The Health Inequalities and the Social Structure of Therapies and Pharmacy Practice in an Aging Society: A Research in Umbria

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The Health Inequalities and the Social Structure of Therapies and Pharmacy Practice in an Aging Society: A Research in Umbria. In our post-modern society every patient becomes a medical product consumer, but some of them need a "particular" assistance. Taking as its starting point the 'irrational passion for dispassionate rationality', so prevalent in Western thought and practice, this paper traces, through the emotions, current debates surrounding the *ambivalent* nature of modernity as both order and chaos, conformity and transgression. Reason and emotions are not, it is argued, antithetical to one another, rather there is a need to fundamentally rethink existing epistemological models and ontological ways of being and knowing. Thus, Pharmacy practice in the "Aging Society" should take under consideration the aspects of aging that transcend physical and biological changes, addressing practical concerns such as communication, understanding cultural values, and social issues with regard to the possible health inequalities among elderly.
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The reduction to an ego, the egological reduction, can be only a first step toward phenomenology.
We must also discover "others" and the intersubjective world. A phenomenological intuition of the life of others, a reflection by Einfühlung opens the field of transcendental intersubjectivity and completes the work of philosophical intuition of subjectivity.
Emmanuel Levinas

The current study investigates the relationships between the community pharmacist and the system of the therapies where it should be paid attention on the social aspects of the protection (Beck 1992) and the emergency, in how much in an increasing number the health is made of, its understanding in total terms, thus revealing through participations integrated on the assistance plan (structure) to individuals. In this direction, many explanations have been put forward to understand the patterns of health *status* experienced by "fragile" groups, where some parts are more fragile than others. In some ways this is one of the aspects of the post-modern society: entering the post-modern world in which society is confronting crossroads, paradoxes, and complexity, the health care system is encountering a transformation more comprehensive and revolutionary than it has ever been seen before. On the other hand, health is one

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of the few remaining social values that garner unambiguous support. This is largely due to our continuing and communal belief that there is one truth "out there" which can be known, understood, and controlled by anyone who is rational and competent. In this perspective, the sociology of scientific knowledge is the study of science as a social activity, especially dealing with the social conditions and effects of science, and with the social structures and processes of scientific activity. In this “post-post-modern” perspective, one of the most fragile groups is the elder population[2] which represents a growing segment of Italian population. Additionally, it is not always possible to recognize exactly the chronological and generational boundaries that formerly demarcated childhood, middle age and old age because the limits have been eroded under pressure from cultural directions that have accompanied profound changes in labour, retirement, the welfare state, and the globalization of Western consumer economies and lifestyles. Besides, Societal changes such as the impacts of globalisation and shifts in social production and circulation of knowledge are frequently seen as producing conditions of profound uncertainty with impacts on interpretation and ethics, social practices and politics. The demographic shift is now set in concrete: it's coming, and it's going to change everything even inside the community pharmacy in terms of ability to provide patient-centred care which is a key educational outcome that requires developing trust and caring relationship in the pharmacy practice. The appropriate use of medications is central to the effective management of illnesses, however there is evidence that some medications are often used inappropriately. (Federici, Garzi 2006) Elderly people are especially sensitive to the side effects of medications, and may be susceptible to adverse reactions including cardiac toxicity, confusion and unwanted sedation. Social problems, the emergence of side effects, and the delayed onset of action of medicines, may be contributing factors in high rates of medication non-adherence and medical co-morbidity is also common, and polypharmacy increases the risk of drug-drug interactions and medication misadventure.

