists have a privileged position in educating patients. Patients can benefit greatly from learning to manage their own treatment and health conditions. The trust that must exist between pharmacists and patients can be achieved through effective communication. Currently, many patients do not have a complete understanding of pharmacists’ role as health care providers. Therefore, patients’ expectations as customers dominate in their relationships with pharmacists. Some of the pharmacists interviewed for this study observed that new immigrants to Ontario bring various interpretations of the role of pharmacists. (Please refer to Appendix 5.e for more quotes on this topic.)

“The only concern that I have is that the public needs to realize, is that as our role changes, right? ... I firmly believe that the days of walking into a pharmacy and walking up to the counter and asking to speak to a pharmacist and not having to wait are gone. I think the patients are having a hard time with that, and they are not used to that because, you know, for the longest time you guys would go to a pharmacy and the pharmacist would drop everything they were doing, and they would come and help you, right? Yes, so I think what I’m getting at is basically the education of the public, you know, they need to understand that as our role evolves, you know, our availability might fade, right?” (P6, paragraphs 46, 48, & 52)
Pharmacists are available to patients on a needs basis. If patients are aware that pharmacists are available to attend to their health needs, then pharmacists will have an opportunity to build on this perception that they can provide patients with high quality, accessible health care services that are complementary to the services they receive at medical clinics. The value of this approach to public health is its potential to improve the quality of health care available in communities across Ontario. Providing regular assistance to patients, clarifying patients’ questions and concerns about their health needs, and being available to assist patients with symptoms they might develop during their treatment are unique advantages of implementing pharmaceutical assistance. Research data show that pharmacists’ participation can improve the management of specific health conditions of patients, such as hypertension, dyslipidemia, heart failure, anticoagulation therapy, asthma, and diabetes (Tannenbaum & Tsuyuki, 2013).

“Pharmacists have a unique opportunity, since patients come to them first, oftentimes, to be able to do a lot of health promotion and a lot of patient education, and so the times when I actually ... I’m able to spend with the patient discussing, either making recommendations or discussing a particular medication therapy, are the times that I enjoy the most.” (P5, paragraph 24)

One important structural factor to allow for effective communication between pharmacists and patients is the availability of appropriate physical space within the pharmacy for private and thorough consultations with patients regarding their treatments and health. For instance, several pharmacists expressed the need to have an opportunity in the pharmacy to communicate properly with patients during their health consultations.

“The doctor doesn’t get a chance to talk to them about the medications, they just write it down. So a lot of them, when they come in here, a lot of pharmacist would assume that they have taken the medication right, and so the good opportunity to set the record straight, sit down and talk to them, even like the simplest thing like taking a medication on an empty stomach or not, and
you know that it can make an impact because of the absorption of
the medication.” (P4, paragraph 10)

Communication with Professional Associations

Pharmacists interviewed for this study reported several challenges in communicating with leaders within the profession, especially concerning issues such as misrepresentation, passiveness, and lack of engagement at different levels within the profession.

“I like to have leaders being good communicators, not just as a representative of us as pharmacists, but also communicating back what actually transpired in any kind of leadership role that they had, yes.” (P2, part 2, paragraph 111)

Several participants cited professional associations as leaders of the profession. However, according to these participants, these associations have been vague in their communication with pharmacists regarding new regulations governing practice in community pharmacy.

“The Ontario College of Pharmacists [OCP], they put very vague instructions on their website, and every time I call them to ask something, this happened more than once, they said ‘it’s the pharmacist’s decision if….’ No, they have to put it there in black and white. ‘If this is the case, you do this, if it’s not the case, don’t do it.’ But they don’t say that. They have all the regulations and it’s very vague. They are protecting themselves. They are not helping the pharmacists.” (P10, part 2, paragraph 28)

“You hear an announcement that comes from OCP and OPA, and there is no follow-up on how to do things. These are big changes for people to be able to do. So I think the biggest concern has been the education of us on what is acceptable and what is not, instead of just a long-winded letter that is very hard and convoluted to
understand, especially for a lot of people, and everyone interprets things very differently. You will see different pharmacies doing things differently. I guess that is the opportunity I have had as a relief pharmacist, to go into different places that I have seen, how everyone interprets things differently. Umm ... Yeah, that is probably the biggest thing, just a misunderstanding of what is going on.” (P4, paragraph 14)

One pharmacist believed that pharmacy associations could do a better job of communicating to pharmacists the changes in scope of practice. The channels of communication used currently, such as email messages and meetings, are not the best means to clearly disseminate changes within the profession. Another pharmacist interviewed for this study spoke about the misrepresentation of pharmacists by professional associations. This pharmacist felt that professional associations are representing the owners and managers of pharmacies rather than the pharmacists respecting their duty as health care professionals.

“I think the thing they can improve on, both OPA and OCP, since they are the two major bodies, it’s just a better means of communication, when changes happen instead of just sending out an e-mail blast and thinking that is the only way to do it. I think they [OPA and OCP] should set up better opportunities, not just having three different days where people could go in, and they understand that everyone has a busy schedule, there needs to be an understanding of how important this is, and how there needs to be buying more of an outreach and grassroots kind of work. So I think they need to figure out what is going to work best when policy changes happen, to communicate them into what is done properly.” (P4, paragraph 44)

“I think we need to do a better job. Our provincial and national organizations, they need to guide us through how people who have
been doing it in best practice, so that people understand that, if we do make a change, it will work. I wouldn’t have specific names that I could give you of people, but I could tell you, I do think the Ontario Pharmacists Association has a role to play there. I kind of have mixed feelings on how they do things, sometimes I think they need to take a firmer stance. I feel as a pharmacist, forgetting the management role, I often feel and have felt in the past, when I was just a staff pharmacist, that they were more to represent the owners.” (P7, paragraphs 53 & 55)

Some pharmacists recognized the role of professional associations in disseminating and engaging pharmacists in transitioning into a new role. Nevertheless, professional associations could have taken a stronger position in some situations that were of great importance to the recognition of the pharmacy profession in the provision of health care. Also, these associations could further assume a stronger position in negotiating the compensation of pharmacists with the stakeholders who ultimately pay for health services offered at pharmacies. (Please refer to Appendix 5.f for further quotes on this topic.)

“I think that they [OCP members] have been good at trying to motivate for change and helping to release some of the anxiety that perhaps pharmacist[s] may have about making change. On the other hand, I think that some of the professional organizations do themselves a disservice, like the whole kafuffle a few years back about generic drugs, and shelf space, and rebates, and that kind of stuff. I think it was damaging to the profession, and so it makes more difficult in terms of credibility for what the profession is there for.” (P5, paragraph 74)

“I think, you know, their role [provincial and national organizations] is to not only help us take steps, like as a pharmacist and a manager, not only help us take steps down the
expanded scope path and down the path of bigger and better things for the profession, but they also need to firmly guard how it is remunerated by either the patient, the insurance industry, or the government, and then ... they need to adopt a model. If the new expanded scope that you are expecting us to take on or wanting us to take on is not a self-sufficient model, if the compensation coming back does not cover the cost of doing the service, it should be a non-starter, we should not be agreeing to it.” (P7, paragraph 61)

Managers and owners of pharmacies are important stakeholders in the process of engaging pharmacists in adopting the new scope of practice. Several pharmacists interviewed for this study reported that managers and owners of pharmacies cannot sense the benefit that their businesses will accrue from the shift in pharmacy practice, from mainly dispensing medications to providing health care services, as a revenue-generating activity. It seems that managers and owners do not have a well-informed or clear view of the impact of pharmaceutical opinion of the pharmacy as both a place of health care and a business. Professional associations could promote opportunities for communication between pharmacists and stakeholders in order to develop an understanding of the advantages and challenges of implementing health care services in the pharmacy. At the same time, increasing cooperation between pharmacists and pharmacy stakeholders can contribute to the development of an environment that fosters the adoption of the expanded scope of practice.

“I think that managers, owners, [and] administrators of pharmacies or hospitals need to also support their pharmacists in ensuring that they are ready for the change, right? If I was an owner that was very complacent and didn’t want the change and just focused on dispensing, then none of my pharmacists would be motivated to give flu shots, or none of my pharmacists would want to go for additional training.” (P6, paragraph 68)
Kotter’s Principle #8: Institutionalizing New Approaches (Policies)

Pharmacists reported that the new regulations have had a financial impact on them, as well as significantly increasing their workload in the pharmacy. The government has made cuts to pharmacies’ revenues by eliminating the rebates and allowances that were paid by pharmaceutical companies to pharmacies and, at the same time, by capping the prices of generic products. These two actions have had a significant impact on the revenue of pharmacies.

“I mean, the main change is how the Ontario government has decided to look at different reimbursement scheme in terms of generic compensations. So in the past, I guess, there were rebates given to pharmacies based on the generics that they choose to dispense, and the government has looked at that and has basically got rid of all those rebates, but they have all mandated pricing, which is huge. Now the pricing of a generic is 75% of the brand name. So obviously then, your sales dollars go down, and potentially your margins go down, so, it’s a huge impact in the profession from this financial standpoint.” (P3, paragraph 28)

Policies that increased pharmacists’ scope of practice were potentially developed without undertaking any viability studies to assess whether pharmacies had the required resources available to implement these changes immediately. Pharmacies need to generate profit to sustain any commercial practice. This study assumes that several types of pharmacies exist and that their business profiles are different in terms of sales, volume sold, business costs, and requirements for their businesses to function well. Therefore, the challenge for pharmacy owners, managers, and other stakeholders becomes finding a business model suitable for such a radical change of activities within their business. Preliminary studies regarding the implementation of changes to practice would have contributed to the adoption of these changes in pharmacies and to pharmacists’ adaptation to new ways of practice.
“Well, I think the changes were drastic for what they have done. They tried to phase it in, but the reality is that I don’t think they did any sustainability models to how pharmacies are going to be viable. I mean, the whole thought process was that a lot of the small stores, independents, would close. Right? And all this would be left with these big corporations and so forth.” (P3, paragraph 30)

Issues related to the financial sustainability of the business of pharmacy can have a trickle-down impact on many areas of the pharmacy profession. For instance, earning less revenue will have a significant impact on the business viability of pharmacies, which could, in turn, potentially close. Pharmacies might have to pay lower wages to pharmacists in order to sustain their businesses. Being able to afford fewer pharmacist employees will generate fewer opportunities for pharmacy students to find employment and to get on-the-job training to develop their practice.

“Not all the changes have been really implemented yet, and we are just getting to the tail end of it now. So really, the crunch will be in the next couple of years to see if that is really going to happen, because, you know, like I said, that more pharmacies are going to close than open at this point in time. So that is going to certainly impact a lot of things obviously. Even the supply and demand issue, such as all these students at UofT [University of Toronto] or any other pharmacy school, for instance, in Waterloo. They are having problems finding positions.”(P3, paragraph 34)

“So, that is the challenge I see that we are in right now. The government wants to either not pay us at all, or pay us significantly less than they pay a physician. What comes out to time is, well, how much less, you know, what our time [is] worth to someone else is. And, at the end of the day, you know, I’m not saying we shouldn’t be paid maybe less or paid ... but if, you
Lack of representation or misrepresentation by professional associations was pointed out by pharmacists as having a negative influence on policy development within the government. One pharmacist claimed that these associations are not representing the interests of community pharmacists as much as they represent the business interests of big pharmacy corporations. He claimed that the support for pharmaceutical opinion surged from within the government, after which pharmacy associations, such as the OPA, chose to step aside from the presiding council. This pharmacist also mentioned that the OCP is more of a professional regulatory body in terms of licensing and registration, but it mistakenly has been viewed as a leader in influencing policy, which should not be its role at all. Another pharmacist mentioned that professional associations are not clear when advising pharmacists about how to perform their scope of practice in light of vague professional legislation.

“I think from a policy standpoint, OPA and what they should be doing, they are lacking hugely. Like, a lot of the changes that came weren’t because of them [OPA], they kind [of] were more worried about business owners, and they were more worried about shoppers sitting on their committees and things like that. They were more worried about reimbursements than they worried about pushing the profession, and every time something comes up, they kind of take the benefit of it. For example, when the big changes happen with the pharmaceutical opinion and the MedsCheck and all that stuff, either came intrinsically from within the government or it came from that creation of the pharmacy council which OPA decided not to sit on. And so there’s all this history of how they are doing it. OCP does what they are supposed to do. They regulate us, they watch out for the safety, actually if anything, they’ve been
serving more as a leadership source, which is kind of sad because they are not supposed to have a policy push. So I have been very disappointed [about] who is supposed to be at leadership in OPA. I think OCP has kind of served as the main source of what we look at for quality and what should be done, although their charge is not to improve the profession. Their charge is to whatever is the best interest of the patient. Fortunately, the advancement of the profession is in the best interest of the patient, so OCP is kind of taking that charge. So that’s been good.” (P4, paragraphs 38 & 40)

“I have called the pharmacy practice [at the Ontario College of Pharmacists (OCP)] several times, and they never give me a straight answer. The laws are not white and black. They are vague. They are putting the burden on the pharmacists to figure out what to do in a difficult situation. That is not fair. They [OCP] want you to do everything online, on the Internet, but you also need people to come and explain, you know, have a meeting, have pharmacists attend and ask questions about the regulations, or this or that. Even when we call the Ontario College of Pharmacists, ‘well, you can read it on our website,’ that’s what they say. They are just brushing off helping you, they just want you to go and read. But, you know, it’s a big website. You have to look for stuff. It’s hard.” (P10, part 2, paragraphs 30 & 32)

Another pharmacist interviewed for this study believed that the people in positions to represent pharmacists within those professional associations do not necessarily come from a neutral academic background, with profound knowledge about the professional context of pharmacists in Ontario. This pharmacist suggested that, more often than not, these people have professional ties to large retail pharmacy chains, and they seem to be seeking to safeguard the interests of those corporations.
“Well, the Ontario College of Pharmacists and the people who are in it are making decisions, and some of those people are just not like, like you have a Master’s or are getting a Master’s, but they are people like, from different pharmacies. One is a representative of Shoppers, one is from PharmaPlus, etc., and they are making decisions that is best for them and for their company. I don’t think they are thinking about everyone, especially independents.” (P10, part 2, paragraph 34)

Nevertheless, public and private initiatives to implement policies that safeguard pharmaceutical opinion and health care services in pharmacies have benefited pharmacists in terms of implementing remuneration schemes and developing recognition for pharmacists as health care professionals. These initiatives are initial steps to making significant changes to the profession; however, further planning and preparation would be beneficial in order to effectively change the pharmacy practice over the long term.

