

# A Pharmacist and a Physician Walk Into a Clinic: The Case for the Virtuous Duo

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## Abstract

Healthcare continues to celebrate individual clinical excellence while overlooking the practical and ethical power of truly interdependent care. Drawing on theories of professional “flow” and virtue ethics, this essay argues that the physician–pharmacist relationship represents an underutilized model for safer, more effective primary care in Canada. It contrasts hierarchical, siloed structures with collaborative, duobased models that better reflect the complexity of modern patients and medication management. Evidence from Canadian primary care settings demonstrates improvements in safety, patient understanding and system performance when pharmacists and physicians work as equals. The paper concludes with pragmatic, low-cost recommendations to operationalize this virtuous partnership.

## Introduction

It is only when the ego falls away – when, to borrow from Mihaly Csikszentmihalyi’s theory of “flow,” the self dissolves into an energized, almost monastic absorption – that a clinician does her finest work.

Csikszentmihalyi described this flow state in 1975 after watching painters forget to eat (Csikszentmihalyi 1975). Two millennia earlier, influential Stoics such as Seneca, Epictetus and Marcus Aurelius had arrived at a tidier formulation: the selfless, engaged mind, epitomized by their hero Socrates, was the very substance of virtue.

Curious, then, that our age, so taken with teamwork in the abstract, still writes its healthcare hagiographies in the singular. We revere the lone caregiver, the brilliant diagnostician, the physician as deity. Of the virtuous duo, we say almost nothing.

This is a peculiar silence, and an expensive one. In Canadian primary care, the solo performance has become an anachronism that the country can no longer afford. This is the case whether one is patched into an Ontario family health team, an Alberta primary care network or a fly-in outpost in the Kivalliq where the pharmacist is. The time has come to retire the old hierarchy and to elevate pharmacist and

physician into something less operatic and more useful: a “duo virtue” model, a circle of care that is seamless, respectful and deliberately interdependent.

## The Tangible Case for the Duo

The conventional model is a pyramid: the physician at the apex, orders flowing downward, questions rising upward through channels that would have dazzled a nineteenth-century shipping clerk. It is efficient only in the sense that a filing cabinet is efficient: tidy, hierarchical and hopeless in an emergency. The modern patient is not a file. She might arrive with five comorbidities, nine medications, a smartphone full of side-effect anxieties and a pharmacist she sees far more often than her general practitioner (GP). When the structure is rigid, the circle of care fractures at its margins and the fractures put lives at risk: through preventable adverse events, drug omissions and abandoned refills.

Contrast this with the duo. In British Columbia, the pharmacists in the Primary Care Network program reported that primary care clinical pharmacists provided 24,098 patient appointments to 7,456 unique patients and identified 30,085 drug therapy problems requiring intervention, monitoring or education during the three-year implementation period; these are the quiet near-misses that never make the media precisely because they were caught (Zed et al. 2025). In Alberta and British Columbia, where formal models have integrated pharmacists into primary care teams, programs have reported improvements in patient care, physician support and patient satisfaction. In one Alberta primary care network, 90% of surveyed patients reported that the pharmacist was helpful in improving their understanding of their condition and medications (College of Family Physicians of Canada and Canadian Pharmacists Association 2019).

Canadian reviews of primary care pharmacist integration similarly associate pharmacists’ participation with improved medication management, hypertension control, prescribing quality, chronic disease management, and healthcare

utilization outcomes (Khaira et al. 2020; Miller and Pammett 2021).

These are striking gains, offering new mechanics of safety. A pharmacist who catches a duplicative anticoagulant, a dose that crept upward after discharge or who calls the physician because a refill pattern has gone dark is practising medicine's oldest virtue under pharmacy's contemporary scope: attention.

### The Ethical Case, Without the Piety

Every profession has its liturgies. Bioethicists speak of beneficence and non-maleficence; pharmacists of therapeutic appropriateness and medication safety; health system managers of scope, accountability and workflow. The patient wants to be heard, to be cured or relieved of pain, to sleep through the night and not be harmed by the tablets meant to help her. Call it virtue if one reads Aristotle, beneficence if one reads Beauchamp and Childress and fairness if one reads Rawls. In practical terms, the moral proposition is simpler, if two professionals possess partial knowledge of the same patient, and if either refuses to respect the other's knowledge, the resulting ignorance cannot be considered accidental. It is chosen (Aristotle 1999; Beauchamp and Childress 2019; Rawls 1971).

