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PHARMACISTS NEED TO DO THE RIGHT THING!

Ethics, noun: The science of human duty. Webster Dictionary, 1913

Pharmacists have a duty to patients. Pharmacists need to do the right thing. I'm concerned, based on some recent personal observations, that pharmacists are not doing the right thing. Pharmacists are not exercising their duties to patients. Pharmacists are abdicating their duties to corporate employers or allowing assistants/technicians to overextend their technical duties into the professional pharmacist arena, resulting in substandard care, potential and actual harm to patients, and a clear violation of professional duties.

I've had a varied 37 year practice, 20 years in hospital, working in drug stores, consulting to pharmaceutical companies, editor of the Journal of Pharmacy Practice, editor of 4 books, 3 of which focus on drug injury and pharmacists duties. I am currently an Associate Professor of Pharmacology at Rush University where I teach a clinical pharmacology course, and a member of the faculty at the University of Illinois College of Medicine where I serve on committees and participate in special educational programs. I also have an extensive litigation consulting practice, and in consultations, I frequently examine pharmacy malpractice cases. In addition, I spend about one day a month as a pharmacist, usually in a 'chain' drug store. In the past year, I've been assigned to multiple stores in 4 or 5 different chains.

I'd like to share some of my experiences of 'floating' from store to store and chain to chain, from the perspective of a 'working' pharmacist. I look at this from my consultative perspective by analyzing a set of circumstances surrounding an alleged prescription error or deviation from the standard of care for pharmacists.

There are two primary observations that concern me and are the bases of my statement above, that pharmacists are not doing the right thing. First, pharmacists should be counseling patients by explaining the use of new medications but that is not happening. Second, technicians are performing professional tasks which by regulation and standards should be reserved for the pharmacist. Both of these issues have great potential to place patients at harm.

"Do you have any questions about your prescription?" asks the technician/cashier who was scanning the bar code on the prescription as she directed the patient to sign the screen indicating she was receiving the prescription. What the patients usually don't know is that when they sign the screen, or the paper log, they are waiving counseling by the pharmacist. "No" is the usual response by the patient. Incredibly, this question is sometimes asked by the technician who receives the prescription from the patient on intake. However unless the patient is counseled, told/confirmed what the medication is for, how to take it, how to store it and any special precautions, how can the patient have any questions? Indeed, the 'offer to counsel' is an OBRA 90 (Omnibus Budget Reconciliation Amendment) requirement that beneficiaries of federally funded programs be provided a Drug Utilization Review (DUR) and Counseling. Last minute negotiations and compromises resulted in the counseling requirement being reduced to an 'offer to counsel'. While the offer to counsel may be made by a pharmacist or designee, the actual counseling may only be provided by a pharmacist or student pharmacist under direct supervision of a pharmacist.

One of my introductory statements I make as I walk into a new pharmacy is, "I counsel

every patient on every new prescription." As I check the prescription I make a notation on the bag or receipt that 'counseling' is indicated. To my dismay I've seen and discovered that technicians, under my temporary supervision, ignore my direction. Instead they ask the simple question, "Do you have any questions?", or proceed to provide the patient counseling themselves!

Why am I concerned? It has been written and demonstrated that the last act, of picking up the prescription bottle, describing the drug and the label to the patient, asking some clarifying questions and generating questions by the patient, can detect 90 to 95% of prescription errors. It has also been written and demonstrated that educated patients are compliant patients. Therefore the act of counseling, wherein the pharmacist talks with the patient about his drug therapy, is valuable. Effective counseling is not supplanted by a patient package insert. Indeed, some companies have adopted a business policy of counseling all patients with new prescriptions. These companies recognize that this is a good practice, and it is good business. A few states have pharmacy regulations requiring counseling by the pharmacist on new prescriptions. I've asked technicians in these various stores, "Do your pharmacists counsel patients, or do they wait for the patients to ask questions?" It almost unanimous to the latter! What a tremendous lost opportunity.

An additional grave concern is that technicians are overstepping the functions that they are allowed to do in a pharmacy. In many cases technicians are performing tasks that should be reserved for a pharmacist. For those readers who are not pharmacists, let me briefly describe the prescription filling process. A prescription comes in on paper, fax or as a telephone call (email will happen too). It is 'interpreted' and the data/ prescription information is entered into a computer. Computer software screens the new drug order for high/low doses, drug interactions, allergies and in some programs, drug/disease interactions. If the program detects one of these an alert is flashed on the screen. The alert requires review followed by an override by a pharmacist in order for the prescription order to proceed. I instructed all of my technicians that I was to be notified of and would determine if the alerts could be overridden. Almost universally this instruction was new to them, as it was routine for the alerts to be overridden by technicians.