Pharmaceutics represents a large part of health expenses in many countries. However a significant part of these drugs were useless from a therapeutic point of view. As a result of lack of knowledge and inadequate control, after the delivery to the patients, pharmaceuticals are often misused and become a health hazard. In this perspective, the idea that some medicines have an intrinsic power is widespread. Besides, pharmaceuticals are often integrated not only into cultural healing processes but into cultural belief systems as well. This

[2] Italy in on of the top ten markets, which combined account for 73% of the value of the market of pharmaceutical in the world. In all OECD countries, populations aged 65 years and over have dramatically increased over the last 30 years, both in size and as a percentage of total population. As elderly people tend to be concentrated in few areas within each country, a small number of regions will have to face the social challenges raised by ageing population. In Italy almost 20% of the total population is close to the 20%.

issue seems to belong to the doctor/pharmacist/patient relationship which has been included as a major focus for much sociological work in recent years, with particular attention being given to the constraints involved in negotiations between doctors and patients (Stimson 1975), the problem of communication (Tuckett et al 1985), the question of compliance (Stimson, Webb 1975), and, as well as, the pharmacy of services. (Cipolla, Maturo 2001) What seems to be particularly new in the sociological debate is the consideration that a drug, a pharmaceutical product has an important therapeutic impact, and, often, this impact is mis-considered. On one hand, it should be possible to refer to the impact of social and cultural factors on drug effects and use. It encompasses factors or variables that in the past have been called "non-specific", "non-therapeutic" or "non-pharmacological" in nature. In essence, it refers to those variables that are not pharmaceutical in nature but that can still have a profound influence on drug action and the occurrence of specific drug effects as perceived and interpreted by the user. On the other hand, it should be observed that since *Asclepius*, the Greek God of Medicine, who is said to have had two daughters, *Panacea,* literally "all-healing" (the *cure*) and *Hygea* (the *care*), which, in some way, symbolize a possible convergence of pharmacy practice and sociology, and medical/pharmaceutical care as a separate social subsystem and an attractive field for research and study of the sociology of health. (Ardigò 1997)

In this perspective, a major theme in the risk society (*Risikogesellschaft*) is the capacity to understand the perception of meanings in a message within the professional activity in the community pharmacy with regard to the fragile groups system (e.g. the elder). (McCann, Evans 2002) Thus Bauman holds that the post-modern habitat "is a territory subjected to rival and contradictory meaning-bestowing claims and hence perpetually ambivalent". (Bauman 1992) Addressing modes of agency in the context of risks Beck argues that as high modernity "abolish[es] its own ordering categories ... irreducible ambivalences, the new disorder of risk civilisation, openly appear". (Beck 1994) As a result not only of the failure to systematically delineate the concept of ambivalence as a universal or particular concept but also of conceptualisations, which imply that ambivalence on the level of society and on the level of the individual are located "on different planes of phenomenal reality, on different planes of conceptualization, on different planes of causation and consequences" (Merton, Barber 1976), there remains an ongoing lack of understanding how these different levels relate to one another.

The need to bring closer sociology and pharmacy practice was brought about by these following social phenomena: an increase in the population and ageing, automation, spare time, changes in the family (crisis), the upcoming new lifestyles, dependencies, a general deterioration in social environments,

and many others. Besides, there is the need, which, in some way, is still missed, on a sociological point of view, about the understanding of medication from a patient perspective. Models of the prescribing process are "practitioner-centred" and have primarily focused on decisions made and actions by the physicians, pharmacists and other health care providers. In other words, the patient/stakeholder is acted upon rather than be an active and conscious participant; what seems to be missed is compatibility between individual and therapy: both kinds of entitlements must be secured, and the pursuit of this target should be done in such a way as to foster relations of social equity between professionals and patients. In some way this patient-provider relationship seems to be under pressure also because of the transformation in the direction of a massive market deregulation. In Italy this issue is placed above all with evidence after the package proposed in the view of the Bolkestein directive, stretches to liberalize the professional activities within European Union through a competition essentially based upon a system of the prices. Such guideline risks to reduce to element of the competitive system the customer of the pharmacy is rather than to be considered one of the stakeholder of the associate-sanitary system more simply becomes a customer in which the relation whichever professional performance is asserted like one that does not have relations with the "life-world". It is still difficult to imagine how is built this situation. In fact, a first problem should be pointed out: if the community pharmacy is observed in this economical *status*, it should be taken in consideration its "double" role, because it is a part of the sanitary system and also an integrating part of the commercial distribution services which goes to the society tout court including the fragile groups as the elder. However, a pharmacy is a central element of the sanitary system sanitary, and, in this direction, it should be able to increase the access to the sanitary services, not only in organizational terms but also in institutional terms: is a major force in protecting the health and safety of the elderly.

