



Learning Objectives

Upon successful completion of this lesson, pharmacists will be able to:

1. Define pharmaceutical care
2. List four benefits of collaborative health care
3. Identify four requirements for collaborative practice
4. Identify four ways to improve communication with physicians
5. Identify common drug-related problem categories
6. State the three components of a drug-related problem
7. List three components required when documenting a drug-related problem
8. Understand the value of applying evidence-based medicine principles in practice

Instructions

1. After carefully reading this lesson, study each question and select the one answer you believe to be correct. Circle the appropriate letter on the attached reply card.
2. To pass this lesson, a grade of 70% (14 out of 20) is required. If you pass, your CEU(s) will be recorded with the relevant provincial authority(ies). (Note: some provinces require individual pharmacists to notify them.)

Answering options

- A. For immediate results, answer online at www.pharmacygateway.ca.
- B. Mail or fax the printed answer card to (416) 764-3937. Your reply card will be marked and you will be advised of your results within six to eight weeks in a letter from Rogers Publishing.

Disclosure: The author, expert reviewers and Pharmacy Practice magazine have each declared that there is no real or potential conflict of interest with the sponsor of this lesson.

Communicating with Physicians

By Nora MacLeod-Glover, BSc Phm

Introduction

A good starting point for a discussion on pharmacist/physician communication is with the September 1996 Joint Statement on Approaches to Enhancing the Quality of Drug Therapy by the Canadian Pharmacists Association and the Canadian Medical Association.¹

The goal of this joint statement is to “promote optimal drug therapy by enhancing communication and working relationships among patients, physicians and pharmacists.” It acknowledges that physicians and pharmacists have complementary and supportive responsibilities toward the patient in their shared goal of providing optimal drug therapy and they need to work cooperatively and collaboratively toward that goal.

This lesson will deepen the understanding of the need to communicate effectively with physicians by reviewing the basics of pharmaceutical care and exploring collaborative practice. It is important that pharmacists identify and acknowledge the role they play in making these philosophical approaches to clinical practice a broad reality.

Learners will also be provided with a structure for communicating and docu-

menting drug-related problems; this activity will be supported with a review of evidence-based medicine (EBM) principles. Proficiency in EBM skills is necessary to ensure that drug-related problem recommendations are appropriately supported with clinical data.

Learning about pharmaceutical care, collaboration and how these contribute to pharmacists communicating more effectively with physicians will enable pharmacists to:

- Achieve goals of pharmaceutical care
- More effectively influence patient-care decisions
- Contribute to developing a team approach to patient care, along with physician and non-physician care providers
- Increase the quality and safety of health care delivery

Active listening, as well as effective verbal and written communication skills are essential for successful communication with physicians; refer to earlier lessons in this series to learn more about these basic, core communication skills.

Physician Perspectives on Pharmacy and Pharmacists

Awareness of research into physician perspectives and attitudes towards pharmacy



and pharmacists can assist pharmacists in identifying and overcoming barriers to establishing collaborative relationships and the delivery of pharmaceutical care.

In 1998, 2,600 Californian physicians received a three-part questionnaire to explore current expectations of pharmacists, actual experience with pharmacists and future expectations of pharmacists. The study results,² published in 2002 reported that "overall, physicians do not know what to expect of pharmacists." Strongest responses of agreement related to current expectations and experiences with pharmacists were given to the following statements:

- I expect pharmacists to be knowledgeable drug therapy experts.
- I expect community pharmacists to educate my patients about the safe and appropriate use of their medications.
- I expect pharmacists to assist my patients in selecting appropriate nonprescription medications.
- In my experience, pharmacists are a reliable source of general drug information.

