

CASE AND COMMENTARY

What Does Good Pharmacist-Physician Pain Management Collaboration Look Like?

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Abstract

Physicians and pharmacists have critical roles in addressing the current opioid epidemic and ensuring appropriate care for patients with pain. Both physicians and pharmacists have responsibilities to ensure that opioids are prescribed and dispensed for legitimate medical purposes and to meet legal requirements. Health care systems have implemented policies to curb opioid prescribing and dispensing, but many of these policies place additional pressures on clinicians and can cause friction between physicians and pharmacists. Cases discussed in this article highlight 5 optimal physician and pharmacist behaviors that can help foster better collaboration between these clinicians, improve management strategies, and improve care of patients with pain.

Multiple Opioid Prescribers

Case. KT is a 33-year-old man who enters a pharmacy with a history of chronic back pain. He hands the pharmacy technician 2 prescriptions: one for oxycodone extended release (ER) 40 mg, 1 tablet every 12 hours; and one for oxycodone 5 mg, 1 tablet every 4 to 6 hours as needed for pain. As the pharmacist is reviewing the prescriptions, she sees the patient has recently been taking hydrocodone/acetaminophen 10 mg/325 mg, 1 tablet every 4 to 6 hours as needed for pain, and that these new prescriptions are from a different physician who practices in a nearby state. Concerned about the significant increase in opioid dosage and the potential presence of multiple prescribers, the pharmacist calls the office of the physician who wrote the new prescriptions and asks to speak with the physician. After a brief hold, the physician answers the phone and asks the pharmacist in a noticeably defensive tone, “Why are you questioning me? What do you know about this patient?” The pharmacist begins to explain her concerns about the patient’s dosage, but the physician interjects and states that she should fill the prescriptions as they were written. The pharmacist then tries to discuss the potential concurrent opioid prescriptions from 2 different prescribers and verify the increase in dosage. The physician reiterates that the pharmacist should fill the prescriptions as written. At this point, the pharmacist states that she won’t be able to fill the prescription without verification that the physician is aware of the other prescriber and the past use of a lower dosage prescription opioid. The physician quickly provides the needed information, confirming that the patient has been instructed to take the long-acting ER

dosage consistently, discontinue hydrocodone-acetaminophen, and hold off on the short-acting opioid for a week to adjust to the higher ER dose and take that medication only as needed. The physician ends the call by telling the pharmacist, “You don’t have the knowledge, so you shouldn’t attempt to practice medicine.”

Commentary. A patient has obtained opioid prescriptions from 2 different physicians, with a significant increase in dose and associated risk. Pharmacists, like physicians and other health care professionals, are committed to optimizing patient outcomes and ensuring patient safety. Pharmacists have a professional responsibility to comprehensively review a patient’s medication profile and to review all possible safety concerns in a patient’s medication regimen while also considering current **evidence-based pain management** and geriatrics guidelines. In addition to their professional practice responsibilities, pharmacists must also meet legal obligations, including Drug Enforcement Administration (DEA) **requirements for controlled substances**. DEA rules mandate that both physicians and pharmacists have responsibilities to ensure that controlled substance prescriptions are written for a legitimate medical purpose.¹ Certain factors, such as prescriptions from different states and multiple prescribers, can be red flags for potential opioid use disorder.

Community pharmacists often have the benefit of access to information about patients’ medications prescribed by multiple physicians and can comprehensively evaluate medication regimens for safety and other potential therapeutic problems. What they often lack is access to important information such as diagnoses and prescribers’ goals of therapy. Significant concerns about a patient’s medication(s) might require the pharmacist to contact the prescriber to discuss the concerns, verify information, and provide recommendations. In addition, a patient’s health plan might also require that pharmacists verify information with the physician’s office in order to adjudicate the prescription claim. Increasingly, pharmacists are required to include a diagnosis code with the prescription claim or verify that the prescriber was contacted to discuss high opioid dosages. Physicians and pharmacists are under tremendous time pressure, and calls are not made lightly. Some questions can be addressed by office staff, but others are most effectively resolved by a direct conversation between the prescribing physician and the pharmacist.

Effective, comprehensive chronic pain management often necessitates **multidisciplinary coordination** and a multimodal approach to care.² More generally, interprofessional collaboration is key to high-quality, patient-centered care.³ The Table details selected behaviors that can facilitate improved physician-pharmacist collaboration and the resultant management of patients with pain.³ In all cases, the patient is best served when pharmacists and physicians communicate in an effective, efficient, and professional manner, without bias, and with a patient-centered focus that facilitates collaboration and active engagement in finding solutions and resolving conflict. Clinicians also have a professional responsibility to understand and appreciate the roles and responsibilities of others in promoting the best care.

Table. Desired Behaviors of Clinicians for Optimal Collaboration in Pain Management

- Communicate respectfully, openly, and without bias, with a patient-centered focus.
- Establish rapport and build trusting relationships.
- Embrace and appreciate the roles and responsibilities of other health care professionals.
- Show empathetic behaviors for the patient and other health care professionals that include avoidance of stigma.
- Actively engage in finding solutions and resolving conflict.

Source: Interprofessional Education Collaborative³ and Owen JA, Skelton, JB, Miller WA, Moon JY, and Romanelli F (unpublished data, 2020).