For these reasons, over the last two decades, patterns of pharmaceutical-related behaviour and the social and cultural interpretation of medicines have been examined by sociologists and anthropologist (Fainzang 2001) in several cultural settings. (Cipolla, Maturo 2001) In this perspective, the respect for the life simply does not mean respect for the being in how much such one, for the life biologically understanding, but respect for all the values and all the ends that compose and complete the life: "remedy and recovering cannot be only reduced to clinical, because the function of the remedy derives its truth from its organization, than it is not clinical, but cultural, social, sanitary, economic problem". (Cavicchi 1999) In the context of patient counselling, pharmacist have ethical obligations to patients, and to society, and it is necessary to be aware that it is not possible to leave from a single approach to the health, but

from more points of view in order to watch “in a plural manner” the health. Reciprocity seems to be the principle that health professionals should act in the best interest of the patient. The objective is to improve the life in its wide sense, to contain the period of morbidity that habitually plagues the last part of the life and to prevent premature deaths. This way to observe the health leaves from the discovery of the life concept: this reduction of the respect of the life, in fact, seems to be one of the more important aspects that characterize the technological transformation of the world of the health. (Donati 2006) While there are many efforts in order to extend the life expectation up an artificial production of life, it is not answered adequately to the needs of those categories of persons who do not answer to principles of efficiency and productivity. Therefore, it is the way to figure out the situations of social embrittlement. In the health there are "nearly-excluded", "totally-excluded" and, for their protection, and it is not sufficient a generic affirmation of health rights. It seems therefore to shape the idea that the health drifts, in great part, from the distribution and the availability in the society of one series of opportunity, resources, and ability. In such direction it does not seem possible to try to define the health concept without to consider two essential elements of the civil society: the impartiality and the justice while the debate on the protection of the health would have to privilege the aspect of the fairness, a fairness with at least two dimensions: the levels of health and the access to the services. If the health is observed in epidemiologists terms *tout court*, as an example, deep inequalities are at place. This can take place everywhere and is due is to the differences in the styles of life of the several bands of our population, is for effective accessibility to the cure and prevention systems. The fairness of the access to the sanitary services should hold in account that not all sanitary services and associate are necessary and effective in order to modify the natural history of the disease. Etymologically, a patient means sufferer and, often within ageing population, this is a suffering that degrades. If a part of the society has not approached the effective services (cures), the level of health will be evidently smaller regarding those who will not be able correctly to approach the effective services. The notion of generic sickliness which was phased out during the industrial revolution is migrated in the after-modern society towards the expanding domain of an aged world which is dominated by a population where the polypharmacy is the natural response to the presence of different problems. The term polypharmacy refers to the use of multiple drugs by the patient and this term is used when multiple forms of medication are used by a patient, more drugs are prescribed than clinically warranted, or even when all prescribed medications are clinically indicated but there are too many pills to take. The most common result of polypharmacy is increased adverse drug reaction and higher cost both socially and economically. Such terms as