While no strong themes related to future expectations for pharmacists arose, the findings of the study showed that physicians are not opposed to having pharmacists more directly involved in patient care. Overall, younger physicians had higher expectations of pharmacists than their older counterparts. Based on this research, pharmacists need to communicate more clearly and consistently to their physician counterparts about what it is they do; an understanding of the role of each health-care provider is an essential component of any collaborative care environment.³

A 2001 qualitative study involving general practitioners and community pharmacists in Northern Ireland⁴ explored barriers between the two professions that influence the development of closer inter-professional working relationships and the extension of prescribing rights to pharmacists. Data was collected through a series of focus groups. The primary theme among the physician discussions was the 'shopkeeper' image of community pharmacy, and its impact on the accessibility to the pharmacist and the conflict between

business and health care. While the general practitioners expressed no concern about their ability to access the pharmacist, they felt that in locations where pharmacy store hours were limited, patients might have difficulty accessing pharmacy care. General practitioners also reported being unaware of the training and education of community pharmacists. Given the similar nature of community practice in Canada, it is possible that some Canadian physicians will hold similar beliefs.

Pharmaceutical Care

As early as 1987, discussion about the pharmacists' role in medication management and the structure of how best to deliver care was discussed by Strand⁵ in looking at the functional and structural prerequisites for clinical pharmacy. Pharmaceutical care, as a distinct function for pharmacists, was directly explored in 1990,⁶ and defined by the Council of the International Pharmaceutical Federation (FIP) at its Council meeting in September 1998:⁷

"Pharmaceutical care is the responsible provision of pharmaco-therapy for the purpose of achieving definite outcomes that improve or maintain a patient's quality of life. It is a collaborative process that aims to prevent or identify and solve medicinal product and health-related problems. This is a continuous quality improvement process for the use of medicinal products."

FIP supports a structured approach to achieving the goals of pharmaceutical care and offers these three distinct steps to delivering pharmaceutical care:

- Pharmaceutical care requires that a professional relationship between the patient and pharmacist must be established and maintained.
- Pharmaceutical care requires that records of medication provided to a patient must be kept and with the patient's informed consent, additional patient-specific information must be collected, organized, recorded, monitored and maintained.
- Pharmaceutical care requires that patient-specific medical information must be evaluated and, in the case of prescribed medicines, a therapy plan must be developed involving the patient and the prescriber.

Collaborative Care

Setting the stage for effective communication with physicians requires creating a collaborative environment that supports and fosters sharing of knowledge and perspectives from a variety of health-care providers.

Health Canada⁸ supports collaborative patient-centred care as a means to:

- improve population health/patient care,
- improve access to care
- improve patient safety and communication among health-care providers
- encourage more efficient and effective employment of human resources.

Numerous collaborative care initiatives are underway in Canada. Many of these are described in a recent publication: Action! Collaborative Care – A special report for physicians and pharmacists on the movement toward interdisciplinary primary health care.⁹

One national primary health-care collaboration initiative is the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative.¹⁰ This initiative, spearheaded by 10 national health-care associations and a health-care coalition has developed a collaboration toolkit to help raise awareness about collaborative care and facilitate practitioners transitioning to this health-care model. This toolkit can be found at: <http://www.eicp-acis.ca/en/toolkit/default.asp>.

Current research into collaborative care

Despite the general confusion within the physician community over the pharmacist's role, studies looking at pharmacist/physician collaboration have demonstrated positive patient outcomes. As such they showcase opportunities for pharmacists to effectively collaborate with physicians in the primary-care setting. Some of the research into outcomes related to collaborative care is described below.

A Canadian study published in 2003 reported the outcomes of a randomized controlled trial in family practices in 24 sites in Ontario.¹¹ Physicians and patients (within the same postal code) were randomly selected to receive either usual care or an intervention arm in which patients were asked to participate in a face-to-face medi-

cation review with the pharmacist to identify and recommend resolutions for identified drug-related problems (see below for more on drug-related problems). After meeting with the pharmacists, physicians reported intention to implement 76.6% of the pharmacist recommendations. After 5 months, physicians had implemented 46.3% of the recommendations, 9.3% of recommendations were partially implemented and 16.7% were attempted to implement but were not successful. Reasons for unsuccessful implementation were related to patient reluctance, a previous attempt and failure for the same recommendation and lack of time to deal with the recommendation. Interestingly, physicians reported that they learned something new as a result of 53.2% of the consultations with pharmacists. While the results of the interventions did not have a statistically significant impact on clinical outcomes, it did show that physicians were receptive to pharmacist recommendations.

