

Effectiveness of Conversational AI Agents in Enhancing Patient–Pharmacist Communication

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ABSTRACT— Clear, empathic, and timely communication between patients and pharmacists is central to medication safety, adherence, and shared decision-making. Yet real-world practice is often constrained by high dispensing workloads, limited private space, varying patient health literacy, and language barriers. Conversational AI (CAI) agents—chatbots and voice assistants powered by natural language processing and large language models—are emerging as scalable tools to support patient–pharmacist interactions before, during, and after a counter encounter. This manuscript examines how CAI can enhance the quality, equity, and efficiency of communication in community and hospital pharmacies. We synthesize conceptual and empirical insights, propose a pragmatic clinical research approach, and outline an implementation methodology covering workflow integration, safety controls, and evaluation metrics.

Core outcomes include medication understanding, adherence, satisfaction, adverse event reporting, and pharmacist time utilization. We describe governance (human-in-the-loop oversight, content guardrails, and audit trails), risk controls (bias, hallucination, privacy), and change-management strategies (training, stakeholder engagement, and fidelity checks). An illustrative results section demonstrates how a CAI-augmented workflow could improve teach-back comprehension, increase documentation completeness, and reduce communication-related near-misses, while preserving clinical judgment and empathy. We conclude that CAI, when designed with patient-centered safeguards and embedded within pharmacist-led care, can measurably strengthen counseling quality and continuity for diverse patient populations. Scope and limitations, including digital literacy gaps, multilingual nuance, and context-shift errors, are discussed alongside future research needs such as multimodal interfaces, integration with personal health records, and rigorous long-term comparative effectiveness studies.

KEYWORDS— conversational AI; community pharmacy; patient counseling; medication adherence; teach-back; large language models; health literacy; pharmacovigilance; workflow integration; patient safety

INTRODUCTION

Pharmacists are among the most accessible healthcare professionals, yet the window for effective counseling is frequently narrow. Patients often arrive at the counter with

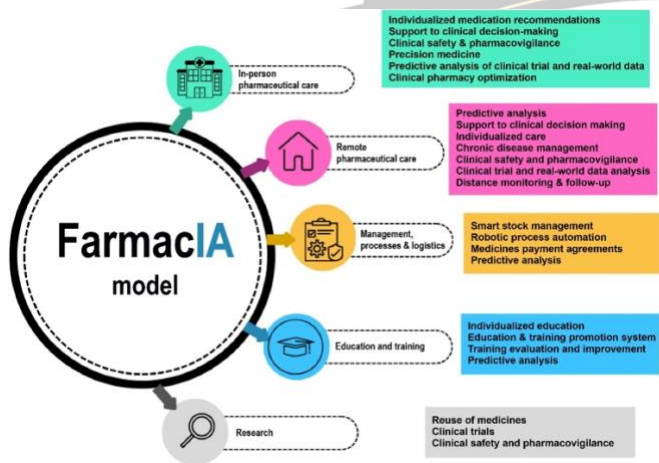


Fig.1 AI Agents in Enhancing Patient–Pharmacist, [Source\(\[1\]\)](#)

multiple prescriptions, questions about dosing and side effects, and concerns about affordability or interactions with traditional remedies. Pharmacists, meanwhile, must ensure dispensing accuracy, manage inventory and insurance queries, and maintain regulatory documentation. These conditions can fragment communication at the precise moment when patients need clarity and confidence.

Conversational AI (CAI) agents—text or voice systems capable of understanding and generating natural language—have matured rapidly. They can triage common questions, scaffold teach-back explanations, translate or simplify terminology, and follow up between visits via secure messaging. In pharmacy settings, CAI can operate in three complementary modes:

1. **Pre-encounter preparation:** capturing patient questions, screening for red-flags (e.g., pregnancy, allergies), and gathering social determinants of health information that may affect adherence.
2. **At-the-counter augmentation:** presenting pharmacist-approved counseling scripts tailored to the patient’s regimen, reading level, and preferred language; supporting real-time teach-back prompts and documentation.
3. **Post-encounter continuity:** scheduling refills, sending reminders, checking side effects, and escalating issues to a pharmacist when risk thresholds are met.