“I think it definitely has improved our profession and, you know, pharmacist’s opinion is the same thing. The government has stepped up and said, ‘if you make an intervention of any sort or you make a recommendation, and the patient happens to be an Ontario drug benefit recipient, we will pay you for that service.’ That is something that we need to do more of, and we need to expand those types of things. However, the other private insurers, because it is just an added cost, they have not gone down that road. Although we still have to make those interventions, and you know that is the area that we need to be paid for services.” (P7, paragraph 31)
Kotter’s Principles #4 and #7: Communicating the Vision; Consolidating Improvements and Producing More Change (Professional Development)

Pharmacists perceived the need to upgrade their own skills and qualifications in a timely manner to expand their practice. However, they identified concerns which might have an impact on their ability to perform clinically, such as having opportunities to upgrade their skills and planning for the resources required to perform a patient-centered role.

“We need to do it [change and adapt to new scope of practice] right away, but we need to feel confident and competent in being able to perform these … So perhaps more courses, more opportunities for people to get that comfort level, because pharmacy has been sort of, just, I don’t want to say in a rut, but a bit, I mean, which [has] been good. I mean, we have been going down the path and doing what we have been permitted to do legally. So that’s been great, but now all of a sudden, all changes are coming about. So that’s, I think, really a positive move forward, but who is going to be doing all of this? So, for sure we want to train the students here at the faculty to be prepared before it’s even accepted, but to be prepared once it does become legislated, that they will be able to perform this. You can’t just do it without having any kind of certification. So that’s what the challenge will be.” (P2, part 2, paragraph 27)

The education currently available to pharmacists is abundant and easily accessible for those in urban areas. Moreover, many resources can be accessed online, allowing pharmacists to easily upgrade their skills.

“I think, you know what? The education piece is there, because, you know, from obviously our studies in general and then the fact
that we have lifelong learnings [sic] as a mandate, I think there is lots available out there, whether it’s, you know, webinars or live CEs [Continuing Education] or, you know, reading journals. We have access to a lot of information, and even the computer resources that we have now, they are so much better than, you know, when I graduated for example 20 years ago, 20 plus years ago.” (P8, paragraph 66)

“But even, you know, we have some great resources through the Canadian Pharmacists Association, they have listservs, so I’m always very motivated by reading the cases that are presented, and the advice that comes, and I think that is an excellent form for pharmacists and other health professionals too, to sort of support each other, right?” (P8, paragraph 72)

However, the educational aspect of pharmacy practice has some unclear scenarios. It is clear that pharmacists need to upgrade their skills and competency to perform clinical services. Nevertheless, as one pharmacist stated, it becomes less clear as to how these skills and qualifications will be taught, learned, and assessed as part of the busy working life of practicing pharmacists. Some of the questions posed by pharmacists who were interviewed for this study were:

1. How are these qualifications going to be ranked and recognized by the governing bodies?
2. How are pharmacists’ qualifications going to trickle down to the patient?
3. Are all pharmacists performing clinical services or just the ones that are certified for certain skills? How is this model going to work in the perspective of public health?
4. Is this a viable practice model given that different pharmacies perform different services, determined by the needs of patients that are customers of the pharmacy?
5. Is this practice model convoluted from the patients’ point of view, in terms of understanding and being aware of what pharmacists can do for them?
One pharmacist suggested the importance of training pharmacists to embrace a patient-centered scope of practice. However, while practice change of this nature has been an ongoing debate within the profession, few initiatives have been fully successful (Rosenthal et al., 2010, p. 37). Therefore, training and education should not be the only factors required to transition pharmacists’ practice into patient-centered care. Another pharmacist went so far as to suggest that a better selection process for students applying to pharmacy schools should be implemented to ensure that, in the future, the majority of pharmacists would engage in professional development.

“I think it has to start with their [pharmacists’] education, like a formal training. I think [it] is highly dependent on professors, and their mentality, and how they mould the students while they are in school. I think the university is doing a good job, essentially preparing students and getting them accustomed to their practice. When you graduate, you are expected to do much more than sign prescriptions. You are expected to do flu shots, you are expected to do medication reviews, collaborate with physicians, etc. Then, it should be second nature for them [the students] when they come out [graduate from university], right? Actually, if anything, that should be the primary method of practice. Dispensing should be kind of secondary, right?” (P6, paragraph 66)

“We have to be probably a little more selective in who we accept in pharmacy programs, to make sure that these are people that are, you know, the type of personalities and that they have the background that shows that, you know, they want to move the profession forward, right? Looking at how we admit people into pharmacy schools and the interview process ... I think it is a combination of that.” (P6, paragraph 70)
One pharmacist summarized the educational challenge of transitioning pharmacists into a new scope of practice. Pharmacists need to develop confidence and competence, and they need to recreate the pharmacy practice model to embrace new ways of practice. Pharmacists now have a greater workload, and so they need to use their time wisely to work and adapt to greater responsibilities. Perhaps more flexibility in pharmacists’ schedules would help pharmacists to develop skills and competence. Mentorship could be an efficient way for pharmacists to learn in practice and to build confidence in delivering patient-centered care.

“I think that some of the pharmacists that graduated a few years ago don’t feel fully confident in their skills. Greater opportunities to enhance those skills would be creating a flexible timing with those pharmacists working 24 hours a day. I think [that] will help to make it easier for those pharmacists to adapt to the changes. It’s about confidence, competence, creating, and figuring how you can restructure your current pharmacy practice so that you can culminate the change.” (P5, paragraph 64)

“I’ve done my injection training, and I’ve done my certified diabetes training. One of my pharmacists saw what I do, and she enjoys it, so she is doing training now for diabetes. My other pharmacist is going for injection training. So they follow the lead, right?” (P6, paragraph 68)

Factors related to pharmacists’ education were cited as influential in pharmacists’ adoption of the new scope of practice in Ontario. These factors included training and the intrinsic motivation of pharmacists and their team leaders. Development of professional policies and funding of opportunities for pharmacists to upgrade their skills were also cited as important factors influencing the adoption of the new scope of pharmacy practice.

“Yes, so, I think that, then, for people that are actually already working as pharmacists, I think, you know, is [sic] highly
dependent on, one is their intrinsic motivation to do this type of thing, and then two is like the motivation of their manager, or their boss, or their team leaders, or how much they are pushing them.”

(P6, paragraph 70)

“Yes, there needs to be an improvement on training on the grassroots, but the problem is that all these pharmacists have been doing this [improvement and training] for years, so I think for them there either needs to be policy rules that say ‘you have to do this,’ with consequences, or there needs to be money that follows. Is [sic] the only two ways that you cause any great shift.”

(P4, paragraph 48)

The problems currently faced by pharmacies have created a strain on new pharmacy graduates who are entering the market seeking work. At the time of this study, fewer employment opportunities in the market may have resulted in an oversupply (or glut) of professionals. Pharmacy graduates have been relocating elsewhere in pursuit of job opportunities, are having fewer opportunities to negotiate salaries with employers, and are encountering professional salaries that are often set below their expectations (Gregory & Austin, 2014). During a period of low demand for pharmacists (i.e., an “employers’ market”), individual pharmacists’ abilities to negotiate workplace conditions (e.g., time for clinical services, additional technical support to facilitate direct patient care, etc.) are reduced significantly. As Gregory and Austin (2014) have argued, this situation means that many new graduates are simply accepting any pharmacy job available, regardless of the quality of working conditions. One study participant questioned the rationale for continuing to graduate so many pharmacists each year in Ontario, as well as for accepting so many international pharmacy graduates, during a time of oversupply in the profession. This participant suggested that pharmacy schools diminish the acceptance rates of students into pharmacy programs. Another participant questioned the content of the education delivered to students as they become pharmacists. This pharmacist suggested that the Pharmacy Examining Board of Canada (PEBC) examination should not be the only standard to check
pharmacists’ competence to practice in Ontario. Pharmacists’ knowledge is one important aspect of assessing new pharmacists, but perhaps further investigation would contribute to assessing how pharmacists learn and perform with respect to the profession’s mandate. Sharing a professional culture with its own values and beliefs can bring pharmacists together to take charge of their roles and responsibilities.

“Well, certainly I think that at some point in time we should kind of relook at the number of students we graduate. That’s first and foremost, because the reality is that they are not ... it’s very difficult to find positions right now, and we are graduating 240 from UofT, 120 from Waterloo, whereas, even when I graduated, I guess that was a while ago, like 12 years back, it was just a class of 120 for all of Ontario. Before, in the last five years, pharmacy has grown a lot in terms of the number of pharmacies opening up, but that certainly [has] declined now ... those numbers have declined significantly, and thereby, you know, creating a different supply and demand, I guess, with respect to the pharmacy students, and even, you know, people look into getting admitted I guess, they’ve had less people applied [sic] in the profession as well.”

(P3, paragraph 37)

“There also again [are] another lot of things [that] have to be understood. It’s the flux of the quality of education and pharmacists coming in, especially looking at standards based on, like, you know, pharmaceutical, you know, the PEBCs, and like the examining boards, but also looking at the standards not just meeting the requirement of knowledge, but the understanding of, like, that education is not just giving people knowledge but is also developing the way that they think, and perhaps not everyone that
Kotter’s Principle #5: Empowering Others to Act on the Vision (Paradigm Shift)

The perception of the community pharmacists who were interviewed for this study regarding their professional role continues to be that of a health care provider focused on patient care. The pharmacists interviewed for this study expressed enthusiasm regarding the perspective of having a new scope of practice.

“I think it’s also very exciting that pharmacists are taking on a more active role in patient care, beyond just being the purveyors of medication and educating the patients on medication, but actually, we will be able to now, with the immunization, be acknowledged for the pharmaceutical opinion. We used to always do that for free as well.” (P2, part 2, paragraph 15)

According to another pharmacist, it is constructive to think that pharmacists are optimistic regarding the paradigm shift that the profession is undergoing in terms of changes in practice. Resistance can be expected, especially due to the fact that these changes will require more work and time from pharmacists to adapt to practice. During the interviews for this study, different ideas were presented about how the pharmacist can contribute to health care as a patient-centered professional, such as educating patients, following up on patients’ treatments by having access to laboratory test results, and intervening in drug therapies for patients by collaborating with their physicians.

“Well, because they [pharmacy professionals] are just starting, I like to think that they are agreeable and optimistic [with changes in practice], that they are ... it’s something that certainly the society and patients will benefit from, but it certainly will mean more work for them. It will mean recertification, it may mean more
expense to have a technician, it will mean them changing their mindset as well, letting go.” (P2, part 2, paragraph 67)

“I do also kind of see the pharmacy being more involved, you know, following up on common diseases, hopefully being able to order lab tests, you know, cholesterol tests or blood glucose test[s] and things like that, being able to interpret the result, and hopefully make changes to therapy, you know, work in conjunction with their primary care physician.” (P6, paragraph 20)

Considering several causes of resistance to implementing changes in pharmacy practice, the central question of this study is: What barriers exist to translating the vision of community pharmacists as patient-centered health care providers into practice? Perhaps patients’ recognition of pharmacists’ competence in delivering health care is at the forefront of pharmacists’ success in the role of health care providers. Pharmacists themselves cited the need to be recognized by the public and other stakeholders as health care professionals. In this new context, pharmacists voiced their competence to provide patients with differentiated health care services and to improve access to health care for Ontarians. Some pharmacists mentioned the different standard of pharmacy practice in other locations, which has improved patients’ access to public health.

“I’m excited. I think I’m really excited for vaccinations actually. So I really hope that it goes through, and I have my hopes up. My research was on vaccinations for my masters, and I saw a really big impact in the U.S. I think that it will be a big deal for public health. It’s just, you know, easily accessible, better times, and it will start to change the perception of people ... it seems like something so silly, like to give an injection, but it will really change how people view pharmacy and how they view the pharmacy and as a place of a single holder, I don’t know ... yes, so that will be really nice I think, instead of just being the bad guys who decide when not to give drugs on our whim, which is how
some people view us. I think it will start changing into a place of health care. Not that it already isn’t, but it will just improve that mentality I think.” (P4, paragraph 18)

“I’ve seen the profession move from where you just fill the prescription that the doctor has written without question to pharmacists prescribing, pharmacists evaluating drug therapy, doing regular rotation reviews, get [ting] engaged in providing services such as injections and the like, and I think this is very positive, I came from the U.S. where this [pharmacy practice] is far advanced in this respect.” (P5, paragraph 12)

Resistance to Change

There are other challenges in translating the vision of community pharmacists as patient-centered health care providers into practice. The strategy for changing pharmacists’ professional practice needs to resonate with the professional culture of pharmacy (Rosenthal et al., 2010, p. 37). Therefore professional culture should be taken into consideration when identifying and addressing pharmacists’ resistance to adopting new ways of practice (Rosenthal et al., 2010, p. 37). Challenges to practice change have been identified through research, such as lack of time, inadequate compensation, patients’ lack of interest, and low incentives from physicians and other pharmacists (Rosenthal et al., 2010, p. 37). According to Kotter and Schlesinger (2008), undergoing change processes in organizations has an emotional impact on the people within the organization because of the sense of losing control of outcomes, regardless of whether the change results in a better outcome. Therefore, people usually avoid changes for four main reasons: 1) a desire to keep something that they feel is valuable, 2) an incomprehension of the change and its consequences, 3) an assumption that there is no reason for the change, and 4) a low acceptance of changes (Kotter & Schlesinger, 2008). Therefore, resistance may be expected towards a complete and permanent transformation of pharmacy operations, from being an establishment focused on selling drug products to becoming a health care oriented business practice.
Pharmacists will need to dedicate time and effort towards adopting changes to their practice. New pharmacy graduates have the advantage of starting their careers with a different professional mandate and of having acquired a complete skill set to perform under the new scope of practice. Perhaps it will be easier for them to emerge into new ways of practice, creating momentum for a paradigm shift within the pharmacy profession towards a more patient-centered, health care oriented practice. Pharmacists interviewed for this study reported that the vision of pharmacists as a health care, patient-oriented professional persists in the profession. (Please refer to Appendix 5.g for more quotes on this topic.)