Another Canadian study, the SCRIP study¹² (The Study of Cardiovascular Risk Intervention by Pharmacists) demonstrated the value of community pharmacist intervention in cholesterol risk management in patients at high risk for cardiovascular events. In this randomized controlled trial, which included 54 community pharmacies, patients at high risk for cardiovascular events (atherosclerotic disease or diabetes mellitus with another risk factor) were randomly assigned to receive either a pharmacist intervention (education, brochure on risk factors, point-of-care cholesterol measurement, referral to physician and follow-up for 16 weeks) or usual care (the brochure on risk factors and general advice only with minimal follow-up). The primary end-point was made up of two components: a physician-ordered fasting cholesterol panel or the initiation or increase in the dose of a cholesterol-lowering agent. The primary end-point was reached in 57% of intervention patients vs. 31% of patients in the usual-care arm. Due to the benefits associated with the pharmacists' intervention, the external monitoring committee recommended early study termination. This study demonstrates the value of collaborative care between pharmacists

and physicians in providing preventative health care; not surprising given the accessibility of pharmacists and the frequency of interactions that occur between patient and pharmacist.

Strategies for effective interdisciplinary collaboration

The Joint Statement between CPhA and CMA offers several strategies for collaborating to optimize drug therapy. Several of these suggestions require health system change; however, the statement offers the following strategies which can be adopted by practitioners immediately.¹

- "Respecting and supporting patients' rights to make informed decisions regarding their drug therapy.
- Supporting both professions' relationship with patients and promoting a collaborative approach to drug therapy within the health-care team. Care must be taken to maintain patients' trust and their relationship with other caregivers.
- Sharing relevant patient information for the enhancement of patient care, in accordance and compliance with all of the following: ethical standards to protect patient privacy, accepted medical and pharmacy practice, and the law.
- Increasing physicians' and pharmacists' awareness that it is important to be readily available to each other to communicate about a patient for whom they are both providing care.
- Enhancing documentation (e.g., clearly written prescriptions and communication forms) and optimizing the use of technology (e.g. e-mail, voice mail and fax) in individual practices to enhance communication, improve efficiency and support consistency in information provided to patients."

Access to a pdf of this Joint Statement can be found at: http://www.pharmacists.ca/content/about_cpha/who_we_are/policy_position/pdf/CMA_CPhA_Joint_Stat.pdf#search=%22Joint%20statement%20CPHA%20and%20CMA%22.

More specific strategies that you can employ to enhance communication with physicians include:

- Recognize that trusting, respectful relationships take time to build. In the

community, try to meet physicians with whom you interact regularly – if needed, make an appointment to meet face-to-face to introduce yourself and the services your pharmacy provides. When meeting a physician is not practical, establish trusting rapport by ensuring your written and verbal communications are concise and professional.

- Ask physician offices how they prefer you to communicate with them (for example, by phone, e-mail or fax). To assist physicians who prefer to communicate by phone, ensure you have a "physician's only" line to ensure they by-pass long phone messages. Consider getting a portable phone to permit easier movement throughout the pharmacy and reduce the likelihood that you will need to put a physician on hold.
- Recognize when an issue can be handled by the physician's staff and when you really must speak to the physician. For example, clarifying illegible or incomplete prescriptions may be handled by nursing staff who may find the information in the chart; requesting a medication change related to an identified drug allergy to a prescribed medication would be handled by the physician.
- If you feel you need to speak with the physician, be assertive – never apologize for making the call. Be prepared by anticipating questions the physician may have and having alternatives in mind or references handy if you need to request a change to a prescribed medication.