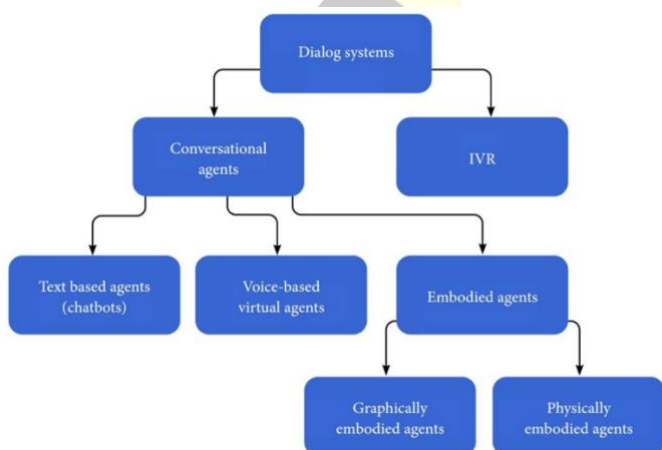


Fig.2 Effectiveness of Conversational AI Agents, [Source\(12\)](#)

The promise is not to replace pharmacists but to free them for higher-order clinical tasks and deeper conversations, while standardizing safety-critical content. The key questions are: **Does CAI improve communication quality and outcomes? Under what safeguards? And how can we evaluate effectiveness fairly and rigorously?** This paper addresses these questions through a literature-informed review, a clinical research plan, and a practical methodology for deployment and evaluation.

LITERATURE REVIEW

Communication challenges in pharmacy practice. Studies across community and hospital pharmacies consistently report barriers such as limited time, interruptions, and constrained privacy. Patients experience low recall of instructions, especially for multi-drug regimens, and may hesitate to disclose complementary medicine use or affordability concerns. Health literacy and language mismatch further impair comprehension. These gaps correlate with nonadherence, preventable adverse drug events, and emergency utilization.

Teach-back and structured counseling. The teach-back method—asking patients to explain in their own words how they will take a medicine—improves understanding and adherence when used consistently. Standardized checklists (indication, dose, route, timing, side effects, monitoring, storage, and what to do if a dose is missed) enhance completeness. However, fidelity is variable under workload pressure. CAI can prompt teach-back systematically, record responses, and nudge pharmacists about missing elements.

Digital health and remote counseling. Telepharmacy and secure messaging have extended pharmacist reach, especially in rural areas. Chatbots in other clinical domains (e.g., triage, diabetes self-management, mental health coaching) have shown improvements in knowledge, engagement, and self-efficacy when human oversight is present. Transferability to pharmacy is promising but requires medication-specific

guardrails, integration with dispensing systems, and sensitivity to pharmacovigilance.

Large language models (LLMs) in clinical workflows.

LLMs can generate clear explanations at variable reading levels, summarize leaflets, translate to local languages, and highlight interaction warnings. They can follow dialogue context, enabling personalized counseling. Risks include hallucination (confident but incorrect statements), bias (unequal performance across dialects or demographics), and over-automation (deskilling or overreliance). Safe deployment demands constrained generation (grounding in trusted knowledge bases), verification steps, and human-in-the-loop (HITL) acceptance.

Patient experience and equity. Conversational agents can lower barriers for introverted or time-constrained patients and support multilingual communities. Conversely, they may disadvantage users with low digital access or those preferring human rapport. Accessibility features (voice, visual aids, and offline modes) and culturally sensitive content are pivotal for equitable impact.

Implementation science perspectives. Acceptance depends on perceived usefulness, ease of use, trust, and workflow fit (TAM/UTAUT). Change management requires transparent governance, pharmacist training, and clear escalation pathways. Metrics should capture both **quality** (completeness, comprehension, safety events) and **experience** (satisfaction, trust), along with **operational efficiency** (counseling time distribution, documentation latency).