“New students are early adopters ... a proof of the fact that some pharmacists are very excited about the changes in the scope of practice, [...] some of them are very excited and some them, who come from practice, instead, are very restrictive or are more anxious. What if to increase scope comes an increase in responsibility, so those people who are not ready to take on that increased responsibility? They are hedged towards adapting to and adopting change.” (P5, paragraphs 82 & 84)

Organizational cultures are in a constant process of change, but transformational changes in culture can be triggered and accelerated by contextual factors (Hodges & Gill, 2014). The professional culture of dispensing medication opposes the initiatives of new pharmacy graduates to use their newly learned skills in patient-centered practice. One interviewee expressed his opinion that change in pharmacy culture should start with the new generation of pharmacists. This interviewee questioned whether the incentives to move the profession forward are adequate and positioned in the best manner within the profession to foster change in professional culture. Based on the findings from this research, the researcher questions whether external incentives are what pharmacists need to become health care professionals in practice.

“I think to change culture, you start with whoever is coming in now. The problem is that they can graduate here and they go on to the real world and see what is happening, and they get recultured
based on their incentives and their bosses and things. So I think [it] is going to, again like I said before, [it] is going to take time, but the incentives have to be in the right place, and the rules have to be there from the people high up I guess.” (P4, paragraph 50)

Resistance to change can be attributed to questions and doubts regarding the results of these changes (Kotter & Schlesinger, 2008, p. 132). People involved in the change process might question the impact of changes on their future circumstances and wonder whether the future will be better than their present context. Resistance can be diminished by teaching those involved in the change process about the benefits that changes can bring to their lives. Educating and informing people about the change can help them understand the rationale for implementing the changes and how these changes can impact them (Kotter & Schlesinger, 2008, p. 134). Engaging people with the change process and providing training, tools, emotional support, and other incentives can motivate people to embark on a change process (Kotter & Schlesinger, 2008, p. 136). Then, people may become willing to cooperate with the change process.

“I’m the CE coordinator for this area, so I’m trying and agree to continue education events to encourage people to just see one patient, book one smoking cessation consult, just start small, because I know it’s hard for people to change when they have been subjected to a certain routine for so long, right? There is a bit of a fear aspect, there is the money aspect, there is the ‘not feeling supported’ aspect, there is the feeling bullied aspect, because, you know, a lot of people are dictated what they are supposed to do by media head office or something beyond their own means. So I think there are like a number of factors that become maybe barriers, but I think, really, if we look at the big picture, it’s the patient’s benefit for us to have more rights and an expanded scope. It’s definitely more convenient for the patient.” (P8, paragraph 46)
In community pharmacy settings, pharmacists are overwhelmed with business obligations, which occupy much of their time and contribute to resistance towards adopting new ways of practice. These business-related obligations conflict with pharmacists’ role as health care providers, possibly reducing pharmacists’ willingness to implement changes towards a patient-oriented practice in pharmacy. Pharmacists are currently working towards the sale of drug products by dispensing medication to patients. Dispensing activities generate revenue for pharmacies, requiring that pharmacists prioritize business interests at the cost of dedicating time to the patient, and sacrifice opportunities to evaluate and review the treatment of patients. Dispensing drug products has been the “bread and butter” of pharmacies, but, perhaps, pharmacists should no longer be focusing their skills solely on this process.

“Well, a paradigm shift would be necessary, because I think the majority of pharmacists, if they work in a busy dispensary, they find they are already strapped for time as it is, just for doing that basic work. So if nothing changes, if you keep doing things in the same way, you will always get the same result, right? So I think, basically some support in changing their current workflow, for example, might be helpful.” (P8, paragraph 64)

Without a clear vision of the future after implementation of changes, resistance to change increases. People resist change when they do not perceive its consequences and realize that they might gain less than what they will need to dedicate to the change process (Kotter & Schlesinger, 2008, p. 133). One pharmacist pointed to his position in community pharmacy as an employee of the business of pharmacy. This pharmacist spoke of the level of uncertainty that this paradigm shift brought to the profession: changing from a role focused on dispensing medication to a patient-centered, health care role. Nevertheless, he was hopeful that business owners and other stakeholders would grasp the importance of this new scenario in community pharmacy and how much pharmacists could do for patients. He believed that pharmacies could still be profitable with a new business model that incorporated pharmaceutical assistance. Lastly, he mentioned that he had always welcomed the idea of a patient-centered pharmacy practice.
“I’m excited for the changes [in the scope of practice].
Unfortunately ... as a person comes in and works for the owners or the business owners or whatever ... if it’s a big corporation or whoever, there is a ... I don’t want to use the word anxiety, but there is a hope that they see the light, that these owners understand how important it is, because I feel like I have bought into it, a long time ago. Maybe that is because I’m a new grad, because I’m more clinically based, or maybe because I’m an academic. I don’t know what it is in myself, but I want to see them do this stuff, and I always feel like I just want to explain to them like how this can make a difference for their patients. Although the business model might not make sense to them, it will actually make sense over the long term. For example, doing a MedsCheck. Yes, it costs a little bit of time, and you can only do it once a year, but if that patient feels that you are taking care of their health, they are more likely to return.” (P4, paragraph 26)

Nevertheless, another pharmacist spoke of a noncohesive perception of pharmacists and stakeholders in the transition of pharmacies into health care service provisions. This pharmacist felt that the business-oriented stakeholders of pharmacies were losing the broader view of having pharmacists perform the greater good for the society, while pharmacies could still be profitable through these activities. From the viewpoint of pharmacists, they are being required to do more work and training without seeing any immediate gain in time or pay for performing their jobs. This difference between stakeholders’ and pharmacists’ perceptions of the role of the pharmacist, and the lack of alignment between pharmacists’ and stakeholders’ initiatives to implement health care services in community pharmacies, may have caused difficulties in implementing long-term changes in pharmacy practice.

“I think there is a huge divide. I think some people who are more business-oriented, because it came around the same time that they
made huge cuts, are seeing it [the new scope of practice] as just another way to make them happy. Other people see the bigger picture, which is the direction for the profession to go that will better serve the health of Ontarians. ... More pharmacists now are seeing all those salaries cut, and all these new reimbursements are going to pharmacies and not the pharmacist. ... Pharmacists are literally seeing their workload expectations increase, and yet have seen a drop, a drastic drop, in salaries.” (P4, paragraph 30)

Another source of pharmacists’ resistance to adopting the new scope of practice is the lack of patient recognition of pharmacists’ role as health care providers. One pharmacist suggested leadership development within community pharmacy as a means to promote and teach patients about pharmacists’ knowledge and skills as health care providers. Leadership is important in guiding change initiatives, encouraging the people involved in the change process and aligning efforts to implement changes over the long term (Kotter, 1995). Pharmacists are important members of health care teams, providing differentiated health care services that compliment other services available to patients in the context of public health. Pharmacists are available to patients in a unique manner that differs from the role of other health care professionals.

“So a pharmacist has, I think, a very prominent role in society, in health care, they are [a] very viable part of the health care team. We are the medication experts, and we should be promoting ourselves in such a way that other health care providers should be able to connect with us, and consult with us, and for any reason to do with medication and beyond, and because also, you know, medical conditions and so on, and I think we should also be leaders in the health care professions, and having leadership in the community as well, and to move the profession forward and have an active role in, you know, as advocates for patients and health care in general.” (P2, part 2, paragraph 1)
Health Care Integration

Pharmacists in this study indicated that they have been pressured to exercise their scope of practice to guarantee their position in the health care field. Other health care professionals, such as nurses, physicians, and physicians’ assistants are also increasing their scope of practice. These professionals compete against pharmacists for providing several health services under their legal and regulated competency.

“So if we compare ourselves to other professions like registered nurses, their scope has increased dramatically over the past 10 years, right? You have nurse practitioners that are now able to prescribe. There is also another profession that is really grounded—physicians’ assistants. The physicians’ assistants are getting very popular, so they are able to prescribe. So, I mean, if we don’t make these changes now, and if we delay it, then, you know, the government might not see the value in giving pharmacists an expanded scope, and someone else already put their foot forward.” (P6, paragraph 56)

One pharmacist suggested the importance of integrating community pharmacy into the public health system to the extent that pharmacists become a mandatory part of health care teams, not only an optional service for patients. This pharmacist pointed out the importance of finances and education for this integration to happen successfully. According to this pharmacist, pharmacy professionals should not be expected to assist patients altruistically, but rather they should be compensated for their effort and time.

“Again, so there is the money side, and then there is the training side. So I think there has to be proper training and understanding of what you can go in, and then it has to be decided ... it’s backed up with enough money. It can’t just be like [out of] the goodness of their hearts that people are doing this, you know what I mean? So,
I think there has to be a larger push of, like, quality versus quantity. There has to be a push towards, you know, pharmacists being integrated into care and being part of teams, and that is mandated, not just something that you can do if you want, and I think that is kind of the important side of it.” (P4, paragraph 34)

Health care integration between pharmacists and physicians is important when drug products are being administered to patients in the pharmacy. For instance, some pharmacists may possibly not have adopted the immunization practice due to the fact that their pharmacies are not located close to medical clinics with doctors, nurses, and medical equipment, important in the event that a patient suffered any serious side effects and, as a result, needed medical assistance when receiving a vaccine.

“I think the largest changes are doing the injections, because you usually need to have ... You usually have a medical clinic beside them. If there is a reaction, or something happens with the injection, they can go to the medical clinic right away. I don’t think the smaller pharmacies are doing that, because you don’t want to have a problem, and there is no doctor in the area or a walk-in clinic beside you, if you need to help them right away. I think the larger pharmacies are doing more of that because they have the necessary aid.” (P10, part 2, paragraph 4)

Nevertheless, the current expectation is that pharmacists deliver health care services at the pharmacy. This expectation requires pharmacists to review and evaluate the medications that patients are taking to determine the appropriateness of the treatment. Currently, however, pharmacists do not have access to patients’ complete health histories, making it challenging for them to perform high quality medication reviews for patients. One important condition to successfully integrating pharmacists into the health care team is to grant pharmacists access to patients’ health histories.
“The MedsCheck is a very good system, and I wish, in the future, we will be able to know, because as it is right now, if the patient doesn’t have all his prescriptions or her prescriptions in our store, then we are in no position to know whether they are eligible for a MedsCheck or not, or maybe there is a conflict of the medication while they are using, while we are filling these prescriptions.” (P9, paragraph 20)

“For example, the patient has been on a medication for quite some time, and then, for one reason or another, the medication is finished, and the patient goes into a walk-in clinic. At that point, the doctor is in no position to know what is going on. He or she [may] prescribe half the strength or double the strength, so ... it comes to me, I should be in a position to adjust, but then there is no documentation for the practitioner to adjust it. So, when I call or I fax, there is no documentation, this patient did not fill the prescription in our store. It’s just a word of mouth we cannot rely on.” (P9, paragraph 56)

Aligning Change Initiatives

The pharmacists who participated in this study had different ideas regarding how to implement the new scope of practice. They also had different opinions concerning what licensing requirements would be necessary for pharmacists to expand their scope of practice. One of the pharmacists interviewed for this study proposed a customized model of service in the pharmacy, wherein each pharmacy would specialize in certain areas of care according to their patient population and their health care needs.

“If you have a lot of diabetic patients and you are selling a lot of meters, then maybe I should read a bit more, I should prepare myself more to train on those meters. If I have a lot of patients who
have acne, for example, I should read a lot more on different types of products. I don’t think you should need to take a special course to learn about diabetes education. I mean, as a pharmacist, you should have a good idea about it.”(P10, part 2, paragraphs 16 & 18)

Pharmacists are qualified to perform a greater array of services, which makes them more versatile business professionals, as well as able to contribute with new ideas to the business, such as how to perform services for the patient, which might be a way of differentiating patient service in the market and improving patient care. Thus, there is an advantage to having pharmacists, rather than technicians and assistants, on the job. Motivation is necessary in undertaking the extra workload required to become the first to market services at the pharmacy.

“We are able to do more functions than just the regular pharmacy assistant would, or a pharmacy technician, in terms of patient counselling and doing special projects.”(P3, paragraph 4)

One pharmacist pointed out several aspects of the pharmacy profession that have improved, such as attending to the patient, working together with other health professionals, and changing the pharmacy curriculum to focus on patient-oriented practice. These changes have not been widely implemented in pharmacy practice, but they are an important step towards successful implementation of new ways of practice.

“Yes, for sure, I think the practice has improved and evolved, just because of, I think, inherently through the curriculum it’s really gone from a dispensing kind of oriented, being accurate and so forth, based, to more of a patient counseling and doing more projects based and, you know, having like more clinic-based practices. I’m not saying it happens every day in community pharmacy. It doesn’t, but certainly is a lot more now than it ever was, that’s more patient-focused, in terms of also looking at the
patient from a holistic perspective, in terms being integrated with other health care professionals, and certainly a lot of the family health teams, they have the nurse, the doctor, the pharmacist, they are all in a clinic, and physio, and they are working together and so forth.” (P3, paragraph 49)

Some of the pharmacists who participated in this study were adapting successfully to the new scope of practice by offering a few health services at the pharmacy. Some pharmacy owners were incentivizing their pharmacists to perform well in providing health care services at the pharmacy. In addition, pharmacists were being innovative about creating new health solutions for patients. Many times, they still did it without any payment for the service they provided, but they did it aiming to create business loyalty by having the patient return to their pharmacy. There was space for new and supportive health-oriented services that could significantly improve treatments and support currently available health care for patients. However, pharmacists mentioned that resistance in terms of adapting to a new professional culture undermined the provision of health services in community pharmacies. These services were not available in every pharmacy. Workload and time availability were still barriers for community pharmacists in advancing practice.