Six potential goals of therapy or clinical outcomes at which patient care is usually directed:¹³

1. cure the disease
2. eliminate or reduce symptoms
3. arrest or slow the progression of a disease
4. prevent a disease or reduce/eliminate disease-associated symptoms
5. normalize laboratory values
6. aid in diagnosis

Communicating Drug-Related Problems

Most of our communication with physicians will be related to having identified a drug-related problem. A drug-related problem is defined as ^{11, 13} an undesirable event experienced by a patient that involved, or is suspected to involve, drug therapy and which interferes with achieving the desired goals of therapy. Table 1 offers a comprehensive list of potential drug-related problems.

Whether communicating drug-related problems in writing or verbally, it is important to be concise and succinct. When stating or documenting a drug-related problem, the pharmacist needs to include a description of the patient's problem or condition, the drug therapy involved (including product names and dosing) and the relationship between the two. Table 2 demonstrates how the drug-related problem would be structured to meet these requirements.

Documenting a Drug-Related Problem

There are several formats available for pharmacists to use in documenting. The format selected should meet the practitioner's needs within their workplace.^{13, 15-18} At a minimum, information documented should include:

- Goals of therapy (these need to be agreed upon by all collaborating health-care providers)
- Recommended interventions to resolve the drug therapy problem, achieve the goals of therapy and/or prevent new problems. If more than one appropriate intervention exists, the practitioner may wish to list the alternatives with advantages and disadvantages of each so that the prescriber understands the rationale for the recommended intervention.
- Follow-up or monitoring that may be required.

The National Association of Pharmacy Regulatory Authorities has a number of pharmacy practice resources available to pharmacists (see www.napra.org and look under Pharmacy Practice). Two forms that may be useful in communicating drug-re-

lated problems with physician's offices can be found at:

- <http://www.napra.ca/pdfs/practice/drugtherapy.pdf>
- <http://www.napra.ca/pdfs/practice/related.pdf>

Other forms that pharmacists may find useful to use in the course of documenting interventions are available:

- <http://www.napra.ca/pdfs/practice/interview.pdf>
- <http://www.napra.ca/pdfs/practice/intdoc.pdf>
- <http://www.napra.ca/pdfs/practice/docform.pdf>

For non-prescription interventions that you wish to inform a physician's office about

see:

- <http://www.napra.ca/pdfs/practice/patient.pdf>.

Evidence-Based Medicine

Evidence based medicine (EBM) was first discussed in the literature in 1992 when Gordon Guyatt and his Evidence-Based Medicine Working Group published a paper outlining a new philosophy that represents a paradigm shift in which there is less emphasis on intuition, unsystematic clinical experience and pathophysiological rationale for clinical decision-making and more emphasis on the outcomes of examining evidence from clinical research.¹⁹ EBM requires that the practitioner continue

TABLE 1

Eight drug-related problem categories and specific common causes for each one^{1, 11, 13, 14}

Drug-related problem	Common causes of the drug-related problem
The drug therapy is unnecessary	<ul style="list-style-type: none"> • There is no indication for the drug therapy • A drug is being used chronically that was intended for acute treatment • The patient is taking social or recreational drugs • Several drug products are being used where a single drug entity will suffice • The condition is more effectively managed with non-drug therapy • The drug therapy is being used to treat an avoidable adverse reaction associated with another medication
Additional drug therapy is required	<ul style="list-style-type: none"> • A medical condition requires drug therapy that is not currently being prescribed • A medical condition that requires drug therapy is unrecognized • A drug the patient is taking for a valid indication is causing non-dose related side-effects for which treatment is required • The patient requires therapy for prevention • Drug therapy is required to create an additive effect with existing therapy
The drug product is ineffective	<ul style="list-style-type: none"> • The current drug therapy is not effective for the condition it was prescribed • The current drug therapy is not the most effective available for the condition • The patient's condition is not responding to the prescribed drug therapy • The dosage form is inappropriate for this patient • The prescribed drug therapy is not the most cost-effective
The dosage is too low	<ul style="list-style-type: none"> • The dose is too low to produce the desired effect • The dosing interval is too infrequent • The duration of therapy is too short

Continued on opposite page

to apply traditional care skills: a sound understanding of pathophysiology allows the clinician to determine whether trial results apply to their specific patient; knowledge of patient values and desires is also an important factor in clinical decision-making.