This is why respect sits in a wholly different category than manners. Manners are the little rituals we perform so that the day proceeds pleasantly. Respect is operational. It determines whether the pharmacist feels unshackled to question a prescription that looks askew, whether the physician regards that question as an intrusion or an early-warning system, and whether the patient sees and experiences the team as a braid or a tug-of-war. One can run an office on manners. One cannot run safe and high-quality care on them.

### The Data, and the New Third Partner

Canada has 48,450 pharmacists licensed to practice, according to CIHI's 2024 data. Of those, 29,399 were employed in direct patient care; in the jurisdictions where place of work data were available, 77% of pharmacists in direct care worked in community care (CIHI 2025). This pharmacist-rich workforce functions as a distributed clinical sensor network for Canadians, hiding in plain sight beside the greeting cards and the blood pressure machine.

Here the new, quiet third partner enters: artificial intelligence (AI), which in this context is neither a miracle nor a menace but an instrument. Think of AI as the stethoscope of the shared electronic medical record. On a well-designed screen, the pharmacist sees, at a glance, which of his diabetic patients has not picked up a metformin refill in 42 days; the physician, logging in from across town, sees the same flag. Neither provider is replaced; both are, for the first time, looking at the same virtual screen. The pharmacist closes the

adherence gap; the physician interprets the clinical pattern behind it. The algorithm, properly deployed, makes the conversation possible and educational and routine.

This will not happen automatically. Canadian pharmacists have been using digital health tools, e-prescribing systems and drug information systems unevenly across jurisdictions, and national surveys have emphasized both the promise and the fragmentation of these tools (Canada Health Infoway 2024). The Canadian Pharmacists Association's 2024 primary care white paper likewise called for standardized, interoperable access to health data across practitioners as a foundation for interprofessional collaboration and stronger primary care (Liu et al. 2024). Put plainly: if the pharmacist and physician do not see the same facts regularly, they will not reliably converge on the same patient care plan.

Bridging this operational dysfunction need not require sweeping structural reform. The tools exist; it is the communicative protocol that remains stubbornly absent.

### Two Recommendations, Both Cheap

If the duo-virtue model is to be more than this essayist's conceit, health-system leaders need to do two unglamorous things. Neither requires a new building, a new bureaucracy or a new line item.

Rather, mandate co-developed collaborative care agreements that require every family health team and primary care network to put in writing how its local GPs and pharmacists will communicate: who calls whom, about what, within what window. Measure success by counting documented medication reviews and the decline in conflicting prescriptions. The technology exists, yet the mandate is missing.

Establish joint peer review and shared audit metrics. Require GPs and pharmacists to conduct quarterly structured reviews of their shared complex patients: the polypharmacy retirees, the medically complex adolescents and the frail elderly on multiple specialists' plans. Track patient satisfaction scores and adherence rates. Fold it into existing continuing professional development hours.

Cost: minimal. Dividend: high. What is hardest is the political will to ask two proud professions to stop being polite to each other and to start being useful together.

### The Hippocratic Imperative

The virtuous duo is not, in the end, a modern innovation. It is the recovery of something very old. Hippocrates wrote that "Life is short, the art long; opportunity fleeting, experiment perilous, and judgment difficult" (Hippocrates 1849: 303).

He also entreated that "externals cooperate." Hippocrates, practicing on the island of Kos in the fifth century BCE, already understood that medicine was never a solo act. Transplanted to a Canadian primary-care clinic in 2026, he

would not be surprised by the pharmacist at the next desk; he would be surprised it took us this long to put her there. The art of healing is relational, or else it is nothing.

The circle of care closes only when the ego loosens its grip. This being when two trained professionals, neither above the

other, both indispensable, subordinate themselves to the single, shared and holistic goal: the health and well-being of the person in front of them.

That is the virtuous, flow state. And, not incidentally, that is also what works. **HQ**

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