“Some pharmacies have adopted them extensively and have, you know, kind of jumped in with both feet and have been able to work them into their practice and integrate them very well into practice. Other pharmacies, from my understanding, have done very little and aren’t interested in doing any of these expanded scopes, whether [it] be MedsCheck, or pharmaceutical opinions, or anything. Our pharmacy, we are somewhere probably there in the middle. We definitely promote it, and encourage our staff to do it, and I think that the biggest challenge there is the time factor.”(P7, paragraph 33)
“Like I said, we are not running any of those clinics, but we could if there were pharmacists [to] overlap, so I’m feeling confident and competent to manage the change, but understaffed to be able to actually fully implement the changes” (P5, paragraph 48)

The profession may benefit from acting in several spheres to gain momentum for changes to happen in community pharmacy, such as developing clear rules and policies, approving and implementing policies successfully, reducing bureaucracy in the change process, and educating the public regarding pharmacists’ competence and what pharmacists can do for patients. All of these actions can contribute to pharmacists accepting a new paradigm for their practice and cohesively adopting new ways of practice. Collectively, these actions can create the optimal environment for changes to happen within the profession. These actions cannot build momentum for change if they happen in separate phases at different points of time.

“I think there needs to be a balance between making sure that these changes are brought out well, but then also not taking so long that it gets caught up in bureaucracy, and to maintain the momentum it’s being developed. I think once you have people on their toes that they don’t understand what [a] pharmacist is doing and everyone is keeping up with change. That may be the good thing, that people are viewing the pharmacy [as] changing, and things are changing around them, but then also the profession is having to adapt and then [the] mentality of people out there is changing so that they have to adapt.” (P4, paragraph 64)

According to one pharmacist interviewed for this study, pharmacists in Ontario could look back far enough to remember the days when a pharmacy was primarily a health care establishment.

“I practised during the time where you are walked into a pharmacy and you feel like you were in a temple. We had this serenity, philanthropy, and respect. This is gone. This is gone with the
flyers, the paper rolls, and the toilet paper, and everything around.

It affected the entire image of pharmacy.” (P9, paragraph 60)

Kotter’s Principle #3: Creating a Vision (Sense of Professionalism)

The pharmacists interviewed for this study still demonstrated commitment to their role as health care providers. These pharmacists expressed that they feel drawn to the patient and committed to the health and safety of those they serve. In addition, some pharmacists mentioned that they enjoy speaking with patients and feel proud of their role in improving patients’ health outcomes. When speaking to community pharmacists, some of them expressed interest and altruism in their actions to provide pharmaceutical assistance at pharmacies. Some also have expressed regret in regards to not having adequate time to dedicate to patient care. This study did not find any pharmacist who opposed their role as a health care professional. (Please refer to Appendix 5.h for more quotes on this topic.)

“I enjoy being a resource to patient[s]. ... I really enjoy when we get to have the moment and the time to have those conversations about things that are important to them, when there actually is a clinical question instead of just dealing with insurance and the patient trying to get a discount on money and things like that. This is the bad side of the job. The nice part of the job is when you sit down with the patient and you actually feel like you made a difference.” (P4, paragraph 8)

“I love to help people, I love communicating with them, I like to interact with them, gather information from them, and it’s usually very relevant to what they’re experiencing, so really treating them as a whole person, not just a medical condition that may be treated with or without a medication.” (P2, part 2, paragraph 3)
“I think that the change has been positive, but again, I think I have seen where pharmacists can do far more, so that is why I keep saying that there is much further that we can go as a profession.”

(P5, paragraph 46)

One pharmacist interviewed for this study felt that selling products that are not related to patients’ health care takes time and effort away from patient-oriented care in the pharmacy. Furthermore, commercial activity that is unrelated to the health of patients could diminish the public’s perception of pharmacists’ professionalism. One pharmacist expressed that pharmacies in other locations did not sell items that were usually bought at common retail stores and markets. On the same note, in Europe, pharmacies were mainly health care oriented establishments. In addition, according to some interviewees, in many of the states in the U.S., pharmacists established their health care practice.

“The Ontario College of Pharmacists should prevent certain pharmacies from selling stuff that shouldn’t be sold in a pharmacy, like, I have seen bras sell in the pharmacy, I mean, this sort of thing. You should respect the profession by disallowing the sale of certain items that should not be sold in a pharmacy in the first place. ... It’s taking away from the time of the pharmacy, the pharmacy staff, and what they really should be doing.” (P10, part 2, paragraphs 34 & 36)

“I think that clinically they [U.S. pharmacists] are more involved. There are a lot of, like, the clinics, and a lot more of the outpatient settings and things like that .... Also the idea of having a pharmacist able to prescribe or [the] pharmacist able to refill or vaccinate, for example. Those things have been going on in some states for 20 to 30 years, and in other places, [it] is like Ontario where they are just starting to get it now. For example, New York State, just four years ago was allowed to vaccinate, they were the
last state to be able to do that. In some states, a pharmacist can prescribe, right? So you see these huge differences in practice setting.” (P4, paragraph 6)

The public’s perception of pharmacists’ role as a professional working in retail rather than caring for patients can diminish pharmacists’ engagement in health care at pharmacies in Ontario. According to one interviewee, pharmacists were still underutilized resources in the health care system. For instance, pharmacists have extensive knowledge in pharmacology and in the compounding of medications. Nevertheless, patients need a prescription from a physician for pharmacists to compound a drug product. In this sense, perhaps pharmacists have not yet established the public’s sense of competence and confidence in them as health care professionals. Therefore, responsibility is transferred to physicians to perform duties that pharmacists are qualified to perform.

“I think that we have the knowledge to be able to expand our scope of practice, and it’s not so much urgency, it’s just the fact the pharmacists are being underutilized. I would say that it’s important to fully utilize us according to what it is that we are able to do.” (P5, paragraph 42)

“Anything compounded by a pharmacist needs a prescription, yes. Especially if it’s made up. Even if you buy something off the shelf, two creams, ‘can you mix this up for me?’ I cannot do it. I have a liability. I have to have a prescription from the doctor saying. ‘mix vitamin E cream and vitamin E oil,’ for example. You need a prescription from the doctor to do that.” (P10, part 1, paragraphs 20 & 24)

The pharmacists interviewed for this study have voiced concern regarding their involvement in the sale of products rather than in interacting with patients. Their concern was based on their own sense of professionalism. Pharmacists expressed that they should engage in duties and
responsibilities of a health care professional. In the case of other health care professionals, such as nurses and doctors, they are fully dedicated to the care of patients. The business paradigm that pharmacists experience on the job differs from the health-oriented paradigm of other health care professions. (Please refer to Appendix 5.i for more quotes on this topic.)

“I am becoming more of an administrator than a pharmacist. I don’t have the same social interaction with the physician that I would like to have. In the retail setting anyway, in a hospital is probably different, but not in retail.” (P10, part 1, paragraph 10)

“I don’t want to be relegated to the role of a seller of drugs. I want to be a pharmacist, which is why I studied four years in university. We do compounding, so we are lucky that way …. We make different products that are not available, like suppositories, liquid versions of products that not any pharmacist or pharmacy can do. We have a lab in our pharmacy, so I like that aspect, that you are using your knowledge a little bit more than the average pharmacist.” (P10, part 1, paragraph 18)

The different agendas between pharmacists and other health care professionals can discourage pharmacists from adopting a patient-oriented health practice. Pharmacists may feel that they are not given the same opportunity to dedicate to patient care. Pharmacists also may feel that they are not being fairly compensated for the work they are performing. They may feel demoralized when facing several duties that are not associated with the patient’s interests in community pharmacy.

In addition, pharmacists working in community pharmacy have different professional skills and experiences that may lead them to having different aspirations and goals for their careers and futures. Pharmacists in Canada practise in a variety of work environments, from dispensing medication in community pharmacy to working in hospitals and other health care settings, performing primary, secondary, or tertiary health care practice (Austin & Ensom, 2008, p. 4). In
In this context, opportunities exist for pharmacists to align their work with professional goals (Austin & Ensom, 2008, p. 4). Some community pharmacists identify themselves with the sales and management of the pharmacy business, for which they have been working and responsible for many years. Other community pharmacists may feel more inclined to perform the health-oriented duties in the pharmacy. This dichotomy in scopes of practice of community pharmacists entails a range of responsibilities and duties within the community pharmacy setting. However, this professional scenario might contribute to the noncohesive movement of the pharmacy profession towards the new scope of practice.

“The beauty is that they [hospital pharmacists] practise what they learned, they practise and they implement that on a daily base [sic], without having to worry about a cash register ringing, or maybe a loss in profit or benefit, or whatever the case might be in the giant businesses. They are doing the professional work, despite all the other factors. ... We [community pharmacists] sometimes do that when we have the budget, when we have the manpower and when we have the upper hand to get more hands-on people to help, so we provide an excellent service. As time goes on, with the price war, with the cutbacks, that is what ends up happening.” (P9, paragraphs 84 & 86)

Summary

This research aimed to identify the presence or absence of the elements of a successful change management process in the implementation of changes to pharmacists’ scope of practice, according to Kotter’s (1995; Kotter & Cohen, 2002) model of eight principles. Kotter’s (1995; Kotter & Cohen, 2002) model was used to frame the collection and analysis of pharmacists’ opinions about how the change process is being carried out in their profession. The objective was to describe the impact of changes in the scope of practice on community pharmacists licensed to practise in Ontario, and how these changes in practice are being assimilated at the pharmacist level.
Results from this study suggest that recent changes in the scope of pharmacy practice have caused concerns among pharmacy professionals. Deliberations respecting concerns related to professional self-identity, societal purpose, and inter-professional relationships, which may be affected by the widespread adoption of new ways of pharmacy practice, continue. In addition, concerns related to professional recognition, financial incentives, and adequate time to dedicate to patient care are being discussed among pharmacists. Pharmacists have expressed concerns regarding lack of sufficient uptake of the new scope of practice to meet the requirements of legislation and their role in medication management put forward by professional initiatives such as Blueprint (Blueprint for Pharmacy, 2013). Perhaps most importantly, the pharmacists who participated in this study expressed their concerns and frustrations that, as an opportunity to advance the profession, to enhance the care of patients, and to truly make a difference in the health care system, these changes may not be as successful as they could be due to a variety of structural issues (e.g., remuneration, workload, in-fighting amongst organizations, etc.) within the profession itself. According to the first principle of change management, a crisis in the status quo of organizations can foster change. Urgency to change community practice has been cited and recognized by all pharmacists interviewed for this study. None of the pharmacists were opposed to the idea of changing pharmacy practice. Moreover, they were concerned about the impact of these changes on the future of the profession in terms of income and their relationships with stakeholders, as well as the future of their roles and responsibilities.

The second principle of change management in theory addresses leadership. Leaders are needed to ignite the change process and to keep the momentum of change going within organizations. The pharmacists who were interviewed for this study did not describe a cohesive perception of who are the leaders for changing the scope of practice within community pharmacy. Some participants mentioned managers and owners of the pharmacy business; others mentioned professional associations; and still others mentioned pharmacists themselves as role models for the new graduates coming into practice. In addition, several pharmacists mentioned the difficulties in understanding what professional organizations are suggesting to them and in engaging in these organizations’ initiatives to change pharmacists’ scope of practice. The participants mentioned that these leaders have been somewhat distant from the actual issues
concerning pharmacists practicing in the community. Misrepresentation of pharmacists was cited by one participant as a barrier in carrying the changes within the profession. Further investigation and analysis can contribute to understanding the issues underlying the communication between pharmacists and leaders within the profession, and the commitment that pharmacists in general are making to change their scope of practice. According to study participants, there is a pressing need for front-line pharmacists themselves to feel ownership in the change management process rather than feeling as though they are being told they must change but are not being given the tools and supports required to make that change. Some participants, however, did acknowledge that front-line pharmacists themselves may have been part of this problem, noting that their passivity, their unwillingness to manage conflict or debate, and other traits may have made it challenging for them to rise to the occasion. Further research could shed light on how much pharmacists’ personality traits and psychological profiles stand in the way of taking initiatives to become patient-centered, health care professionals. This research could elucidate the degree of interest and leadership that front-line pharmacists take in the process of changing their scope of practice.

The third principle of Kotter’s (1995; Kotter & Cohen, 2002) change management framework is to create a vision for the process of change for all those involved in executing the change process. Analysis of the interviews conducted for this study points to pharmacists recognizing their vision of becoming health care providers. All community pharmacists interviewed for this study identified themselves with the role of patient-centered, clinical-oriented health care professionals. Nevertheless, communicating and acting upon this vision, especially when dealing with stakeholders such as patients, doctors, and managers and owners of pharmacies, seemed to present several challenges. Pharmacists voiced lack of recognition from these stakeholders of their role as health care providers. Therefore, pharmacists are challenged to engage these stakeholders in the process of changing their own scope of practice. Effectively communicating with, involving, and engaging these stakeholders in the vision of community pharmacists could be characterized as the fourth step of Kotter’s (1995; Kotter & Cohen, 2002) model for change management.
Kotter’s (1995; Kotter & Cohen, 2002) fifth step of change management focuses on empowering those involved in the process of executing changes. This research analysis revealed that pharmacists have faced significant setbacks (especially in the current economic climate of cutbacks) in terms of working conditions to perform patient-centered health care practice. All of the pharmacists interviewed for this research cited time and workload as limiting factors in engaging in patient care. They mentioned the incoherence of the duality existing in the role of community pharmacists, working both in sales of medication and in patient-centered health care. Pharmacists described these roles as being in conflict in terms of principles and priorities. This duality disallows pharmacists to become fully dedicated health care professionals.

The government, in concert with professional associations, has implemented compensation schemes for pharmacists to engage in patient-oriented health care practice. This initiative speaks to the sixth principle of change management, which refers to planning and creating short-term “wins” during the process of change to incentivize the change process to be continued by the people directly involved. The pharmacists who participated in this study cited that the compensation scheme currently in place is not sufficient for fully dedicating their time to patient care. Therefore, pharmacists are not able to refrain from the dispensing process or to delegate this work to other staff members in the pharmacy. The pharmacy owners and managers interviewed for this study indicated that these fees are less than what they formerly received as rebates and allowances from pharmaceutical companies. The pharmacy owners and managers reported that this situation has brought a financial loss to the business of pharmacy. This scenario undermines the rhetoric of patient-oriented care in community pharmacies. In contrast, it actually incentivizes pharmacies to intensify their most lucrative activity: selling drug products.