Sackett²⁰ defines EBM as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.”

Pharmacists need to integrate EBM philosophy and processes, such as researching and referencing primary literature, into their clinical decision-making and their communication with physicians. Doing so will ensure recommendations are supported with current clinical data and as a

result will contribute to building trust with physicians.

Additional information about how to integrate EBM into practice can be found at: www.cche.net/usersguides/therapy.asp and www.med.ualberta.ca/ebm/ebmintro.htm.

Practice guidelines are the result of experts gathering to produce recommendations for prevention, diagnosis and/or treatment of a particular condition and are based on an exhaustive review of currently available evidence.

Not all practitioners have the time or access to the necessary literature databases

to effectively perform literature searches when seeking information needed for clinical decision-making. As such, practice guidelines are a good option for practitioners who wish to integrate clinical evidence into their clinical decision-making. Here are two sites that can be used to access a number of available clinical practice guidelines: <http://mdm.ca/cpgsnew/cpgs/index.asp> and <http://gacguidelines.ca/>.

Bringing it all together

Current research demonstrates that creating a collaborative working environment with physicians can enable the pharmacist to achieve their professional goals associated with pharmaceutical care. Accurate, succinct communication is essential for collaborative patient care. Pharmacists need to communicate identified drug-related problems and corresponding clinically-sound recommendations. Pharmacists will also benefit from communicating their role and how they can contribute to the health-care team both today and in the future.

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TABLE 1

Eight drug-related problem categories and specific common causes for each one^{1, 11, 13, 14} (continued)

Drug-related problem	Common causes of the drug-related problem
The dosage is too high	<ul style="list-style-type: none"> • The dose is too high • The dosing frequency is too often • The duration of therapy is too long
The patient is experiencing an adverse drug reaction	<ul style="list-style-type: none"> • The drug therapy is causing an undesirable effect that is dose-related • The drug therapy is causing an undesirable effect that is not dose-related • The patient has risk factors that make the selected drug therapy unsafe • The patient is experiencing an allergic reaction to the drug therapy
The patient is experiencing a drug interaction	<ul style="list-style-type: none"> • A drug interaction is reducing/increasing the amount of drug available to the patient • The patient is experiencing a drug-disease interaction • The patient is experiencing a drug-drug interaction • The patient is experiencing a drug-food interaction • The patient is experiencing a drug-laboratory test interaction
The patient is noncompliant	<ul style="list-style-type: none"> • The patient is unable to take the drug therapy prescribed (cannot swallow, inject, etc.) • The patient cannot afford the drug therapy • The patient does not understand the drug therapy instructions • The patient prefers not to take the drug therapy • The patient does not remember to take the drug therapy • The drug therapy is not available (i.e. shortage)

TABLE 2 Structuring Drug-Related Problem to Meet Requirements

Drug-related problem component	Example 1 (The dosage is too low)	Example 2 (The patient is experiencing an adverse drug reaction that is not dose-related)
An undesirable event or risk of an event experienced by the patient	The patient is not achieving lipid targets	The patient has developed a rash on his upper body
The drug therapy involved	The daily 10 mg dose of Atorvastatin	Caused by the cloxacillin 500 mg QID prescribed to treat a skin infection
The relationship that exists (or is suspected to exist) between the undesirable event and the drug therapy	Is too low to produce the desired response	May be due to a drug allergy
Summary statement	The patient is not achieving lipid targets because the daily 10 mg dose of Atorvastatin is too low to produce the desired response	The patient has developed a rash on his upper body caused by the cloxacillin 500 mg QID prescribed to treat a skin infection that may be due to a drug allergy.

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Questions

Select the ONE BEST answer for each of the following questions.