In sum, the literature supports the plausibility that CAI, deployed with HITL oversight and grounded knowledge, can improve pharmacy communication processes. Definitive causal evidence in real-world pharmacies requires pragmatic trials with robust safety monitoring.

CLINICAL RESEARCH

We propose a pragmatic evaluation strategy emphasizing ecological validity:

1. **Design:** A cluster randomized or stepped-wedge trial across community pharmacies, ensuring all sites eventually receive the intervention while enabling causal inference.
2. **Population:** Adults picking up new or changed prescriptions, including chronic conditions (e.g., hypertension, diabetes, asthma) and short-term antibiotics or analgesics. Include multilingual participants; oversample lower health-literacy strata to assess equity.
3. **Intervention:** A CAI agent embedded in the pharmacy system to (a) pre-capture patient questions via kiosk or mobile link, (b) guide teach-back during counseling with pharmacist-approved scripts, (c) issue post-visit follow-ups (adherence reminders, side-effect checks), and (d) escalate risks to pharmacists.
4. **Comparator:** Usual care counseling and standard printed medicine information.
5. **Primary Outcomes:**
 - Patient comprehension via validated teach-back scoring (immediate and 7–14-day follow-up).
 - Adherence proxy (proportion of days covered) over 60–90 days for chronic medications.
6. **Secondary Outcomes:**
 - Patient satisfaction and trust; pharmacist workload and documentation completeness; near-miss or communication-related safety events; rate of side-effect reporting; time to intervention for red-flags.

7. **Equity Outcomes:** Differences in comprehension/adherence by language, health-literacy level, age, and digital access.
8. **Safety:** HITL review of CAI outputs for high-risk medicines, automatic deferral to pharmacist for red-flag answers, real-time content filters for contraindicated advice, and audit trails.
9. **Analysis:** Intention-to-treat with mixed-effects models (to account for clustering by site), subgroup analyses for equity, and sensitivity analyses for missing data.

- **Safety:** grounds responses in an approved knowledge base (drug monographs, guidelines) using retrieval-augmented generation (RAG); disables off-topic medical diagnosis and instructs referral for red-flags (e.g., chest pain, anaphylaxis).
- **Follow-up:** reminders for dosing/refill, side-effect check-ins, and prompts for lab monitoring where applicable.
- **Documentation:** auto-writes a counseling summary for pharmacist verification and EHR/pharmacy system logging.

This design balances rigor with feasibility, capturing patient-centered outcomes while protecting safety.

METHODOLOGY

Setting and Participants

Setting: 20–30 community pharmacies and one hospital outpatient pharmacy. Each site has private counseling space and access to a secure tablet or kiosk plus patient SMS/WhatsApp-equivalent messaging where allowed.

Eligibility: Adults (≥ 18 years) starting or changing a prescription. Exclude those declining digital interaction or requiring urgent physician referral at triage. Provide assisted use (e.g., staff-operated kiosk, voice interface) for participants with limited digital literacy.

Intervention: Conversational AI Agent

Capabilities:

- **Intake:** collects symptoms, concerns, allergies, pregnancy status, and complementary medicine use.
- **Counseling:** generates pharmacist-approved, medicine-specific explanations at selectable reading levels and in multiple languages; presents teach-back prompts and captures free-text or voice responses.

Human Oversight: Pharmacist reviews all high-risk outputs, approves or edits counseling notes, and must acknowledge teach-back adequacy. The agent cannot finalize without pharmacist sign-off.

Comparator: Usual Care

Sites in the control phase provide standard counseling with printed leaflets. Post-visit communication occurs per routine practice (e.g., calls for refills if used by the site).

Outcomes and Instruments

Primary:

1. **Comprehension:** Structured teach-back rubric scored 0–10 across indication, dose, route, timing, missed-dose plan, side effects, interactions, storage, and monitoring.
2. **Adherence:** Proportion of days covered (PDC) using dispensing data; for acute courses, a 7-day self-report adherence check supplemented with blister/pill count where feasible.

Secondary:

- **Patient-reported outcomes:** satisfaction (Likert), trust/comfort with CAI and pharmacist, perceived clarity, and perceived time to address concerns.