The pharmacists who were interviewed for this study described a very inconsistent and heterogeneous scenario when it comes to implementing patient-oriented health care practice in community pharmacy. Some pharmacies have adopted many changes in practice, and others have done very little in this direction. According to Kotter’s (1995; Kotter & Cohen, 2002) seventh principle of change management, in a medium- to long-term stage of a change process, changes are consolidated to such extent to support and foster further changes. This claim could
be extrapolated to argue that change is as an ongoing process in modern organizations. The interviews analyzed for this research indicate that community pharmacy (as a whole system) has not yet reached this stage in the change management process within the profession. The evolution of change in the profession is still unstable and inconsistent in respect to the implementation of changes over the long term. Some pharmacists have been increasing their skill sets in order to perform clinical services in the pharmacy. Some pharmacies are hiring, promoting, and developing employees to engage in the change process. The pharmacy managers and owners interviewed for this study mentioned that they have been considering and attempting to change their current business model to accommodate clinical services to the greatest extent possible. Nevertheless, this is not happening consistently in community pharmacy in Ontario.

The last step of Kotter’s (1995; Kotter & Cohen, 2002) change management model would be to institutionalize the changes within the organization. Laws and regulations have been approved for community pharmacists to perform clinical services at pharmacies in Ontario. Approving the new scope of practice for pharmacists through laws and regulations is an important step towards managing change in the profession. Nevertheless, according to Kotter’s (1995; Kotter & Cohen, 2002) model of change management, institutionalizing changes, such as passing laws and regulations that approve a new scope of pharmacy practice, should be the last step to the change process. In fact, approving pharmacists’ new scope of practice through laws and regulations has been the first step taken in the direction of changing pharmacists’ role in health care to a patient-centered role. Kotter’s (1997; Kotter & Cohen, 2002) model recognizes the importance of order in the steps to achieve successful change management. Perhaps changing laws and regulations at this stage in the change process may not be as effective at fostering change in pharmacy practice. Simply changing the regulations and enabling legislation for increasing pharmacists’ scope of practice does not automatically translate into practice change. The community pharmacists interviewed for this study expressed that they were struggling to achieve the desired outcome of becoming patient-oriented health care professionals. In a mature change process, new behaviors of employees in an organization are already embedded with their notion of professional success. The results of this study indicate that many concerns and doubts relating to the outcomes from
these changes exist among pharmacists, as professionals, with regard to their financial status, roles and responsibilities within the health care realm, workload, and career opportunities.

One finding of this study was that pharmacies are having to reengineer, that is, restructure, their businesses to a leaner model in order to adopt pharmacists’ new scope of practice. A leaner model directly connects activities to revenues, including increasing operations in the activities that provide the highest financial return to the business. In this case, cuts to drug product prices put forth by the Ontario government with the objective of reducing drug costs to patients may have incentivized the dispensing practice at pharmacies and delayed the transition of pharmacists to a patient-oriented health care practice. To date, practice changes in pharmacy mandated by government policies and put forth by professional associations have not fully engaged pharmacists in patient-oriented care. Sustainable transformation within the profession to assimilate patient-oriented health care is still a vision that remains to be fully executed in practice. Change management strategies such as Kotter’s (1995; Kotter & Cohen, 2002) eight principles model may be used by leaders in the pharmacy profession to engage pharmacists in patient-oriented health care practice. However, all leaders in the community pharmacy realm, such as the Ontario government, pharmacy associations, and pharmacy owners and managers, should be aligned with the vision put forth for the pharmacy profession. Leaders should consider if the vision of pharmacy resonates with all those involved in the transformational change of pharmacy practice. This transformational change requires not only the dedication of pharmacists but also the support of stakeholders who operate and own the pharmacy business. Studies show that pharmacists’ involvement in health care can benefit patients (Tannenbaum & Tsuyuki, 2013; Makowsky et al., 2009). The recognition of the advantages in increasing pharmacists’ roles in patient care can only exist if cooperation and engagement exists among pharmacy stakeholders. Business and political interests within the pharmacy realm need to be aligned for those involved in the implementation of changes so that optimal decisions towards changing pharmacy practice can be made. Therefore, changing the policies that govern practice in pharmacy is an important step, but follow-on on activities also requires diligence, dedication, and support from pharmacy stakeholders for sustainable long term changes in practice.
The second finding of this study was that the uptake of pharmacists’ new scope of practice can be increased if leaders in the profession take into consideration how pharmacists feel towards, think about, and adapt to changes in practice prior to implementing them. Leaders can learn from pharmacists about the hurdles in the process of changing practice. They can recognize these hurdles through the lens of pharmacists, address barriers to change, and incentivize the uptake of new ways of practice. Leaders may support changes in practice by communicating with and exploring pharmacists’ vision of their own role as health care professionals, a role in which changes in practice have a direct impact. Pharmacists interviewed for this study expressed that they felt that the dispensing process was below their skill sets as health care providers. Supporting pharmacists might be the most efficient way to implement practice changes, given that pharmacists have always been receptive to a role in health care. Pharmacists aspire to more than just the success of the business of pharmacy. In addition, pharmacists ultimately will be the executors of change. Therefore, pharmacists’ vision to become fully dedicated health care professionals can provide leaders in the profession with an opportunity to foster change. Although pharmacists have a role working for the business of pharmacy, they have been trained to become health care providers, looking after the interest and well-being of patients. In contrast, pharmacy owners and managers look after the interests of the business. A gap exists between the two sets of priorities. Nevertheless, the business of pharmacy can contribute to changes in practice if managers and owners support the suite of health services that can be provided by pharmacists. In addition, the Ontario government and professional organizations can better lead the implementation of changes in practice if those changes are aligned with pharmacists’ willingness to and capability of adopting them.
Chapter 6
Conclusion

This study used a qualitative research method for data collection and analysis, in light of change management theories, to explore pharmacists’ lived experiences in community pharmacy, which could influence the way they practise health care. Analysis of the data concerning the perspectives of pharmacists was based on a constructivist paradigm, which defined gaps between the existing scientific knowledge and the actual pharmacy practice that is delivered to patients. This research found that the introduction of changes within pharmacists’ scope of practice had a significant impact in their perspectives of their own positions, responsibilities, and experiences as pharmacists and members of the health care system.

Kotter’s (1995; Kotter & Cohen, 2002) theories of change management were used as the theoretical framework for this study. Tsuyuki and Schindel (2008) first used Kotter’s theories to analyze their own research experiences with community pharmacy. The current research used Kotter’s model to explore the opinions of pharmacists regarding practice change occurring in their profession. Twelve community pharmacists, all of whom were at the time licensed and practising in Ontario, were interviewed for this study.

Interviewing was chosen as the data collection method for this study in order to capture pharmacists’ perspectives concerning their roles, positions, and responsibilities as health care professionals in the face of current changes to their scope of practice. Transcripts of individual participant’s interviews were examined using inductive coding techniques for content analysis. Codes were sequentially categorized according to their relation to one of Kotter’s (1995; Kotter & Cohen, 2002) eight principles of change management: Managing Time and Resources, Professional Cohesion, Business Model of Pharmacies, Communication, Policies, Professional Development, Paradigm Shift, and Sense of Professionalism. These categories provided a structure to describe the relationship between Kotter’s framework and the actual change management process happening in community pharmacy.
Managing Time and Resources

This study found challenges associated with pharmacists having sufficient time available to implement the new scope of practice. Pharmacists’ time is divided among several responsibilities and obligations, such as dispensing medication, supervising technicians, managing inventory, and performing other activities as part of the pharmacy business. The reduction of pharmacies’ income was indicated by pharmacists as a contributing factor to the time constraints they faced in their practice. Pharmacies hired fewer staff members to divide the workload among, to restructure the operational activities of the business, and to allow pharmacists to dedicate more time to patient care.

In community pharmacy, managing pharmacists’ time is directly related to the remuneration pharmacies receive for delivering their services to the population. Hiring pharmacy technicians to support pharmacists’ role in dispensing medication to patients may present both advantages and disadvantages to pharmacists. Pharmacy technicians can potentially share the workload with pharmacists. However, pharmacists in this study indicated their strong beliefs that if pharmacists still are accountable for reviewing the technical work performed by technicians, then the technicians cannot be solely assigned to the pharmacists’ role working as a drug dispenser. Therefore, according to the pharmacists who participated in this study, this arrangement, if well planned and defined in terms of roles and responsibilities for both pharmacists and pharmacy technicians, could relieve the conflict between objectives, duties, and priorities that comprise pharmacists’ work agendas.

In addition, pharmacists were still limited in their capacity to review patients’ health conditions, as they did not have access to patients’ medical histories and clinical data. Nevertheless, pharmacists in this study believed that offering clinical services at pharmacies makes sense from a public health perspective.

Professional Cohesion

Pharmacists having a common goal and acting together to defend their interests can strengthen the profession’s ability to plan and execute changes in practice. Pharmacists in this study
indicated that aligning several initiatives, such as effectively negotiating with stakeholders within the community pharmacy realm, creating momentum for change within the profession by promoting the pharmacist within the community, and influencing decision makers to accept changes to pharmacy practice, is important.

Business Model of Pharmacies

Pharmacists cited challenges in dispensing medication concomitantly with delivering a full suite of clinical services under the current business model of pharmacies. Revenues have decreased for pharmacies; therefore, the workload has increased for pharmacists. Several issues emerge from the socio-economic situation of the pharmacy profession, such as fewer jobs, lower salaries, increases in pharmacists’ workload due to reduced staff in the pharmacy, and reductions in training opportunities for pharmacists. Currently, pharmacies are being compensated by the Ontario government on a fee-for-service basis for delivering health care services. Nevertheless, owners and managers of pharmacies may feel that these services have a lower financial return than that derived from having the pharmacist dispense medication to patients. One of the central questions of this research as described by participant pharmacists was: Can pharmacies be profitable enough to afford paying pharmacists to dispense medications and deliver patient care? Pharmacies are commercial establishments that can only sustain their practice if they generate revenues to pay for their associated business costs. Perhaps a unique remuneration model is yet to be developed that can better compensate pharmacists to provide health care services. A viability assessment of health care services provided at pharmacies, including the costs associated with allowing pharmacists’ time to be dedicated to patients, can assist pharmacy managers and owners in implementing health care services for patients.

Communication

Pharmacists in this study indicated that in order to achieve the ideal of a patient-centered practice, there would need to be significant improvement in communication with different stakeholders. For example, pharmacists encountered challenges in collaborating with physicians as part of a health care team. Participants in this research noted that physicians have been, at
times, unwilling to give up health services under their scope of practice to be performed by pharmacists. However, pharmacists indicated they could relieve doctors’ workload by seeing patients who are waiting for treatment. Some of the hurdles identified by study participants in communicating effectively with physicians included too little availability for physicians to speak to pharmacists on a regular basis, thus causing delays in addressing changes to patients’ treatment, and unreadable prescriptions causing delays at the pharmacy as well as loss of productivity in patient care. Nevertheless, some pharmacists reported building long-term relationships with physicians to the benefit of patients.

The study results show that many patients still perceive pharmacists as professionals working for the business of pharmacy, selling drug products to customers, rather than as health care providers. Pharmacists in this study suggested that many patients are not aware of what pharmacists can do for them. Moreover, patients cannot find the same health care services in every pharmacy. To address the lack of role clarity and of service delivery consistency, the pharmacists who participated in this study suggested that communicating effectively with patients, to develop their perception that certain conditions can be treated at the pharmacy, can lead to patients’ recognition of the competence of pharmacists as health care professionals. Compensating pharmacists for performing these services, to motivate pharmacists to develop new skills in performing clinical services and to have patients appreciate the convenience of having health care delivered at the pharmacy, is an important step for pharmacy owners being able to offer these services. In addition, innovative health care services that are complementary to the health care received by patients from other health care professionals can be developed in the pharmacy.

Pharmacists in this study also voiced their concern that professional associations are vague in their communication with pharmacists regarding new regulations governing practice. The channels of communication used currently, such as email messages and meetings, are not the best means to clearly disseminate changes within the profession. Also, pharmacy associations could represent pharmacists’ interests by recognizing their actual compensation needs to fulfill their expanded scope of practice. These associations could have an important role in negotiating
the pharmacists’ compensation with the stakeholders who ultimately pay for the health services offered at pharmacies. The pharmacists in this study suggested that the government (i.e., the Ministry of Health and Long Term Care), working in conjunction with pharmacy associations, could incentivize the provision of these health services by developing a reimbursement scheme that is consistent with the cost of delivering these services to patients.

The study results suggest that managers and owners of pharmacies may not have an informed and clear view of what remunerated cognitive services, such as pharmaceutical opinion, can actually provide to the pharmacy, both as a business and as a place where health care is delivered. Managers and owners of pharmacies are important stakeholders in the process of engaging pharmacists in adopting the new scope of practice. Promoting opportunities for communication by increasing cooperation between pharmacists and their managers/pharmacy owners can contribute to developing an environment that fosters the adoption of the expanded scope of practice.

**Policies**

Pharmacists reported that the new regulations have had a financial impact on them, as well as significantly increasing their workload in the pharmacy. These participants indicated that reduced revenue had a significant impact on the business viability of pharmacies, which, in some cases, may lead them towards lower operating margins and, ultimately, closure as a business. Pharmacists in this study indicated their concerns that owners will potentially have to pay lower wages, or hire fewer pharmacists, to sustain their businesses. Fewer jobs for pharmacists will generate fewer opportunities for pharmacy students to find positions and to get on-the-job training for their practice. Therefore, one of the challenges of pharmacy owners, managers, and other stakeholders becomes finding a business model that will support such a radical change of activities within their businesses. Simply changing the regulations and enabling legislation to increase pharmacists’ scope of practice does not automatically translate into practice change.
Professional Development

As one pharmacist in this study pointed out, the education currently available to pharmacists is abundant and easily accessible for those in urban areas. One pharmacist mentioned that, in addition, many resources can be accessed online, allowing pharmacists to easily upgrade their skills. Pharmacists, in general, perceived the need to upgrade their own skills and qualifications in a timely manner to expand their practice. However, it was not clear to pharmacists how these skills and qualifications would be taught, learned, and assessed as part of the busy working lives of practising pharmacists. The pharmacists interviewed for this study suggested ways of integrating professional development into pharmacists’ work agenda: more flexibility in pharmacists’ schedule would help pharmacists to develop skills and competence, and mentorship could be an efficient way for pharmacists to learn in practice and build confidence in delivering patient-centered care. Factors related to pharmacists’ education were also cited as influencing pharmacists’ adoption of the new scope of practice in Ontario, such as pharmacists’ and their team leaders’ training and intrinsic motivation, the development of professional policies, and funding opportunities for pharmacists to upgrade their skills.