1. Pharmaceutical care is best defined as:

- The responsible preparation and processing of prescription and non-prescription medications intended to enable the patient to achieve defined goals of therapy.
- The responsible provision of pharmacotherapy for the purpose of achieved definite outcomes that improve or maintain a patient's quality of life.
- Identifying an undesirable event experienced by a patient that involves drug therapy and interferes with achieving goals of therapy.
- The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

2. Collaborative patient-centred health care will achieve all of the following EXCEPT:

- Increased health care costs.
- Improved access to care.
- Improved patient safety.
- Increased efficiency of human resources.

3. Collaborative care requires that health-care providers:

- retain professional autonomy.
- generate profession-specific care goals.
- maintain existing hierarchy.
- clearly communicate their care role.

4. Current research into collaborative care has shown that:

- pharmacists are able to reduce the frequency of adverse events post-discharge
- collaboration between physicians and pharmacists is unlikely.
- pharmacists have a role in preventative health care.
- physicians are clear on the pharmacists' role in health care.

5. Community pharmacist interventions always result in improved patient outcomes.

- True
- False

6. The Joint Statement between CPhA and CMA offers which of the following strategies for collaborating to optimize

drug therapy?

- It is important to be available to other care providers when they need to discuss a patient-care issue.
- Sharing information with other care providers can enhance patient care.
- All care providers need to respect a patient's right to make informed decisions regarding his or her care.
- All of the above.

7. When stating a drug therapy problem, the pharmacist needs to include:

- the individual responsible for causing the drug therapy problem
- the relationship that exists between the undesirable event and the drug therapy
- the harm to the patient if the problem is not resolved
- the follow-up that needs to occur to ensure the problem is resolved.

8. Patient DG is a 36-year-old male who presents to your pharmacy complaining that his tennis elbow pain is not being managed by the prescribed medication (naproxen 125 mg BID). What is the category of drug-related problem that DG is experiencing?

- the patient is non-compliant
- the drug product is ineffective
- the dosage is too low
- additional drug therapy is required.

9. Patient LM presents to your pharmacy 12 days after her 30-day supply of antihypertensive medications should have run out. She presents you with a new prescription for an increased dose of the same medication. What is the category of drug-related problem that LM is experiencing?

- the drug therapy is unnecessary
- the patient is non-compliant
- the patient is experiencing an adverse drug reaction
- additional drug therapy is required

10. Which statement is TRUE regarding relationships with physicians?

- Apologizing is one way to show respect for a physician's time when needing to have him or

her come to the phone.

- Technology can interfere with relationship-building.
- You can expect, as a health professional, that physicians will respect your opinion.
- Trust in a professional relationship can take time to develop and is built on experience.

11. Documentation of a drug-related problem contains all of the following components EXCEPT:

- Monitoring plan
- Patient assessment notes
- Goals of therapy
- Recommended interventions

Use the following information for questions 12-14. Patient GG, a 72-year-old man with chronic obstructive pulmonary disease is a patient at your pharmacy. On review of the patient's profile you realize he has never received a pneumococcal vaccine.

12. What is the category of drug-related problem that the patient is experiencing?

- the patient is non-compliant
- the patient is experiencing an adverse drug reaction
- the dose is too low
- additional drug therapy is required

13. State the drug-related problem as you would communicate it to the physician:

- Please consider providing this patient with a prescription for pneumococcal vaccine.
- The patient has chronic obstructive pulmonary disease and requires a pneumococcal vaccine.
- The patient requires a pneumococcal vaccination as soon as possible.
- The patient is at risk of contracting pneumonia and therefore requires a pneumococcal vaccine.

14. What might be the shared goal of therapy for this patient in this case?

- cure the disease
- normalize laboratory values
- prevent a disease
- reduce symptoms

15. All of the following strategies can

Questions continued... Select the ONE BEST answer for each of the following questions.

enhance collaboration with physicians, EXCEPT:

- Ensure you speak directly with the physician on all patient-care matters.
- Determine which method (phone, fax, e-mail) a physician's office prefers to use to communicate.
- Implement a "physician only" phone line.
- Introduce yourself to the physician to establish a face-to-face relationship.