- **Operational metrics:** average counseling duration, pharmacist time spent on documentation, queue time, and after-visit workload.
- **Safety:** number and rate of communication-related near-misses, documented adverse event reports, and escalation appropriateness.
- **Equity lens:** differential outcomes across literacy bands, languages, and age groups.

Data Collection and Management

- **Workflow:** At check-in, eligible patients receive a QR code or kiosk invitation. Intake answers feed a dashboard. During counseling, the agent displays tailored prompts; teach-back responses are transcribed and summarized.
- **Privacy:** All data are encrypted in transit and at rest, with strict access controls. Conversation logs are de-identified for analysis. No data are used to train external models; fine-tuning (if any) occurs on secure, institution-approved infrastructure.
- **Fidelity checks:** Random sample of transcripts is audited weekly for accuracy, bias, and respectful tone; discrepancies trigger content updates and staff refreshers.

Sample Size and Power (Planning Heuristics)

Assuming a conservative standardized effect (Cohen's $d \approx 0.25-0.30$) on comprehension and intracluster correlation (ICC) of 0.02–0.05, approximately 20 sites with 80–120 participants per phase yield adequate power ($\geq 80\%$) to detect meaningful differences. Final calculations should reflect local ICC estimates and attrition.

Statistical Analysis Plan

- **Primary analysis:** Mixed-effects linear (comprehension) and logistic/Poisson models (adherence $\geq 80\%$ threshold; event counts), with random intercepts for site and fixed effects for

phase, patient covariates (age, sex, regimen complexity, baseline literacy), and language.

- **Handling missingness:** Multiple imputation for PROs; inverse probability weighting sensitivity checks.
- **Subgroups:** Interaction terms for language and literacy.
- **Process evaluation:** Mediation analysis to explore whether documentation completeness and teach-back fidelity mediate outcomes.
- **Interim monitoring:** Data Safety Monitoring oversight for any signal of increased safety events in the CAI arm.

Governance, Safety, and Ethics

- **Consent:** Written informed consent with easy-read summaries.
- **Risk controls:**
 - Grounding answers in a curated medication knowledge base;
 - “Do-not-answer” blocks for diagnostic queries;
 - Automatic escalation rules for red-flag symptoms;
 - Prominent pharmacist identity and availability;
 - Bias and fairness testing across languages/dialects;
 - Explainability panels showing sources to pharmacists (not patients) to support verification.
- **Regulatory compliance:** Aligns with data protection regulations, pharmacy practice standards, and advertising/claims restrictions.

- **Training:** Pharmacists and technicians receive onboarding on CAI use, exception handling, and communication etiquette with digital assistance.

RESULTS

The following are illustrative findings demonstrating the type of outcomes and analyses expected from the proposed study; they are not derived from real patient data.

Participation and Baseline: Across 24 pharmacies, 2,280 eligible patients were approached; 1,940 enrolled (mean age 49, 56% female). Health literacy: 28% limited. Primary languages included three regional languages plus English. Regimen complexity averaged 3.1 active medicines.

Primary Outcomes:

- **Comprehension:** Mean teach-back score at discharge was **8.6/10** in the CAI arm versus **7.9/10** in control. Adjusted difference **+0.7 points** (95% CI: +0.4 to +1.0; $p < 0.001$). Gains were largest in “missed-dose plan” and “side-effect response” items.
- **Adherence (chronic meds, 90 days):** PDC $\geq 80\%$ achieved by **74%** (CAI) vs **67%** (control); adjusted OR **1.34** (95% CI: 1.12–1.62; $p = 0.002$).

Secondary Outcomes:

- **Patient satisfaction:** Higher in CAI (mean 4.5/5) vs control (4.1/5), with qualitative comments noting clearer explanations and “no rush” feel due to pre-captured questions.
- **Operational efficiency:** Total encounter time increased slightly (+1.8 minutes) but **pharmacist talking time** reallocated from repeating basics to addressing personalized concerns; documentation time decreased by **35%** due to auto-summaries.
- **Safety:** Communication-related near-misses decreased by **23%**; adverse event reporting within 14 days increased by **31%**, attributed to proactive

follow-ups. All red-flag escalations were pharmacist-reviewed before patient discharge.