Paradigm Shift

The pharmacists who were interviewed for this study expressed enthusiasm regarding the opportunity to take on a more patient-centered role. Nevertheless, they noted that resistance can be expected, especially due to the fact that these changes will require more work and time from individual pharmacists in order to adapt to practice. However, the pharmacists in this study also indicated that they felt confident in their abilities to provide patients with important health care services and thereby improve access to health for Ontarians. Resistance to change is increased when there is not a clear vision of the future once the changes are implemented. Resistance could be diminished by incentivizing those involved in the change process to believe that changes will bring about a better situation for their lives. Some of the causes of resistance cited by pharmacists were a lack of a coherent and cohesive vision within the pharmacy community for pharmacists to move beyond the business/retail function; differences in pharmacists’ and stakeholders’ vision initiatives on the extent of pharmacists’ time dedicated to, and resources
necessary for the implementation of health care services in community pharmacy; and a lack of patient recognition of the pharmacist role as a health care provider.

Considering several causes of resistance towards implementing changes in pharmacy practice, pharmacists in this study raised an important question: What barriers exist to translate the vision of community pharmacists as patient-centered health care providers into practice? As noted by participants, ultimately, it will be patients who will determine whether pharmacists are trusted and accepted as front-line health care providers. To this end, there is hope that new pharmacy graduates may be able to create momentum for a paradigm shift within the pharmacy profession, by having the advantage of starting their careers with a different mandate and a new set of skills for their profession. Nevertheless, the professional culture of dispensing medication seems to be a barrier to the efforts of new pharmacy graduates to use their newly learned skills in patient-centered practice. The incentives to move the profession forward need to be adequate, and they need to be positioned in the most appropriate manner within the profession to foster a real change in professional culture.

Health Care Integration

Nurses, physicians, and physicians’ assistants could compete with pharmacists in providing several health services. One pharmacist suggested the importance of integrating community pharmacy into the public health system to the extent that pharmacists become a mandatory and expected part of health care teams. Participants in this research noted that pharmacists in general should not be expected to assist patients altruistically, but they should be compensated for their effort and time. The current expectation is that pharmacists deliver health care services at the pharmacy. The delivery of health care services in the pharmacy requires pharmacists to review and evaluate the medications that patients are taking to determine the appropriateness of the treatment. Currently, pharmacists do not have access to patients’ complete health history, which was identified as a significant impediment to practice change. Without integration in the system and access to the same kinds of information (such as laboratory test results) that is available to physicians, nurses, and other health providers, it is simply more difficult for pharmacists to exercise clinical judgment and to take on new patient-care responsibilities.
Aligning Change Initiatives

Pharmacists in this study expressed their concerns regarding the mixed messages being sent by employers, regulators, professional associations, and other stakeholders. On the one hand, there is considerable rhetoric claiming that pharmacists are trusted health care professionals; on the other hand, pharmacists are being forced by some employers to fulfill quotas for activities such as vaccinations or medication reviews, which seems to undermine professionalism. Similarly, pharmacists are being given new authority to renew and adapt prescriptions, but they are not being given authority to access the laboratory test results that would allow them to make informed clinical decisions. These misalignments make it difficult to embrace and implement the changes in pharmacy practice and its professional culture.

Sense of Professionalism

The pharmacists who were interviewed for this study demonstrated commitment to their role as health care providers. They felt drawn to their patients and committed to the health and safety of those they serve. They enjoyed speaking with patients and felt proud of their role in improving patients’ health outcomes. Some also expressed regret in not having adequate time to dedicate to patient care. One pharmacist felt that selling products that are not related to the health care of patients takes time and effort away from patient-oriented care in the pharmacy. Many pharmacists in this study postulate that the public perceives the pharmacist’s role as a person working in a retail operation rather than a health professional caring for patients. This public perception can diminish pharmacists’ enthusiasm to embrace new roles. The business paradigm that pharmacists experience in the workplace differs from the health-oriented paradigm of other health care professions. This confusion over professional identity that may exist among many patients can then affect a pharmacist’s own sense of professionalism and pride, which, in turn, can undermine efforts to assume new professional roles and responsibilities.

Study Limitations

Pharmacists who volunteered to participate were interviewed for this study. Participants have shown a great level of interest and cooperation in the developments of this study and the
transformation that community pharmacy is going through in terms of radical changes to their scope of practice. Therefore, these pharmacists might not be a true representation of the perspective of the majority of community pharmacists. Pharmacists who are unwilling to be involved in the transformation of the pharmacy profession might have been excluded from the study. Omitting those pharmacists’ perspectives on the change process happening in community pharmacy might lead to a bias towards pharmacists being greatly involved, committed, and engaged with the changes in the profession. In addition, most of the pharmacists interviewed for this study were involved with academia as students, teaching assistants, or clinical preceptors. Again, this characteristic of many participants could present a bias in favour of pharmacists being professionals engaged with the transformations happening in their scope of practice. In addition, this group of individuals may share an organizational culture with its own values and beliefs regarding the transformational changes happening within community pharmacy.

It is relevant to point out that at the time they were interviewed, all of the participants in this study were practising pharmacists in the province of Ontario. Their perceptions and feelings may not reflect those of pharmacists working in other Canadian provinces. In addition, the study explored only the perspectives of pharmacists regarding the current changes happening in community pharmacy. The perspectives of other stakeholders of community pharmacy could be of great value in eliciting the variety of issues that surround the implementation of practice changes in community pharmacy. It is, however, equally important to note that exploratory qualitative research of this sort does not purport to be representative; instead, it is indicative of critical themes within the profession during this time of significant change. As such, this research has provided insights for further consideration with respect to change management in pharmacy.

Strengths and the Next Steps of this Research

The findings from this research can further support leaders (e.g., regulators, academics, employers, etc.) in the profession in supporting pharmacists throughout the change process. The study results point to several aspects of the change process that can be planned and executed in a better order and pace to ensure that changes will be implemented effectively and sustained in the long term. The results reflect the testimonials of pharmacists, who ultimately will be the
executors of the change process, regarding what has been successful and what needs improvement in the implementation process. These pharmacists’ testimonials contain details on how to improve the change process in their profession.

The next steps of this study would be to explore the perspectives of other stakeholders of the change process in community pharmacy by gathering and analyzing their views on the implementation of changes in pharmacy practice. This analysis could provide insight regarding how leaders within community pharmacy develop initiatives to implement changes to pharmacists’ scope of practice. These initiatives should be further tested and adjusted during the implementation process. Pilot studies would be useful in initiating and testing some of the initiatives proposed in this report. Educational programs to upgrade pharmacists’ skills could be integrated into the business model to enable pharmacies to deliver a full extent of health care services. New compensation models for pharmacies and pharmacists could be developed and explored as a vehicle for changing both behaviors and professional culture. According to study participants, both pharmacy owners and pharmacists require incentives to maintain motivation to execute such a demanding transformational change in pharmacy practice.

As a pharmacist with experience working for one of the largest stakeholders of community pharmacy, the pharmaceutical industry, I consider it a privilege to have been able to explore a new field of pharmacy practice during this research. I was surprised to encounter common values and beliefs with community pharmacists, despite differences in professional practice. I realized the work challenges to which community pharmacists have been subjected and the duality of their roles as health care providers. The conflicting situation that exists for community pharmacists is unfair to them as health care professionals, to say the least. It is very challenging for them to take ownership of their own responsibilities and roles when there is such a great disparity between what is expected of them as health care professionals and what is demanded from them in the labour force. Perhaps the defensive way of avoiding conflicts is reflected in pharmacy practice, when pharmacists hesitate to fully embrace the new mandate of the profession. This may be the origin of all reasons why initiatives in changing practice are not moving forward. In contrast, jobs in the pharmaceutical industry usually have clearly defined
roles and responsibilities, as well as salaries that reflect the hours worked for the company.
Community pharmacists currently seem to be caught between what they should do as health care providers and what has to be done for the business.

Tools to change practice in organizations, such as the model described by Kotter (1995; Kotter & Cohen, 2002), can foster initiative, order, and pace in the change process. Change management tools can help pharmacists to achieve long term practice transformation. However, impulse and motivation for the change process needs to exist within individual pharmacists. Practice change further requires dedication from pharmacists and from the other stakeholders of community pharmacy, including managers and owners of pharmacies, the government, the pharmaceutical industry, other health care professionals, and patients. Pharmacists still must prove their willingness to become what they aspire to be: fully dedicated health care professionals. If they are given the proper conditions, pharmacists can truly exercise their competence for the benefit of patients.

*Give them the right conditions, and they will show you what they are made of...*
Bibliography


Rosenthal, M., Tsao, N. W., Tsuyuki, R. T., & Marra, C. A. (2015). Identifying relationships between the professional culture of pharmacy, pharmacists’ personality traits, and the provision of advanced pharmacy services. *Research in Social and Administrative Pharmacy, 12*(1), 56–67. [http://dx.doi.org/10.1016/j.sapharm.2015.05.003](http://dx.doi.org/10.1016/j.sapharm.2015.05.003)


### Appendix 1: Pharmacists Expanded Scope of Practice in Canada

#### Table 1

**Pharmacists’ Expanded Scope of Practice in Canada**

<table>
<thead>
<tr>
<th>Expanded Scope</th>
<th>BC</th>
<th>AB</th>
<th>SK</th>
<th>MB</th>
<th>ON</th>
<th>QC</th>
<th>NB</th>
<th>PEI</th>
<th>NL</th>
<th>NWT</th>
<th>YT</th>
<th>NU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide emergency prescription refills</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renew/extend prescriptions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change drug dosage/formulation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make therapeutic substitution</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribe for minor ailments/conditions</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate prescription drug therapy</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order and interpret lab tests</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Administer a drug by injection</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulated Pharmacy Technicians</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1. All pharmacists in Alberta who have “additional prescribing authority” can prescribe a Schedule F drug (prescription-only), including those for the treatment of minor ailments.
2. QC, NB, NS, PEI & NL: only as part of assessment and prescribing for minor ailments.
3. SK: legislation introduced; expected implementation by fall 2015.
4. MB: as Continued Care Prescriptions under section 122 of the Regulations to the Pharmaceutical Act.
5. ON: restricted to prescribing specified drug products for the purpose of smoking cessation.
6. ON: administration of influenza vaccination to patients five years of age and older, administration of all other injections and infusions for demonstration and educational purposes.
7. QC: in case of a supply shortage of the drug in question.
8. QC: for demonstration purposes only.
9. PEI: implementation is pending pharmacist education and the development of standards of practice.

Source: (CPhA, 2015)
# Appendix 2: Comparison of Change Management Models

## Table 2

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify Problem(s)</td>
<td><strong>Lewin-Step 1</strong> Unfreezing</td>
<td>Establish a sense of urgency</td>
<td>Analyze the organizational need for change</td>
<td>The idea and it’s concept</td>
<td>Define the desired results and change plans</td>
</tr>
<tr>
<td>Consult with Behavioral Science (OD) Expert</td>
<td><strong>Schein-Stage 1</strong> Need for Change; People must be dissatisfied with the present</td>
<td>Form a powerful guiding coalition</td>
<td>Create a shared vision and common direction</td>
<td>Define the change initiative</td>
<td>Create capability and capability to change</td>
</tr>
<tr>
<td>Gather Data &amp; Begin Preliminary Diagnosis</td>
<td><strong>Lewin-Step 2</strong> Moving/Changing</td>
<td>Create a vision</td>
<td>Separate from the past</td>
<td>Evaluate the climate for change</td>
<td>Design innovation solutions</td>
</tr>
<tr>
<td>Provide Feedback to Client</td>
<td><strong>Schein-Step 2</strong> Cognitive Restructuring</td>
<td>Communicate the vision</td>
<td>Create a sense of urgency</td>
<td>Develop a change plan</td>
<td>Select and deploy solutions</td>
</tr>
<tr>
<td>OD expert &amp; client members diagnose problems</td>
<td><strong>Lewin-Step 3</strong> Refreezing change to make permanent</td>
<td>Empower others to act on the vision</td>
<td>Support a strong leader role</td>
<td>Find and cultivate a sponsor</td>
<td>Reinforce &amp; sustain business benefits</td>
</tr>
<tr>
<td>OD expert &amp; client jointly plan actions</td>
<td><strong>Schein-Step 3</strong> Refreezing involves self and others.</td>
<td>Plan for and create short term wins</td>
<td>Line up political sponsorship</td>
<td>Prepare target audience, the recipient of change</td>
<td></td>
</tr>
<tr>
<td>Take action</td>
<td><strong>Schein</strong> - To be permanent, change becomes a part of self, relations with others, &amp; system in which people exist.</td>
<td>Consolidate improvements producing more change</td>
<td>Craft an implementatio n plan</td>
<td>Create the cultural fit-making the change last</td>
<td></td>
</tr>
<tr>
<td>Gather data after action</td>
<td>*Lippitt, Watson, Westley expand Lewin’s Model</td>
<td>Institutionalize new approaches</td>
<td>Develop enabling structures</td>
<td>Develop and choose a change leader team</td>
<td></td>
</tr>
<tr>
<td>Measure &amp; Evaluate results</td>
<td>*After Step 1, add Establish a change relationship</td>
<td>Communicate, involve people and be honest</td>
<td>Create small wins for motivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feedback results</td>
<td>*After Refreezing, add Achieve a terminal relationship</td>
<td>Reinforce and institutionalize the change</td>
<td>Constantly and strategically communicate the change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-diagnose</td>
<td>*Lippitt, et al Five Phase Change Model (1958)</td>
<td></td>
<td>Measure progress of the change effort</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New action if necessary</td>
<td></td>
<td></td>
<td>Integrate Lessons learned</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: (Pryor et al., 2008)
Appendix 3: Research Interview Guide

(Research Question: How are pharmacists adapting or responding to environmental changes in professional practice?)