Additional information from the prescriber will often assist the pharmacist in (1) discussing with the patient how to take the medication(s); (2) providing education on topics such as side effects, drug interactions, risks and benefits, and storage and disposal; (3) monitoring patient experience with medication(s) and medication adherence; (4) identifying and mitigating risks, ensuring that prescriptions are legitimate, and ensuring that unintended duplication of therapy from multiple prescribers is addressed; and (5) improving coordination of medications among clinicians. Without this information, the pharmacist in this case could be faced with the ethical and legal dilemma of deciding whether to fill prescriptions that could be unsafe for KT, while recognizing KT's need for effective pain management.

Transition of Care

Case. CR is a 70-year-old woman who enters the pharmacy with all of her medication bottles and a set of discharge orders from her most recent visit to the hospital after undergoing orthopedic surgery. CR asks the pharmacist for help in sorting everything out and states she is worried about taking too many medications. Looking at the orders, the pharmacist notes that several medications from CR's home regimen have been discontinued and helps CR go through her medications to clarify which ones she should stop taking. After reviewing CR's remaining medications, the pharmacist notes that the discharging clinician has retained her home medications of tramadol 50 mg, 1 to 2 tablets every 8 hours as needed for pain; and cyclobenzaprine 10 mg, 1 tablet every 8 hours as needed for muscle spasms. Additionally, the hospitalist added to CR's regimen oxycodone 10 mg, 1 tablet every 4 to 6 hours as needed for pain; and zolpidem 10 mg, 1 tablet at bedtime for sleep. The pharmacist contacts the hospitalist to explore possible changes in therapy, recognizing the patient's interests in decreasing the number of medications she takes and noting safety concerns for a patient of CR's age taking concurrent opioids and hypnotics, due to the increased risk of overt central nervous system (CNS) depression and falls.⁴

The physician who comes on the line is familiar with the pharmacist and greets her warmly. She states that a nurse colleague took the medication history and verified that the patient had been taking all these medications regularly. The pharmacist explains that the cyclobenzaprine and zolpidem prescribed are on the American Geriatrics Society BEERS Criteria®, a list of medications that are potentially inappropriate to use in the elderly and therefore should be avoided in most instances.⁴ The physician agrees with the pharmacist that the zolpidem warrants caution and gives a verbal order to

change the zolpidem to 5 mg 1 tablet by mouth at bedtime for sleep, with a plan to discontinue in 10 days. While CR's pain is too severe to go without opioid analgesics, the physician agrees with the pharmacist that she does not need both tramadol and oxycodone. Together, they decide to advise CR to use the oxycodone for a short period of time for severe pain and to discontinue tramadol while taking the oxycodone. The pharmacist asks the physician about the cyclobenzaprine, stating concern about the patient continuing it with the opioid and zolpidem because of the risks associated with CR's regimen containing 3 CNS depressants. The physician informs the pharmacist that the patient expressed a strong desire to stay on the cyclobenzaprine. The pharmacist contacts the patient's primary care clinician to discuss the changes in therapy, including a plan to wean her off the cyclobenzaprine and reduce her fall risk.

Commentary. This case presents a very common scenario in community pharmacy in which problems arise for patients in transitions of care from hospital discharge to home. Patients often have questions regarding discharge orders, and community pharmacists often have limited information available except what is written on the discharge prescription orders. Adding to the complexity of the situation is the fact that open lines of communication between pharmacists and physicians can be lacking, with messages often having to be relayed through several intermediaries. There are often multiple clinicians whose input is needed in order to effectively coordinate care, involving many practice settings across the health care system.

The 5 behaviors detailed in the Table were optimally exhibited in this case. Good rapport and trust were exemplified by the physician and pharmacist, and both clinicians placed the patient at the center of care. The physician and pharmacist both expressed empathy for the patient and understood the complexities of navigating the health system. They actively collaborated to promote optimal outcomes for the patient. Once again, recognizing time constraints, the pharmacist succinctly and effectively detailed the problems and provided recommendations for moving forward. Care was improved by both clinicians sharing information about the patient, and a readmission might have been prevented.

In care transitions and common practice situations, collaboration between physicians and pharmacists is paramount to ensuring the best possible care. **Transitions of care** are among the most vulnerable points for patients, given the complexities of their having multiple clinicians and needing to navigate new, existing, and discontinued medications. There is also need for better mechanisms to collect medication histories⁵ and better methods to coordinate care. Pharmacists often find that patients begin taking discharge medications while simultaneously taking medications they had at home prior to discharge.^{6,7} Emphasizing behaviors that reinforce empathy for the patient, together with appropriate communication, collaboration, and respect for the roles of all parties involved, is critical for addressing and resolving potential safety problems and optimizing patients' medication regimens.

Conclusion

Effective management of chronic pain often requires a multidisciplinary, multimodal approach. These cases highlight 5 behaviors that can improve care, avoid untoward events, and facilitate collaboration among physicians, pharmacists, and other clinicians: (1) communicating respectfully, openly, without bias, and in a patient-centered manner; (2) establishing rapport and building trusting relationships; (3) embracing and appreciating the roles and responsibilities of other health care professionals; (4)

showing empathy for the patient and other health care professionals and avoiding stigma; and (5) actively engaging in finding solutions and resolving conflict. Incorporating these behaviors into daily practice can foster a coordinated, patient-centered approach to care and optimize patient outcomes.

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