Dealing with Frustrations in the Interactions Between Rheumatologists and Retail Pharmacists

By Philip A. Baer, MDCM, FRCPC, FACR

"Insanity: Doing the same thing over and over again and expecting different results."
- Albert Einstein

Pharmacy was not a career I ever considered personally, but I must admit it now holds a certain attractiveness. The range of this versatile healthcare profession extends from hospital work to industry, from running a small business to creating formularies for millions of patients, from academic research to community dispensing, and from working in long-term care to running government drug plans. Pharmacists are becoming important members of many rheumatology teams under new models of care.

However, the theoretical esteem with which I regard pharmacists keeps bumping up against the day-to-day realities of physician-pharmacist interactions which I experience in clinical practice. Is it them or is it me? For instance, I am a big believer in giving maintenance non-narcotic medications in large quantities and with multiple refills, thus typically a three-month supply with five refills. In my mind, this saves the patient dispensing fees and trips to the pharmacy. With my electronic medical records (EMRs), I can tell at each visit if a prescription needs renewing before the next visit or not. Yet, I continue to receive faxes from pharmacies requesting refills of prescriptions which have not run out based on my chart. What gives?

Perhaps the patient has changed pharmacies and now needs a whole set of new prescriptions? I asked several patients whose pharmacies frequently request such refills if that was the case—they said no. In fact, one of a pharmacy's most valuable assets is its roster of regular customers and their prescription lists. Pharmacy ads extol the simplicity of transferring over one's prescriptions from another pharmacy. My medical building's pharmacist confirmed that new prescriptions and the prescriber's involvement are not required, unless there are no more refills listed at the prior pharmacy or controlled drugs are involved. It is a simpler process than changing all your pre-authorized payments when moving a bank account to a new bank.

I also wondered why I would get faxes for refills shortly after a patient had been in for a visit and been handed a new prescription. Some remain unexplained, but some were caused by patients not promptly submitting my prescriptions to their pharmacist, leading the pharmacist to then ask me for a refill. I now tell all patients that, whether they are in immediate need of their medications or not, it would be a good idea to file my prescription at their pharmacy to extend their refill period and to ensure the prescription is not lost in the interim. Perhaps I should take up faxing all prescriptions to the pharmacy instead of handing them to patients in the office. Eventually, e-prescribing should solve this problem.

I have many patients who have permission to vary doses of their medications depending on their clinical condition—including nonsteroidal anti-inflammatory drugs (NSAIDs), steroids, even disease-modifying antirheumatic drugs (DMARDs) and biologics. Others are on tapering or escalating drug regimens, where the precise duration of each step up or down is subject to trial and error. I write prescriptions with PRN dosing, or indicate that the dose may vary within a certain range, or that the dose written is a reduced or augmented dose compared to my last prescription. That works most of the time. However, there are some pharmacists who simply cannot handle dose uncertainty. A patient with a perfectly good prescription for methotrexate (MTX) 15 mg/weekly is told to try reducing the dose to 12.5 mg/weekly, and to stay on the lower dose if doing well or revert to the higher dose if worse. I do not need a fax a week later asking for a new prescription at 12.5 mg/week after the patient told their pharmacist they were feeling fine so far on the lower dose.

Some of my other pet peeves regarding pharmacists:

1. Excessive and unfounded worries regarding possible interactions between low-dose MTX and NSAIDs or proton pump inhibitors (PPIs). My solution is to use the recommended CRA message on my MTX prescriptions prophylactically. See the CRA website at *www.rheum.ca/en/the_cra/drug_updates*.
2. Poorly conceived patient drug information sheets, many derived from American databases, which are difficult to comprehend and scary enough to convince patients not to start required medications. My solution is to hand out the *www.rheuminfo.com* sheet for the prescribed medications in advance, again as prophylaxis before the patient reaches the pharmacy.

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Spotlight on the 2016 CRA Award Winners




CRA: Call for Abstracts

You are invited to submit abstracts for presentation during the 2017 CRA Annual Scientific Meeting and AHPA Annual Meeting!

Deadline for submissions is **October 17th, 2016**. Details are available at *https://rheum.ca/en/events/upcoming_events/abstracts_2017*.

The 2016 CRA awards were presented at the CRA Gala Dinner on February 19th, 2016, in Lake Louise, Alberta. Congratulations to all of this year's recipients!

CRA 2016 Award of Distinction Winners

Clockwise from top left:

CRA Teacher-Educator Award
Dr. Lori Albert, University of Toronto

CRA Young Investigator Award
Dr. Nigil Haroon, University of Toronto

CRA Distinguished Rheumatologist Award
Dr. Ronald Laxer, University of Toronto

CRA Distinguished Investigator Award
Dr. Proton Rahman, Memorial University

For a complete list of all CRA 2016 award recipients, refer to *https://rheum.ca/en/the_cra/award_recipients/2016*.

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Finally, as I was writing this piece, I realized that even patients are sometimes unhappy enough with their pharmacists to be driven to vent their frustrations publicly. I was reading one of my favorite investment blogs written by an iconoclastic investment manager, Jamie Hymas. In the middle of his daily market comments, he was upset enough with his pharmacist refusing to split his pill tablets to comment at length. You can read his complaints at *www.prefblog.com*; look for the April 1, 2016 entry.

It is not clear if Einstein is the originator of the insanity quotation headlining this editorial. It is clear that physician-pharmacist interactions would benefit from changing the current model to achieve better results with less aggravation for everyone. Here's hoping it will happen sooner rather than later!

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