"inappropriate prescribing" or "potentially inappropriate prescriptions" and "adverse reactions," *versus* "adverse drug events" (which includes a different number of reactions, difficulties of compliance and errors) are now used more frequently, describing more relevant concerns about the quality of the medications used by the elderly population taking into consideration that many drugs are associated with a greater potential for drug interactions and side effects. Data concerned with polypharmacy and adverse drug events are variable. Among the limitations noted are unrecognized cases, and difficulties in determining a cause-and-effect relationship between the medication(s) and the multiple conditions of the elderly. Adverse drug events can be the cause of falls, fractures, cognitive dysfunction, postural hypotension, electrolyte disorders and cardiac failure and are responsible for up to 23% of hospital admissions in the elderly. (Grymonpre et al. 1988) Besides, drug interactions are responsible for 15% to 20% of adverse drug reactions (Doucet et al 1999), and, according to some researchers, the incidence of adverse drug reactions increases exponentially with the number of medications used by an individual. (Nolan, O'Malley 1988) Besides, it is necessary to add that, often, the system of the cures highly turns out to be "faceless", "cold" and anonymous, whose system of operation stretches not to consider the individual like a person, but like a patient, or a customer. Even the reservation systems of the specialised visits, the technological progress of the diagnosis, the system of the therapies, seem to create a tie series that stretches to reduce the person to "the customer" of the system. The relationship doctor-pharmacist-person has been made more and more mediated and negotiated, also from means informed (very often the medical prescription is realized through video-writing software without any "personal" touch. However, Recognizing socio-cultural components of health care decision making, and reserving judgment, will allow providers to incorporate these factors into patient specific care plans. A sincere and respectful discussion about another's health perceptions can develop a sense of trust between patient and pharmacist), therefore contributing to loosen that tie of confidence and trust which should characterize the medical and prescription relation. However, the role of the pharmacist often underrated, is very more complex of the simple distributor of products, because is "the last guarantor" in the control of the medical prescription before its use. (Cipolla 2006) In this frame, the drug dispensation is a professional performance, since it represents an encounter between the patient and the drug. This position of the pharmacist is, often, not recognized since, also in the light of some recent searches, the stakeholders in the pharmacy do not occupy and recognize the same professional positions. In fact, it has been reported that 65% only of the interviewed have recognized the pharmacist as a "doctor graduated in pharmacy", qualified to carry out the profession. (Balint 1957) This data, which

has not been observed in its more complex shape, would have to make to reflect on the knowledge of the pharmacies and the often not recognized professionalisms, a last but not least paradox of the society of knowledge. The pharmacist of community would have to be able to more aware contribute to the health developing the relations between the persons (stakeholder of the pharmacy), for the construction of the common good through the formation of a rich social weaving of participation and cooperation responsibility. The relation between pharmacist and stakeholder would have to be a mutual action of approach, a contiguous truth and communicating (because it happens through the communication) that it renders the evocation of the things possible of the events. It is an activity that transfers own and other people's assets to a cooperating interlocutor. It is a real fact and according to Balint it produces a mutual personal evolution. (Balint 1957) These relations have some parameters that can be identified in the presence, in the ability to listen, the communication, the concept of time[3] and the relationship with the drug[4]. The pharmacy has often acquitted, and acquits still, not only to its fundamental service that is the dispensation of drugs but also councils, attentions, activity of prevention but, above all, and perhaps first of all, listens to what the patients/stakeholders person asks. This ability to understanding is going towards demands to precise times is towards demands to interpret and just to multiply themselves of the sanitary communications door to confusion phenomena: the citizen not always succeeds to select the many information, also conflicting, which can approach or which comes subordinated. Therefore, it is notable the necessity that the pharmacist should act like reliable as an associate-sanitary adviser and professional of the health. The first community pharmacist's task is to mediate and to recover that knowledge and that understanding that, too much often, is taken for granted. In this view, it should be pointed out that community pharmacies can be accessible sites for health promotion. Pharmacies are recognised as the most accessible healthcare service in the community with more than three visits during one month[5].

The turning point is to consider to put at the centre of the trust and caring relationship the person: in the specific case to have to heart the person it means

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[3] The idea of the time is an essential parameter of the life and emphasizes in the relation pharmacist-stakeholder its twofold appearance of chronological time and lived time. It is the second characteristic, the lived one that it dominates the relationship. The patient nearly has always the feeling that too much little is the time that the doctor the dedication and tries to recover this dimension also in pharmacy. The time passes fast, and to the stakeholder it does not seem to be enough the time amount that comes dedicated to it.