16. Evidence-based medicine principles are important to pharmacy practice because:

- They ensure the right clinical decision is always made.
- They shift decision-making away from intuition and personal experience.
- Everyone has equal access to clinical trial data.
- They reduce the need to explore patient values and health goals.

17. An efficient way a pharmacist can easily integrate evidence-based medicine into his or her practice is to:

- Subscribe to all the core medical journals.

- Be familiar with clinical guidelines for common health conditions seen in his or her practice.
- Attend as many live education events as possible.
- Maintain a current library of textbooks in the pharmacy.

Use the following information for questions 18-20. Patient WM, is an 18-year-old female who has asthma. She has infrequent exacerbations but currently has a friend visiting who has brought a cat to her apartment and it is increasing her symptoms. Previously, her symptoms have been managed with her short-acting bronchodilator that she has required less than twice a week. Now she is using this bronchodilator 1 to 2 puffs every 4 to 6 hours. While her symptoms are being controlled she is concerned about the feeling of her heart racing.

18. What is the category of drug-related problem the patient is experiencing?

- the drug product is effective
- the patient is experiencing an adverse drug reaction

- the dose is too high
- the drug therapy is unnecessary

19. State the drug-related problem as you would communicate it to the physician:

- The patient's short-acting bronchodilator is causing problems for the patient and needs to be replaced with an alternate drug.
- The patient is using too much short-acting bronchodilator and needs to reduce her use.
- The patient is experiencing palpitations related to her salbutamol use which is dose-related.
- The patient is at risk of uncontrolled asthma symptoms and requires the addition of inhaled corticosteroid therapy.

20. What might be the shared goal of therapy for this patient in this case?

- eliminate symptoms
- normalize laboratory values
- prevent a disease
- cure the disease

FACULTY

Communicating with Physicians

About the author

Nora MacLeod-Glover has 20 years of experience as a pharmacist in community-based care, inpatient and outpatient hospital services and medical research. She has recently returned to school and is enrolled in the University of Toronto PharmD program. Nora has developed and facilitated numerous pharmacy education programs on a number of topics; specifically, she has facilitated live communication-focused education programs throughout Western Canada. Nora spent the past 3 years supporting the remediation efforts of pharmacists who have practice weaknesses identified when they are randomly selected to participate in the Practice Review

run by the Ontario College of Pharmacists. Her work included supporting the development of skills related to knowledge management, patient interviewing and communication.

Reviewers

All lessons are reviewed by pharmacists for accuracy, currency and relevance to current pharmacy practice.

CE Coordinator

Heather Howie, Toronto, Ont.

Missed something?

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| 2. a b c d | 7. a b c d | 12. a b c d | 17. a b c d |
| 3. a b c d | 8. a b c d | 13. a b c d | 18. a b c d |
| 4. a b c d | 9. a b c d | 14. a b c d | 19. a b c d |
| 5. a b | 10. a b c d | 15. a b c d | 20. a b c d |

Last Name		First Name	
Primary Licensing Province	Licence #	Secondary Licensing Province	Licence #
Home Address		City	Province
Postal Code	Telephone	Year Graduated	
Email			

TYPE OF PRACTICE

- Drug chain or franchise
 Independent
 Grocery store pharmacy
 Other (specify): _____
 Banner
 Mass merchandiser
 Hospital pharmacy

Please help ensure this program continues to be useful to you, by answering these questions.

- As a result of taking this lesson, do you now feel better able to provide pharmaceutical care for patients on this topic?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------
- Was the information in this lesson relevant to your practice?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------
- Will you be able to incorporate the information from this lesson into your practice?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
------------------------------	-----------------------------	------------------------------
- How satisfied overall are you with our program?

<input type="checkbox"/> Very	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Not at all
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(Please allow 6-8 weeks for notification of score)

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