1. Tell me about your practice (patients you see, colleagues, and your role with physicians/nurses/pharmacy technicians).
2. What is your vision of the role of the pharmacist and the role of the pharmacy profession in society?
3. What do you feel proud of and enjoy about our work?
4. Tell me about any challenges in your current daily practice (Explain what challenges mean):
   a. Were there recent changes in your professional practice?
   b. Can you describe changes in the health care system and in the pharmacy world that caused you some concern? Were these changes necessary? How urgent is it for the profession to change?
   c. What is your opinion about those changes? In your opinion, has the practice improved in the last 20 years? Give examples.
   d. How are you feeling about those changes?
   e. How are you personally and in your practice adapting or responding to these changes?
   f. What do you believe are the obstacles for pharmacists to engage in transitioning from its current role and responsibilities to the new aspired ones?
   g. What will it take to get you personally to change and adapt positively?
   h. In your opinion, are there new systems and structures that can be implemented to facilitate innovations in pharmacy practice?
5. Who do you see as the leaders of the profession of pharmacy, and what are they doing to inspire and motivate you? What are they doing that frightens or irritates you?
6. Do you feel that the pharmacy profession is being compensated for adapting to the new scope of practice?

7. In your opinion, are pharmacists receiving professional recognition for the new scope/patient-centered practice?

8. In your opinion, have the changes in the environment actually improved the practice of pharmacy in Ontario? Give examples.

9. Would you like to add any further comment about the impact of these environmental changes on the professional practice and its future?
## Appendix 4: Pharmacists’ Occupational Profile

### Table 3

<table>
<thead>
<tr>
<th>Pharmacist</th>
<th>Job Title</th>
<th>Other Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2</td>
<td>Part-time community Pharmacist</td>
<td>Faculty Member</td>
</tr>
<tr>
<td>P3</td>
<td>Pharmacy owner</td>
<td>Faculty Member</td>
</tr>
<tr>
<td>P4</td>
<td>Community Pharmacist</td>
<td>Graduate Student</td>
</tr>
<tr>
<td>P5</td>
<td>Part-time community Pharmacist</td>
<td>Graduate Student</td>
</tr>
<tr>
<td>P6</td>
<td>Community Pharmacist</td>
<td>None</td>
</tr>
<tr>
<td>P7</td>
<td>Pharmacy Manager</td>
<td>None</td>
</tr>
<tr>
<td>P8</td>
<td>Community Pharmacist</td>
<td>Home visits and community presentations</td>
</tr>
<tr>
<td>P9</td>
<td>Community Pharmacist</td>
<td>None</td>
</tr>
<tr>
<td>P10</td>
<td>Pharmacy Manager</td>
<td>None</td>
</tr>
<tr>
<td>P11</td>
<td>Pharmacy Manager</td>
<td>None</td>
</tr>
<tr>
<td>P12</td>
<td>Pharmacy Owner</td>
<td>None</td>
</tr>
<tr>
<td>P13</td>
<td>Pharmacy Manager</td>
<td>None</td>
</tr>
</tbody>
</table>
Appendix 5: Additional Interview Quotes

a. “I was going to say the scope of practice also is going to put more of a strain. You know, we got MedsChecks, it’s been around for a while, so MedsChecks, you know, that takes more time, so if you are the solo practitioner in the pharmacy, you have to arrange a special time to do that or other people have to wait. So that is going to be extra … an extra stress on the bottom line of the pharmacy as a whole, because you may have to pay another pharmacist to be on shift while you are doing MedsCheck, for example.” (P2, part 2, paragraph 9)

“The biggest challenge is … I would say time, finding the time to provide cognitive services. … I basically have to make a decision, well, if I’m going to do … if someone want to sit down with me for 45 minutes, I’m going to basically … I come in early [for] my shift or stay after my shift to get it done, because during my shift I need to be in the pharmacy dispensing prescriptions.” (P6, paragraphs 34 & 36)

“Well, there is a lot more paperwork, obviously. I have to keep up with record keeping of a lot of things, a lot of signing, and a lot of scanning prescriptions that we have to do. There is a lot more physical work involved. Which I don’t like as much. I would rather use that time to do some research, or investigate about a product, or read something that is going to benefit the profession and my patients, rather than … ‘Oh I have to scan this or do this.’ The technicians can’t do everything. The pharmacists have to do certain things, you know? Especially on a smaller pharmacy, where I am in charge of multi-tasks.” (P10, part 1, paragraph 12)

“My concern lies around the changes and the expanded scope and the workload that comes with it, with the documentation and follow-up with other health care professionals to let you know, for example, with the extending of a prescription. We now have or we have to, you know, advise the patient, document what we are doing, then we have to send the documentation to the physician to let them know what we have done and in the current environment … that does take time, but there is no added remuneration, there is no added, you know, pay associated with that extra level of paperwork and stuff that we have to do, so it gets challenging if we were to do that, and I will be honest, that limits what we have done for patients.” (P7, paragraph 18)
b. “Even by having a registered pharmacy technician that releases some of our time and
brainpower and whatever, and will be able to release us to speak to the patient.” (P2, part 2,
paragraph 53)

“Personally, in my practice where I work, I don’t think we will be moving forward, with the
pharmacy technician. We have a really great pharmacy assistant, and we don’t have a high
volume pharmacy. So it probably won’t affect us directly in that way. But in other instances, I
could see that will be very beneficial for high volume … high prescription volume pharmacies,
to have a pharmacy technician. Maybe several of them.” (P2, part 2, paragraphs 57 & 59)

“Currently, I mean, I think the dispensing function, I guess, will always be there to some extent,
you know, whether we like it or not. However, with the role of changing into the pharmacy
technicians now, where they are becoming licensed and part of the regulated profession act, they
will be able to, hopefully, take care of some of those more technical skills … duties that we have
and the checking duties, which will then lend to freeing more time for the pharmacist. In a
perfect world, I mean, the pharmacist would, you know, I would say, do 100% professional
services.” (P3, paragraph 14)

“I have two regulated technicians in my pharmacy. They are both regulated, however, they are
currently not using or implementing their expanded scope as of yet. We have not figured out a
way to implement into the work role. Well, I take that back I mean, I guess they are doing a little
bit of the extended scope but not to a full extent.” (P6, paragraph 10)

“Regulated technicians would be handling the day-to-day, you know, dispensing and technical
aspects of the pharmacy, where the pharmacist would primarily be involved with the cognitive
side or the counselling side, and patients would come either on an appointment-based service,
right? To either go through a main medication review or a focused assessment or something like
that, and then, you know, the pharmacist could oversee the dispensing part, you know, if the
technician has a problem and they can refer to the pharmacist if needed, but hopefully they
wouldn’t get always dealing with insurance or third party issues or dealing with inventory issues.
The technician can take care of all that.” (P6, paragraph 20)
“Overwhelming [workload]. You don’t get paid more for it. It’s the same amount I am being paid and I can’t rely on the technicians 100%, because it’s my signature, I am the pharmacist manager, I have to make sure everything is done and we do a lot of deliveries now.” (P10, part 2, paragraph 24)

“I do work in a practice where there is a registered technician, and he signs off prescriptions, but I sign on top of his signature. So, I look at myself at the end of the day and I am redoing what he has done. I don't believe that the new legislation meant to create a duplication of function, and what is left to do is to clearly define the role of one behind that ‘counter.’ How good can that be? I am not sure … but anyways, this is the way it’s going. But I need to hear this in a clean cut, in black and white. What you are doing versus what I am doing.” (P9, paragraphs 32 & 34)

c. “Money makes the world go around, and that is no different in the pharmacy profession right? Because we have decided to … you know, if stores … if pharmacies are making more money, less of them will open, because it’s definitely more risk to open up a pharmacy, and therefore on the backend, there is less employment right?” (P3, paragraph 39)

“So, you know, they [pharmacies] always like to keep expenses down like everybody does … you know, we have to be fiscally responsible and sometimes [it] hurts.” (P2, part 2, paragraph 65)

Well, I think a lot of changes have happened with the, what is it, the reform? Whatever they called it, you know, when they have their claw back. So that definitely is making a difference. Pharmacist hours have changed, have decreased. The manager, the owner of the pharmacist is working more hours himself to make it more viable. (P2, part 2, paragraph 5)

“If you want to simplify it, you can say that there are basically two pockets of pharmacists, right? The old-school and the new-school. The old-schools are the ones that basically, you know, they’ve been around for over 10 years or 15 years and longer, and they are getting big salaries, because right now the salaries for pharmacists is going down, right? Significantly. But these old-school pharmacists are making really good money, it could be $50/hour or more. And there’s the
newer grads. The newer grads are the ones that are doing all the innovative stuff, but the new grads are also paid less.” (P6, paragraph 24)

“There is no full-time positions really that are available in the GTA, even the big corps, you know, they … the people that are getting internship[s] are minimal this year and, if they do, they are out in the high needs area, so there may be in northern Ontario or maybe southwest Ontario, but in the GTA, I can guarantee you there will be very few interns and very few positions, and they will be open-based on attrition and not because the new store openings.” (P3, paragraph 45)

“I think we are all affected by the recent changes, because, I mean, the government took a lot of money out of the system, and I think the money that was put back in [the system] was obviously not necessarily equal. I think that if you are really doing a good job with the clinical, it does take time so, you know, if you are really trying to solve somebody’s chronic problems and you are looking at all aspects of their medication history and their medical conditions and their allergies, etc., the time that is being reimbursed is really not quite enough to certainly be sustainable … if you are doing a very simple patient, yes, ok, that might be a money maker. If you are really not just paying attention the way you should be and doing an inferior job, then yes I think you are probably going to be able to make some money. But I think if you are actually really interested in the clinical, there is still a financial barrier.” (P8, paragraph 42)

“If we move down that road [fee-for-service], the question mark that I have in my head is, you know, fee-for-service, great, I’m actually for that, I think there needs to be some sort of dispensing fee just to cover some basic cost[s] associated with that, but if you want us to go for fee-for-service, the question mark that I have is, who is going to pay that fee-for-that service? Patients don’t want to, they feel that it should be covered, especially if they are being assessed somehow, and if they come into a retail pharmacy, we’ll say for minor ailments, and we’ll say … I guess the example they used the other day at the conference I was at was acne. If a patient comes in, and you book them in for an assessment for their acne, and you have to prescribe for mild to moderate acne, and you start them off with a, you know, you do a 20-minute assessment, and you say, well let’s start with some over-the-counter products. Who is paying for that pharmacist time?” (P7, paragraph 77)
d. “Definitely the profession is changing. It is just in terms of how that is changing. I mean, the financial reimbursement model, being remunerated for cognitive services is changing, so that really brings a new dynamic into our profession.” (P3, paragraph 14)

“I talked a lot about economies and monies and all that and, I’m not just about that, I mean, it’s an important aspect [in] everybody’s life, I’m sure, to some extent. But, that is the reality. Until we get reimbursed for all those, you know, free things, I guess, that we are currently doing, you know, it’s going to be … pharmacies certainly will going to be … like, less up to do those things until we get paid for them.” (P3, paragraph 95)

“Those consultations take easily an hour with the patient. Usually things are identified there during the consultation. You might spend another half hour to one hour after working up the actual case, and then to prep it you might have spent a half hour. You can be anywhere from one hour and a half to two and a half hours into one MedsCheck with one patient, just because of the level of difficulty and the number of things going on. As a business owner, or business manager, I look at that and go, I’m getting 60 to 75 dollars depending on the patient, whether they have diabetes or not, but I have invested, 250 dollars on labour, so that doesn’t really make good business sense.” (P7 paragraphs 39 & 41)

“So, it’s a small amount, and it’s just for a small population right now, it’s the government that is reimbursing for the people that are on Ontario drug benefit. So it’s not just all across the board. So the people that are still doing it, you know, are they going to be willing to pay? That’s the big question. So, like, a cash paying customer. Will they pay the $15 or whatever it is for the pharmaceutical opinion?” (P2, part 2, paragraph 15)

“The owners of the pharmacies and the business side of it have not seen the benefit. They see the benefit from large volumes of medications, getting reimbursements from generic companies, and cutting salaries of pharmacists. There is really no benefit to them for understanding what the services of cognitive services [are]. And right now we bill through the pharmacies. So, anything I do, they get … I don’t actually see. There is no incentive for me, and so the incentives are really skewed in that business model”. (P4, paragraph 12)
“Right now we are only paid for filling that prescription, and, you know, that [in] itself has its own problems, where it drives things to be volume-based rather than … how much do you really need to spend with this patient? So we are not paid by our time, we are paid by volume, whereas in a hospital, you know, the pharmacist specifically working on those floors or in those units, they are not paid by seeing, you know – ‘well you didn’t see 10 patients today, therefore, you only get x dollars of compensation per hour.’ Right? They are paid what they are paid, whether they see three patients today or 15 patients today.” (P7, paragraph 107)

e. I have patients coming in and just asking for Viagra without prescription, right? They don’t understand that they need a prescription. And even just on a national level, forgetting, like, different groups, and again that is, I think maybe because of the immigrant population in Toronto, just on a bigger level, I think is just the perception of what pharmacists can do and what they are allowed to do is really skewed, and I think there is a huge misunderstanding …” (P4, paragraph 12)

“I mean, patient education … I mean, that is what we are, I think. We, you know … we educate the patient not only about the drugs, but also about their disease states […] the more that someone understands what their conditions are, the better they will help manage it themselves.” (P3, paragraph 59)