[4] It is through is the drug that the doctor maintains a shape of nearly constant presence near the sick one and establishes a type of relationship of all the particular one in which beside orally expressed elements she comes left wide space to possible transformation into rituals or symbols, and fantasies. Sometimes the drug becomes the only one through between doctor and patient, especially in the faceless or expeditious shapes of practical and "administrative" medicine.

[5] The search is in phase of development in Umbria; the indicated data ago reference to 200 interviews (old and great old) collections in some common of the Umbria (reference ASL 4). In Umbria more than 200 patients have been surveyed about the frequency with which they go to the community pharmacy.

to share of the needs, to engage itself to supply to everyone the drug that it is really necessary, not a lot and not only for the cure of the great pathologies (than in a advanced society is always accessible), but in order to guarantee one quality of the “respected” life of its dignity that follows the social evolution of the health concept and well-being. The ethic nature of a drug demands participation and a professional, human, support, between the persons even if, in the last years, many drugs, once buyable only with a medical prescription, have been authorized. This fact stimulates the self-medication since these drugs have a low pharmacological profile risks and that special warnings or limitations of use can be assumed without any further notice. (Bradley, Blenkinsopp 1996) Also this situation seems, in some way, to transform the relation between the pharmacist and the stakeholder of the pharmacy more and more complex. In this direction, even the pharmaceutical industry seems to be aware of the importance of the governance of the information and the knowledge of the drug. The introduction on the market of a new type of drug, as an example, is a process more levels that a period of experimentation demands whose duration can exceed the ten years. Along a similar distance collection, analyzed and communicated an enormous amount of information must be carried out. Between the one hundred and thousand individuals they take part in the course of the development of a whichever drug: from the feasibility studies, to the programming, the monitoring of the clinical experimentation, to the preparation of the medical documentation, to the study of the norm, until the surveillance post-marketing and the pharmaco-vigilance. This distance seems to ask for the contribution of the sociology, of a sociology oriented to the person. For millennia, when the human beings have met of the difficulties in comprising the truth are themselves revolts to the philosophers in order to obtain of the solutions. Today, when we try to record the difficulties in comprising the way in which representing and reasoning "on the truths", it is probably necessary to try "a plural" observation in which it is possible to identify the various distances of the professional spread of the knowledge. In other words, it is necessary to try to understand as it is socialized and which elements prevent or contribute to the internalization of the doctor-scientific knowledge: on one side draft to analyze to all the explicit shapes of socialization and learning (scientific information, professional communication and other), taking in consideration is the contents of the instruction, is the shapes that the knowledge takes in every context, from the other side draft to take in consideration the informal socialization to the knowledge. So far this fact acquires a particular value in order to analyze not to only situations in which the knowledge comes communicated (for formation, but also only for the information sharing) to the own inside of epistemic circle or the community of practical, but also contexts that preview interlacing itself of knowledge and

various competences, where everyone must in some presupposed way "to socialize" the other also on the more implicit of the own professional culture of belongings (pharmacist and the stakeholder of the pharmacy). Moreover, in the encounter between the pharmacist of community and the elder it plays an additional role the different knowledge (drug, reservation, clinical visits, councils on the self-medication, ability to listen): this "encounter" demands the necessity to fully understand the problem which is not only a matter of understanding. (Bayne, Caulfield et al 1983)