My concern here is that the technicians in these stores were routinely allowed to do the alert overrides in the first place! This is not, however, an isolated experience. There have been surveys and studies in the pharmacy literature that report alert overrides are commonplace, both by pharmacists and inappropriately by technicians. Sometimes this has severe consequences in a patient such as drug interactions, severe allergic reactions and overdoses. There can even be a failure to recognize that therapeutic duplication has occurred - that is, a copycat drug is being given.

An actual example is a pending case where a patient that was known to be allergic to sulfa was prescribed the sulfa drug Bactrim (sulfamethoxazole/trimethoprim - Roche, Nutley, NJ). The patient took one tablet and had a severe allergic reaction which provoked his body to attack some of his own blood elements (acute hemolytic thrombocytopenia) and caused his kidneys to fail. The patient has recovered somewhat but he is not the same robust man he was before his nearly fatal event. The pharmacy computer had information that the patient was allergic to sulfa. The pharmacy computer records also indicated that someone in the pharmacy called the doctor who approved the prescription. The pharmacy computer also indicated that a mandatory counseling needed to take place based on 'serious allergic risk'. Someone overrode the alert. Was it a technician? I don't know. The prescribing doctor denies he was called. The doctor stated he would have cancelled the prescription - of course! Why didn't the counseling take place? There was supposed to be a bright colored sticker on the bag indicating counseling and advising the cashier to contact the pharmacist. The patient's neighbor swore there was no bright sticker, and that no one talked to her about her neighbor's prescription that she was picking up. The patient and his wife also denied being contacted by the pharmacist about the allergy risk.

Technicians are not trained in the sciences. They cannot know the significance of rotely 'clicking through' the alerts, sometimes with tragic results.

An additional inappropriate action is technicians taking prescriptions from doctors or doctors' offices, either on the phone or from messaging systems. I discovered this as I was checking a telephoned prescription, one that I did not take or write. When I inquired the technician stated, "The pharmacists trust us to do this." Professional pharmacy practice cannot be based on 'trust' of technicians, whose duties are strictly circumscribed by the law! There are nuances in voice, considerations of dose range and questions that are raised when the prescription is being given. The background and training of the pharmacist bears on this interaction, but all of that is lost when this basic duty is delegated to a technician. It is downright dangerous. It is a violation of every pharmacy board regulation that I have read.

The patient's current medication regimen ('profile') is not routinely reviewed in most stores. In one store there is a review policy for the pharmacist to perform a Drug Utilization Review (DUR), in which he is assisted by a computer printout of the profile. In the absence of a pharmacist DUR everyone is relying on the computer software, which does not and should not replace the pharmacist's judgment. In addition they are relying on the technician to NOT override alerts generated by the computer DUR. In most cases professional Drug Utilization Review is simply not happening.

One of my last prescriptions filled was for a young child who was prescribed a liquid codeine/acetaminophen '1 to 2 milliliters every 4 to 6 hours for dental pain.' I took the prescription from the Dentist on the phone. The prescription was entered into the computer by a technician. The computer printed a label. I poured the codeine syrup into a prescription bottle. As I was checking the label, I read '1 to 2 teaspoonsful every 4 to 6 hours'. I couldn't believe my eyes. I re-read the prescription. It was an obvious input error. I pointed this out to the order entry technician, explaining the significance of a 500% dosage error of codeine in a child. It occurred to me later that the technician must have overridden the 'high dose alert' which would have been generated by the computer based on the child's young age. The consequences are obvious! The child could have died!

These are my recent 'hands on' experiences. Such practices have been apparent in many litigation cases that I have examined. By the time the cases get to me, as a consultant in litigation and expert witness, patients have been harmed. Each error could be a fatal error.

The sum total of the lack of counseling, technicians performing pharmacist's functions, and a lack of performance of DUR is an ethical and professional violation. Such sloppy business practices rob patients of basic protections. I like to use the term 'safety net'; the pharmacist, as a professional with an independent duty to a patient, provides a 'safety net' to add to the safe and effective use of medication. If pharmacists abdicate these duties to non-professionals, patients will suffer.

Please don't take this essay as an attack on technicians. Throughout my career I have championed the use of technicians, supportive personnel, to free up pharmacists for professional duties.

Pharmacists need to do the right thing. Our patients' lives depend on it.

Dr. O'Donnell's book: DRUG INJURY: Liability, Analysis and Prevention, 2nd edition (click [here for a preview](#))

Dr. O'Donnell's website: <http://www.pharmaconsultantinc.com/>

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