“People are getting really spoiled. Somebody just called me at five o’clock and said ‘I didn’t get my prescription,’ but she wasn’t home. You know, I don’t have a private delivery service. People are really spoiled here in Canada. I don’t know about other places, and they are putting the burden on the pharmacist to do their repeat, to get it to their house. They are putting the burden on me and the pharmacy. It’s their burden and their responsibility to make sure they order on time, they give us enough time to contact the doctor, etc. What they are doing is, ‘I need my prescription.’ Well, call the doctor and tell him you need your prescription. Why are you getting upset at me? I feel that the pharmacist is caught in the middle, and I am being thrown balls at. Go throw your balls at your physicians for not calling me back. Before I can give them the medicine, I have to make a few attempts to reach the doctor. I can’t just say ‘ok, fine. Here.’ You know? That is frustrating.” (P10, part 2, paragraph 24)
f. “I have to say, I think, I can only name you examples of people that are mentors or leaders to me. It will be difficult for me to name one or two or three for the entire province of Ontario. So that just goes to show, I mean, we are kind of … maybe that someone is missing that really need[s] to carry the flag for pharmacy and say, ‘you know what, we need to push expanded scopes.’ So I think we need more pharmacists involved in, you know, politics, or involved in advocacy and things like that in order to move the profession forward.” (P6, paragraph 90)

“I think OPA definitely needs to step it up, and I think they need to be a little more, you know, firm, and set a little more, you know, focus on what they are going to do. I think they need to, I mean, I think they have a role in both things, like they [OPA] need the profession … to push the profession forward on a professional level, but at the same time they [OPA] need to ensure that there is added compensation falling back to the business owners or the operating pharmacies to ensure that the new scope is a viable option, that is viable.” (P7, paragraph 65)

g. “It requires a paradigm shift in how it is that we think about pharmacy and how it is that pharmacy is funded. So pharmacy historically has been funded according to volume prescription filled, and I think the profession is slowly trying to move to a more clinical practice or a more holistic care, a lot more in terms of cognitive services.” (P5, paragraph 24)

“I think certain pharmacists, and I think I’m one of them, are more receptive to change and have that mindset, but others are very hesitant. Like I said, the old-school pharmacists are much more hesitant to change and to kind of take on new responsibilities, because, you know, they are just not comfortable with it.” (P6, paragraph 62)

“Well, the fact is that I am doing it [extension on chronic medication], and all my colleagues, where I work in the practice, are doing it. It’s a common language. Whether or not, in some other practices, people are ‘iffy’ of doing it. Especially new grads, they are very reluctant.” (P9, paragraph 52)

“I don’t like the fact that there are injections being given in a pharmacy. I think you should get your injection at the doctor’s office, where there is a doctor on hand, a nurse, proper staff,
proper medical equipment. I, personally, wouldn’t go to any … If I wasn’t a pharmacist, even
now, I wouldn’t go to any pharmacy to get a flu shot. I would go to a doctor for this.” (P10, part
2, paragraph 6)

“I think [it] is very challenging [to adapt to professional changes]. Very few people have done it.
There has been some discussion about how to make it more efficient and how to make it more
clinical focused. However, taking that step and breaking the mould that we are currently in is a
very challenging step to take when things have been done a certain way for so long. It is
challenging to blow it up and start all over again, because everybody seems to be set in their
ways.” (P7, paragraph 51)

“I think [if] the pharmacists don’t get out from behind the counter and change the way they
practise, then, you know, we are never really going to get the respect that we kind of deserve
from the other health care professionals. Physicians, nurses, etc., I mean, I think right now the
majority of health care professionals still see us as the pill dispensers and the pill counters, and
for us to change that mentality, we need to really show them that we can do more than that.” (P6,
paragraph 90)

“I believe that the only truth in life is change. Change is the nature of things …. From a
humanistic standpoint, it’s resisted. People like their little comfort zone, and they do not like to
change. However, change is a must, because we cannot do things we used to some 20 or 30 years
ago. You have got to change. Whether I like it or not, I may not like it at the beginning, but
eventually I will like it in the future. So, bottom line, yes, I do like it. But I need to refine it.”
(P9, paragraph 68)

“What is it that you like better? The real truth? The real truth is that the giants and the
corporations have to take their hands off. You know what? As long as their hands are in, the
pharmacy is handicapped. Bottom line. That’s no change, because they will look at the dimes
and nickels, and that is what they are going to run after. Instead, [if] the pharmacist[s] excel in
the clinical part, which is the mandate of the new concept of pharmacy, it has to be clinical and
not a pill counter. The bottom line is going to be that the pharmacist is going to be doing cash
register, receiving, and clinical. Jack of all trades and master of none. You cannot do that. If you ask for a technician, they will tell you, ‘you know what? The bottom line, we have to look at the bottom line, and we know that there is a budget, and there is no budget for more technicians.’ If you want to provide health care, this is what it will cost you.” (P9, paragraph 74)

“I would love to see pharmacists getting out of the pharmacy, you know, and get out into the community and uh … maybe do some educational seminars in ,if there’s like, a nursing home nearby … but you have to have this staff to be able to … somebody to actually have that in their job description that is valued, that you actually can leave the pharmacy and go do that, but that requires, again, that paradigm shift, that what it is, that is the role of pharmacists.” (P5, paragraph 32)

“Smoking cessation clinics, or we are holding a cirrhosis clinic, we are having a diabetic clinic, that is all happening in the next two months just at our location there. So we have other services, like a simple thing, as like an EpiPen service, where, you know, we call patients based on their expiration dates with their EpiPen just to let them know, simply that, ‘you know what, your EpiPen might be expiring fairly shortly, you know, if you still need it,’ that is … or so,… that is really good, I mean. EpiPen[s] are life and death situations, so you definitely would not want to use something that is expired and have that risk of [it] not working obviously, so it’s very appreciative, that type of service that we provide. So we do that on a monthly basis and we call patients and so forth. So, I mean, we don’t necessarily get paid for that, but, I mean, I guess, we may if they decide to refill, I guess, so … but, yes, I mean, those are some things that, you know, it’s almost like you have to think another way to generate business, right?” (P3, paragraph 51)

“Well I think definitely that’s a … we are going in the right direction. I think it’s just because of the paradigm shift. It’s hard for people to get their minds around, ‘how will I sort of change what I’ve become used to all these years and adapt to the new role?’ But I think we all have the knowledge and the altruism to basically make it happen, because even in a busy dispensary, the end goal is you want patient[s] to have good customer service, you want to take time to explain how their medications work, and, you know, you want to do all those things that clinically were very well accepted to do.” (P8, paragraph 22)
“I see the profession taking a proper direction now with a lot of the changes happening. But I think that the problem lays in the intertwining of business and the clinical aspect of it. Although other professions are a business, it’s a lot more forward when there is an exchange of money in the pharmacy. What I do hope happens is that, at some point, pharmacists will be a lot more compensated for their cognitive services and will be less based on volume, so [I hope] there will be a push for quality and not just quantity and then [I hope] there will be a push forward [for] the pharmacy to become a central home for a lot of the community interventions that can occur, since they are more accessible to patients, especially when it comes to like public health and things like.” (P4, paragraph 4)

h. “I don’t know if they have done studies on that based on what has happened to the cognitive services now, but I think that ultimately, yes. Like, people are more aware of what they are taking, of how to take it. Compliance is always a huge issue that we never even think about or even talk about in practice, but the reality is that people do not take their medications properly, and by simply doing a medication review with them, and going through, and letting them understand what the importance of taking it every day is, or taking it timely … I guess taking it on time, really lends to their overall health potentially, right? And also simple things like that [are] important. Compliance, even changing their meds or recommending changes that, you know, might be beneficial for them, obviously is another part of it too that is not really … that is not the intent of MedsCheck, but, I mean, the reality is we do find things that we can improve on in terms of their medications and what they are taking, so we will then suggest changes thereafter. So, I do think that a lot of this stuff has stimulated a lot of good things in terms of direct patient care, a patient-focus care, it’s just a … really it’s the economics of it all how it’s going to … what it’s going to look like based on the economies, I guess.” (P3, paragraphs 91 & 93)

“Oh what I really enjoy and I feel great amount of pride in is the cognitive side of the business … the cognitive side of the profession. So, I mean, of course we feel some pride and, you know, enjoy, like, dispensing prescriptions, but I feel like there is so much more to pharmacy than just
dispensing prescriptions. So I particularly enjoy to sit down with the patient and create goals, targets for helping them attain their goals and targets.” (P6, paragraph 32)

“First of all, I really love health promotion, so I’m quite involved with innovative ways of delivering the healthy lifestyle message, and trying to educate people on having their MedsChecks and that knowledge of power, and trying to get them to not be ignorant. So I think, you know, seeing healthy outcomes, some of your interactions are actually quite rewarding … even the adapting, you know, when you look really deeply into patient dose regimens, and just dosing in general, the amounts of things they are taking, you know, sometimes trying to, you know, peel it back, I think, we don’t work so much in silos like the medical system does, so when we peel it back and look at the full big picture, I think sometimes we are well equipped to see, you know, maybe there is some key underlying factor that is being maybe missed or not being addressed very well, and that is leading to a cascade of all these other problems, and then that leads to a cascade of other prescribing, and the next thing you know you have your patient on 20 medications.” (P8, paragraph 28)

“I hope that at one point, I think it is going to happen soon, that vaccinations will happen in the pharmacy that they can come in for their dose monitoring and that can be medication therapy management done by certain pharmacists. So not all pharmacists will be able to do it, but at least there will be access to pharmacists that can within the community, not just in the family health teams, and that … you know, the MedsChecks will just be a minimum, not the exception of the rule, so that kind of direction I see things.” (P4, paragraph 4)

“Well I have high hopes [regarding the role of the pharmacy profession in a society]. I’m very optimistic. I think, well, we know that pharmacists are the number one trusted professionals …. Which is… I’m always very proud to say that. I think we are really on the fore front. We are highly accessible. We have been, for the longest time, not charging for any extra services, we have always been doing it for free, even if patients don’t ever even buy anything from us. For example in the community pharmacy we would offer them advice, recommendations, suggestions, all free of charge.” (P2, paragraph 12)
“I think it’s frontline health care providers, and being as successful as we are, I think we have a role in helping, kind of, manage and triage things for patients that may not need to see other health care providers, where we can deal with it in the pharmacy by recommending various products. I also think we have a very important role interacting with, you know, advocating, I should say, on behalf of the patient, for … with their doctor if we see something that we do not believe it’s in the patient’s best interest. And lastly, probably, is educating the patient on the usage and expectations of medications and how to manage, you know, side effects and other interactions with other drugs, so they can get optional therapy.” (P7, paragraph 8)

“Well, again, I think they [changes in practice] are really moving our profession forward, and I think they are very positive changes that are going to permit us to have … to help our patients more.” (P2, part 2, paragraph 53)

“Certainly in terms of prescribing. So whereas in Ontario, pharmacists only prescribe medications for smoking cessation, most of which are non-prescription case[s]. In the United States, any time you would call a clinic or hospital-based refill line, it’s usually run by pharmacists, so its pharmacists sort of making decisions about whether or not prescription refill should be authorized or not, and pharmacists also, in terms of the prescribing practices, have the capacity to work with a specific doctor, where the doctor and the pharmacist come up collaboratively with what … essentially it’s like formulary of medications that the pharmacists can prescribe and under what conditions the pharmacist can prescribe. So, let’s say if I were a specialist in the area of diabetes or hypertension or asthma working as a consultant in those areas, then essentially I would do FEV works or I would do blood glucose levels or take blood pressures, and based upon that, I would make a determination as a pharmacist to whether or not the patient should continue on the therapy that they were on, or if the blood pressure had risen above a certain threshold, then I would make a determination that maybe a second medication should be added to the therapy, and based upon this formula that the doctor and I have come up with, let’s say there are these three drugs that I could choose from, which is most appropriate for, I believe, for a specific patient. So the pharmacist and the doctor are collaboratively working
with each other in order to make certain that the patient therapy is modified or continues to be the same, based upon clinical data.” (P5, paragraph 14)

“At the same time, if pharmacies go out and agree to, well, ‘we will just do minor ailments, like give us the authority to do it, we will worry about the compensation later’, which seems to be… How do I say this? People who do not work in retail, people who work in academics, people who work in hospitals, and people who don’t actually own or have no financial stake in that business, are just pushing for more, more, more, because their whole goal is, ‘we just want the expanded scope, we just want to be able to do more, we want to push that profession,’ and that is a good attitude. However, once you get those expanded scope[s], the expectation is [that] you will practice within that expanded scope … and if it does not make sense in most businesses, most business owners are not going to support it [expanded scope of practice], and they are not going to a) allow their staff to the extent of like providing the time and the tools necessary to do those expanded scopes.” (P7, paragraph 103)

i. “Because I work in a hospital environment, and I, you know, I’m actually a hospital employee like every other person that works there, as being a manager, I go to management meetings, I sit in meetings where people say, like, with things within the hospital like, they didn’t … they’ve openly said, ‘well I don’t care about the cost, we need to do this because it’s the right thing to do for the patient,’ because their position is a funded position within the budget of the hospital, there is no requirement for them to, you know, get money out of the system like get money back to compensate for their time. So whether they spend, you know, 20 minutes with the patient on the floor or three hours working with that patient or working off that patient on the floor, you know, the other patient just gets pushed further down the line to maybe tomorrow, right? Whereas when you work in a business, that is not the way it works. You are only paid for doing work for that patient.” (P7, paragraph 107)

“I think the Ontario College of Pharmacists should play a strict role in their licensing or allowing pharmacies, what they can and cannot sell, in terms of these big corporations, like Loblaws, which bought Shoppers Drug Mart, you know. They can be allowed to do or sell whatever they want. I know Shoppers is expanding their food section, because they want more business from
the food industry. They are not concentrating on the pharmacy; they are cutting the pharmacists’
hours there. It’s just a pharmacy by name, more so. To me, it seems that way. They are luring
people into their pharmacies by putting stuff on their flyers to get you in, but you know, it’s not a
department store. You know? I don’t like that and because of this, whenever I go out shopping to
buy something, I always try to go to the independent store if I can, versus a big corporation. I
want to help the other person, because they have no say. They have no voice.” (P10, part 2,
paragraphs 42 & 44)