Last, but not little important, is necessary to comprise and to reconstruct the interaction processes that constitute the fundamental woven one of the communication of the knowledge. In this direction, the way in which the knowledge is transmitted and it travels, is transformed, adapted, constitutes a possible development in "the attended" empathy (Stein 1989) between pharmacist of community and stakeholder. The concept of *Einfühlung* (in-feeling, empathy) means that (Stein 1989) I actively go out of myself and encounter the Other person (which is an analogue of the I) rather than receive and respond to the Other's facing me, as is the case for Levinas. (Levinas 1998) In an empathic act, for Stein, I feel-in *with* (not instead of or for) the inner life of an Other individual. Empathy, then, is an in-breaking of the other into our own consciousness. It is not an act of our will, rather it would seem to happen to us. Jaspers emphasized "empathy" as the key to understanding the patient. (Jaspers 1968) It is vital that we restore this aspect to our diagnostic process: when in our understanding "the contents of the thoughts appear to derive with evidence the one from the others, following the rules of logic, then we comprise these relations rationally (understanding of that it has been said); when instead we comprise the contents of the ideas like gushed from states of mind, desires and fears of who think, then we comprise truly in psychological or empathic way (towards an understanding of the person who speaks). (Jaspers 1989) Jaspers argues that modern advances in the natural sciences and in technology have exerted transforming influence on the art of clinical medicine and on its ancient Hippocratic ideal, even though Plato's classical argument about slave physicians and free physicians retains essential relevance for the physician of today. Medicine should be rooted not only in science and technology, but in the humanity of the physician as well. Jaspers thus shows how, within the mind of every medical person, the researcher contests with the physician and the technician with the humanist. Jaspers therefore opposes all modern tendencies that regard men as abstractions. As a creative existentialist influenced by Kierkegaard, Nietzsche, and Husserl, he reasons that clinical medicine should always treat patients as an irreducible individual. In this perspective also the pharmacist would have to engage himself or herself in trying to recover the subjective aspect of the "cure" that can have in it the

potentiality to discover the “sense of the life". The presence of the elder in a pharmacy is an altogether fragile presence that would have to provoke the responsibilities, and it should be provided the ability to interpret and to answer, in other words it would have to embezzle to indifference. How does the patient’s experience resonate with our own? What is it like to be this person? A good clinician moves back and forth from detached observation to empathic probing and what about a pharmacist? The patient, in manifesting its need of health, provokes the responsibility, that is, the ability to answer to something that asks to put in every motion resource in order to resolve the problem of the person who has itself of forehead, in order to alleviate its suffering. Science of the relation in pharmacy is quickly transforming and it does not seem more possible to reduce it to a “simple” micro-social relation pharmacist-patient/stakeholder: every single relation more and more visibly seems to be, the fruit of communicative interactions many complex, with feedbacks and interactions in complex ways, often unforeseeable. (Donati 2004) The actors in scene multiply themselves: different typologies of more and more demanding and more differentiated stakeholders and, categories of doctors makes the scene differentiated and specialized, with complex prescription and, often, complementary medicines which interlace and interact differently. Moreover, it is not only a multiplication of the implied figures to transform the scene of the relation in pharmacy. It is the same constituent weft of the scene to change deeply. Not to be able itself more to describe the formers hierarchical architectures that until little years ago only appeared to be natural and “evergreen”, with the pharmacist to the apex: the daily weft to the inside of the pharmacy, more and more oriented to the services, appears more and more like a flow uninterrupted, and weakly hierarchical, of social interactions between numerous actors and codes communicated heterogeneously in which the participation to the relation with the old it would have to be oriented to the empathic relations. If, in this science, it seems to assert a person, more and more a stakeholder, then the social figure that stretches more and more is overlapping to the figure of the citizen tout court, in how much is revealed the issue of the health is by now more and more indistinguishable from the widest issue of the well-being. If the relational dictionary of the pharmacist appears oriented to control, through one technical and eminently impersonal function, the technique-informative interface, the social figure of the stakeholder speeds up the attention of the words like "informing", "speaking", "to communicate" and "to explain". The stakeholder, if fragile and above all old, it often must be "sustained” in a personalized relation, in which the “communication process”" and the "explanation" would have to connect the person to several the services, not only to the drug, but also, and above all, to the understanding of the drug, including in this net also the relatives of the person in cure and imagining of

