New Policing Role for Pharmacists Undermines Partnership with Prescribers

As physicians who treat pain, we know firsthand the battles our patients face in gaining access to appropriate treatment, which, when other less aggressive options will not suffice, includes opioids. The ongoing battle gained a new front recently when Walgreens pharmacy chain changed its procedures regarding the processing of prescriptions for controlled substances [1]. The new policy directs its pharmacists, at the point of dispensing, to contact prescribers for such detailed medical information as diagnoses, International Classification of Diseases Ninth Revision codes, patient treatment plans, expected length of therapy, and previously tried medications.

This policy has raised concerns for prescribers of pain medications that such demands [2,3]:

- Vastly increase the number of phone calls and faxes to prescribers for detailed patient medical information.
- Result in denials or delays in delivery of medically necessary medications.
- Ignore the established protocols that define physician–prescriber interactions.
- Impose undue and virtually unattainable time demands upon the prescribing professional and the pharmacist.
- Result in unjustifiable hardship and possible medical harm to patients.

The leaders of the American Academy of Pain Medicine share these concerns. The pharmacist does not have access to the medical record and may not possess specific knowledge about the practice of pain medicine. It is not within professional bounds, nor is it practically tenable, to expect to question the medical rationale or decisions of a prescriber with every controlled substance prescription. Neither can the Controlled Substances Act serve as the basis for reversing from afar medical decisions made by a prescriber without adequate evidence of fraud, negligence, incompetence, or criminal intent.

It is certain that Walgreens and other chain pharmacies that are instituting new policies [4] are not attempting to impose unnecessary barriers to patient care, nor are they intending to cause patient suffering. However, some of these patients are very sick, and a delay in receiving their medication along with the extra stress and travel time that attends a medication denial could result in adverse medical outcomes. It is further important to note that quantity of prescribing and length of therapy may correspond to chronic injuries and long-term painful conditions. The pharmacist generally does not possess the information or the medical expertise to make these determinations.

We of the Academy do not hold that adverse outcomes are inevitable in every case, nor are we attempting to circumscribe communications between medical and pharmacy professionals. Respectfully, however, we do suggest that these developments threaten the collegiality between physician and pharmacist, and that better solutions to increase public and patient safety are possible.

Such tension is demonstrated by the passage in June of a resolution by the American Medical Association (AMA) House of Delegates calling for an end to what it terms “pharmacy intrusion into medical practice [5].” The AMA has further taken the position that it would, if necessary, support legislative and regulatory measures to block pharmacists from interfering in the timely delivery of legitimate medical care.

Although the Academy joins with the AMA in opposing unduly cumbersome pharmacy requests, we warn that new regulations could unintentionally interfere with necessary communications between pharmacist and prescriber regarding side effects, drug–drug interactions, and other safety issues pertaining to the patient.

The Academy further notes that a pharmacist’s precise actions necessary to comply with applicable law are not always clear-cut. Under federal law, pharmacists have a duty, corresponding to that of a prescriber, to verify that a prescription has been issued “for a legitimate medical purpose” and “in the usual course of professional treatment” before dispensing [6]. In recent years, circumstances have led to a search for policies to reduce harm. These factors include sanctions from the Drug Enforcement Administration against pharmacy chains and distributors, increased numbers of deaths attributed to opioid drugs, and the battle in Florida against “pill mills,” which are illegal facilities with no connection to legitimate pain medicine [4,7].

Unfortunately, converging influences have placed pharmacists in a double bind: They are expected to be “the last line of defense” against prescription drug abuse on the one hand and to stay out of medical decision making on the other. The implications for public health and patient safety are immense on both sides. A collaborative path forward must respect the unique needs and demands of both sets of concerns.
Our organization has long advocated for more effective communication and partnership between physician and pharmacist. A timely sharing of relevant medical information among professionals enhances patient care. The challenge lies in streamlining processes so that time is not wasted and barriers are not erected that harm patients.

Some areas to explore include the following:

- Advancing the sharing of electronic health records.
- Advocating for the eventual electronic prescribing of Schedule II medications.
- Recognizing that pharmacists have a duty, ethically and legally, to facilitate timely delivery of legitimately prescribed medical care.
- Recognizing that physicians have a duty, ethically and legally, to assist pharmacists with confirming the authenticity of prescriptions.
- Recognizing that physicians also have a duty, ethically and legally, to assist pharmacists with verifying a legitimate medical purpose for controlled substances.
- Acknowledging that a pharmacist may or may not possess the information or credentials needed to reverse a medical decision.
- Encouraging all physicians to welcome the professional input of pharmacists with regard to allergies, drug–drug interactions, drug–disease interactions, strengths, therapeutic alternatives, and patient safety issues.

Education is a primary key to progress. As the national chain pharmacies craft education programs to instruct their pharmacists in appropriate prescribing of controlled substances, the Academy stands ready to provide support and consultation to ensure the patient voice is not lost in the effort to meet regulatory or governmental expectations. Simultaneously, we propose education for all health care professionals who prescribe and dispense opioids to increase knowledge of the prescription drug abuse problem and the prescriber’s role in how to help prevent it.

The Academy remains committed to battling prescription drug abuse and mortality but is equally concerned that solutions do not threaten legal access to medications for patients with legitimate need. We call on physician and pharmacist groups, regulators, lawmakers, pharmaceutical industry leaders, and other involved stakeholders to find rational, constructive solutions that respect the partnership between pharmacists and prescribers so necessary to patient welfare.

LYNN R. WEBSTER, MD*
*President, American Academy of Pain Medicine, Salt Lake City, Utah; *Medical Director, CRI Lifetree, Salt Lake City, Utah, USA

References
6 Code of Federal Regulations, Title 21 CFR § 1306 .04 Purpose of issue of prescription.