Pharmacy Madness
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The patient had only minor shortness of breath upon climbing two flights of stairs, despite a left ventricular ejection fraction of 30%. He was stable and doing well on digoxin, diuretics, beta blockers and an angiotensin-converting enzyme (ACE) inhibitor. However, a troublesome dry cough was becoming intolerable to the patient. After discussion with him, we elected to consider a trial of an angiotensin receptor blocker in place of his ACE inhibitor. Accordingly, I wrote him an appropriate prescription for an angiotensin receptor blocker for this three-month trial. That afternoon, I received a voice-mail message from his local pharmacy. I returned the call, fully expecting to discuss a suggested change to another “sartan.” Instead, I was surprised by the information that the patient’s health care plan did not have an angiotensin receptor blocker on its formulary. I was especially troubled because he belonged to one of the largest health care plans in northern California. I was told by the pharmacy that I had to call the plan’s formulary number directly to plead my case for the change in medication. Accordingly, I called the number. After a series of sorting through recorded telephone prompts, I was told that I needed to hold for the next available “pharmacy technician.” Every 30 seconds, a recorded message assured me that my call was important, and extolled the virtues of the pharmacy charges or reimbursement plan, patients ask me to write prescriptions for all of their OTC medications. The price of medications prompts some patients who have difficulty paying for medicine to ask (and sometimes beg) to receive free samples, and as many as possible. When I write prescriptions for multiple medications for elderly patients, I receive letters trying to “educate me” on why, in a given patient, I should switch from one drug to another in the same class.

At our academic institution, the outpatient pharmacy was closed because it lost too much money. I sit on our Pharmacy and Therapeutics Committee, which approves new drugs. The ONLY criterion for formulary approval in a given class is PRICE. New drugs face an incredible barrier to being approved unless they are cheaper. There is a circulating pharmacy SWAT team whose goal is to reduce inpatient pharmaceutical costs in specific areas.

Patients also contribute to pharmacy madness. Frequently, I need to write two prescriptions for the same medications, so that the patient can send one of them to a mail order pharmacy. Depending on the particulars of their pharmacy charges or reimbursement plan, patients ask me to write prescriptions for all of their OTC medications. The price of medications prompts some patients who have difficulty paying for medicine to ask (and sometimes beg) to receive free samples, and as many as possible. When I write prescriptions for multiple medications for elderly patients, I have grave concerns about their compliance and their ability to pay for the medications.

In reviewing all of the above, I believe that PHARMACY MADNESS has gone too far. In order to restore rationality to this process, it seems to me that certain principles need to be considered:

- Economics is the underlying driving force. Thus, pharmaceutical companies need to re-think their pricing of drugs. Many countries have price controls on pharmaceutical products. It is estimated that Americans overpaid $16 billion in 1998 on a total bill of $120 billion.
- Physicians should have an opportunity to prescribe appropriate medications for their patients.
- Health plans need to remove hassle factors and bureaucratic disincentives as ways to control prescribing patterns.
- The whole process needs to be simplified and as uniform as possible.
• Special considerations need to be available for certain groups such as the poor and the elderly.

Sorry, I had other principles to discuss, but I have to go. I have to phone a pharmacy about a “simple” medication change.

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