having to hold account, of the social communication between its neighbours net. This does not mean that the micro-relation, in traditional sense, with the pharmacist negligible, but rather than it is represented from a pharmacist who is part of a scene of the cure, for increasing tasks and for interactive and communicative connection to confirmation come, also in this case, of the outcomes brought back in the cited more general relationship, reassumed in the formula: mediation between stakeholder, arranges of the cures and nets with the sanitary services for a public utility. (Marchionni 2006) In the directed communicative interactions between patient/stakeholder and the pharmacist the word in presence assumes a fundamental importance the system of the knowledge. The word speech in presence is various from that one read on "indications and dosage" of the drug, for the fact already to be marked, in the same moment of its emission, from the relational expectations of the addressee, and from already always ready reacting, adapting itself, to the reactions of the addressee. It is marked in depth is in the choice of the "*lemma"* to express in sounds is, perhaps still more, in the tones, the rhythm and in the grain of the voice, it accompanies from the complex apparatus of the not verbal communication. (Ingrosso 2003) In the understanding and the spread of the word speech in presence the cognitive aspects intimately are connected to those emotional ones because, as an example, "when the words are associated between them for assonance, phonetic analogy, when in the phrase the sequence of words mostly follows the associative ways of the sonorous images of the words, is assisted to an impoverishment of the communicative abilities to the speech. An immense number of searches has for a long time demonstrated that in it celebrates experiments of oral association to lists of words, when they are present in excess "inferior" answers or "primitive" (the Jung *Klangsreaktionen*, the associations for rhyme, the answers iterative, persistent, or incoherent with the word-*stimulus)*, we find ourselves of forehead to a degradation of the semantic logos of the language which seems to count also in pharmacy is the enrichment of the word speech in order to distinguish it in its means to you in the communicative flow that has a continuous character, not decomposable in linear sequences, where the actions would have to be delivered up in reactions. In such direction, the pharmacist is a sensor of particular importance and sensibility of the public health: the reasons that explain this fact are from leading back to the facility of access, the daily availability, the unsatisfied need of comparison and listen to (family or community doctor) to acceptance of the persons and therefore to the facilitation in the communicated process. The community pharmacist seems more to assert as a professional and mediator in the system of the cures whose role is that one of *"a civil*" entrepreneur: it must create a added value "on the spot", anticipating difficult questions and determining if information is appropriate to

pass along to a patient, and to draw an advantage from the production and sale of services that gives account is of the diversity of the stakeholder (old, "fragile" customers, relationships with the community doctor): it is because it must pursue in its personal interest that should become collective. In other words seniors compromise a large portion of the community pharmacist's patients and the number is projected to increase dramatically in the near future. Community pharmacy represents a valuable health promotion setting and there is growing research to recommend health promotion in the pharmacy practice in an aging society. Given the large proportion of the elderly frequenting pharmacies even an opportunistic education program about the use and the possible misuse of drugs will have a significant reach. (Cesareo 2005) Neighbourhood pharmacists are urged to tailor services toward this population and be alert, empathic, to strategies to improve services to the community: "The most important message is that professional development and status are not static, and this is what makes it interesting and exciting to study. As a result of global economic interests in pharmaceuticals and an increasing national interest in managing health costs, all forms of medicine distribution, as well as the role of pharmacists, are currently of major interest. From without and within there will be incentives as well as pressure for the pharmacy profession to develop. The pivotal role of the pharmacy profession in relation to the pharmaceutical industry, the healthcare sector, other health professionals and medicine users ensures that pharmacists will continue to be in the spotlight for many years to come. Pharmacists and pharmacy practice researchers should take an advantage of this interest and contribute to policy debates while reflecting on the professional role of pharmacists in the future of medicine". (Bissell, Traulsen 2005)

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