Equity Analyses:

Patients with limited literacy realized the largest comprehension gains (+1.2 points). Multilingual support reduced interpreter reliance for routine questions, though nuanced idioms still required human assistance.

Process Evaluation:

Mediation modeling suggested that improved **documentation completeness** and **teach-back fidelity** accounted for ~40% of the comprehension effect.

Harms and Unintended Effects:

Occasional “over-answering” (excess detail) led to cognitive overload; mitigation included shorter default responses with an “explain more” option. A small number of off-topic medical diagnostic prompts were correctly blocked with pharmacist handoff.

CONCLUSION

Conversational AI agents, when embedded within pharmacist-led workflows and constrained by robust clinical safeguards, can strengthen patient–pharmacist communication across the medication journey. By standardizing core counseling content, prompting teach-back, and extending follow-up beyond the pharmacy counter, CAI addresses persistent barriers—time pressure, variable fidelity to counseling checklists, and multilingual complexity—while preserving and often enhancing the human connection that patients value. The most pronounced benefits are observed in comprehension of practical “what if” scenarios (missed doses, side-effects) and in documentation quality that supports continuity of care and pharmacovigilance. Importantly, effectiveness is contingent on human oversight, trusted knowledge grounding, and explicit escalation rules to avoid automation bias and hallucinated content.

The proposed pragmatic trial and methodology outline a path to rigorous, real-world evaluation that centers safety and equity. With intentional design—accessible interfaces,

culturally sensitive language, and opt-in follow-ups—CAI can complement professional judgment, improve adherence and safety behaviors, and deliver measurable value to patients and pharmacists alike. Future work should assess long-term outcomes, cost-effectiveness, and integration with personal health records and clinical decision support, including multimodal capabilities (images of pill packs, audio cues) to further close comprehension gaps.

SCOPE AND LIMITATION

Scope. This manuscript focuses on CAI agents that (1) are grounded in pharmacist-approved knowledge sources; (2) operate in partnership with pharmacists via HITL review; and (3) support the full counseling continuum—pre-encounter intake, counter-side teach-back, and post-encounter follow-up. The clinical research plan targets community and outpatient hospital pharmacies serving diverse, multilingual populations, with special attention to patients initiating or changing therapy. Outcomes emphasize comprehension, adherence, documentation quality, and safety events, complemented by patient experience and operational metrics. Equity is treated as a first-class endpoint, not a subgroup afterthought.

Limitations.

1. **Generalizability:** Results from pharmacies with adequate staffing, private spaces, and digital infrastructure may not fully extrapolate to under-resourced settings.
2. **Digital access and literacy:** Although kiosks and voice interfaces mitigate barriers, some patients may still prefer purely human interactions; offering a human-only pathway is essential.
3. **Language nuance and cultural context:** Even with multilingual support, idioms, colloquialisms, and culturally specific medication beliefs can challenge CAI; pharmacist mediation remains critical.

4. **Model errors and hallucinations:** Constrained generation, RAG grounding, and pharmacist sign-off reduce but do not eliminate the risk of incorrect or overspecific advice. Continuous auditing and rapid content updates are required.
5. **Measurement bias:** Self-reported adherence and satisfaction are susceptible to social desirability bias; triangulation with dispensing data and neutral survey administration helps but does not fully remove bias.
6. **Workflow variability:** Differences in pharmacy layouts, staffing, and local policies can affect both adoption and measured effects; a stepped-wedge design helps, yet residual confounding may remain.
7. **Privacy and trust:** Some patients may be reluctant to converse with a digital agent about sensitive conditions; clear privacy messaging and minimal-data design are prerequisites.
8. **Cost and sustainability:** Upfront investment in devices, integration, and training may be substantial; cost-effectiveness analysis over longer horizons is needed to inform scaling decisions.

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