

Chronic pain

continued from page 1

4. Get to know patients who regularly bring in opioid prescriptions.

Most pain patients, after bumping around a sometimes-uncaring health-care system, are delighted to have a health professional take an interest in them. You can diplomatically ask why the patient is taking the pain medication when you counsel them. If you get a negative reaction, it could mean the patient has had a poor experience with a pharmacist in the past. I belong to an online chronic-pain support group and one of the most popular topics under discussion is "Why I Hate Pharmacists." Everyone complains about "The Look" – that glare of suspicion and hostility that pharmacists shoot at patients with an opioid prescription.

5. Be aware of the physical challenges of your patients.

Often when I limp into a pharmacy, I'm surprised to find that there is no place to sit down. Sometimes there's hardly room to stand. This makes waiting for prescriptions very difficult but, like many people who take opioids, I don't drive anymore; returning to pick up a prescription may not be possible, and I am forced to stand, wedged up against a shelf of cough syrups, and wait for my prescription to be filled.

6. Try to practise empathy with everyone.

How would you feel if you had to go into a pharmacy with a prescription for methadone, or OxyContin®? Could you cope with the stigma of taking chronic opioids? Think how you would feel if you were in pain and suffering from multiple side effects, and someone treated you like a drug addict every time you picked up your medication.

When I was practising pharmacy, I thought I always kept in mind the saying, "There but for the grace of God go I." Having been on the other side of the pharmacy counter, I now realize how little understanding I had of my patients and their conditions. I hope I keep the thoughts I've shared in mind when I get back on the pharmacists' side of the counter.

What Went Wrong

Dear college,

My allergist prescribed a drug to help with the severe itchiness I sometimes get all over my body. I got the medication from the pharmacy and took one to two tablets each night, as directed on the label, over the next three months.

When I went to the pharmacy to order a refill, I found out that a dispensing error had been made. I had been taking hydrochlorothiazide, a drug used for high blood pressure, for the last three months!

I've read on the Internet that hydrochlorothiazide can cause dehydration, low potassium, low blood pressure, and high blood sugar. Thankfully, I haven't noticed anything unusual over the past three months, but if the error had never been noticed, I would have received a refill of the wrong medication too, and taken it for another three months.

Horrified about hydrochlorothiazide

The pharmacist involved reports:

- The prescription was clearly written for hydroxyzine 25mg tabs, 1-2 tabs po qhs as needed, 60 tabs.
- "The prescription was written for 'tabs.' Hydroxyzine is customarily ordered as capsules. I inadvertently misinterpreted and processed this prescription as hydrochlorothiazide."
- When the patient ordered a refill of her "itching medication," the error was identified.

What steps could be taken to prevent such a situation?

1. Always ask yourself about the appropriateness of therapy, dose, route, frequency, duration, and dosage form before dispensing. In this case, answering these questions may have assisted with detection of the error:
 - a. Is it appropriate to take hydrochlorothiazide at bedtime?
 - b. Is it appropriate to take hydrochlorothiazide on an as-needed basis?
 - c. Is it appropriate to take 25-50mg of hydrochlorothiazide as a starting dose?
2. Pay attention to the prescription's details. In this case, the prescription pad was pre-printed with "ALLERGY & CLINICAL IMMUNOLOGY." At other

times, prescribers may include the drug's indication. This provides another opportunity to confirm that you are dispensing the right drug.

3. Involve two pharmacists in the dispensing process – one to process the prescription, and another to perform a final check. If this is not possible, step away from a prescription and try to clear your mind before conducting the final check.
4. When performing the final check, adopt the attitude that there is something wrong with the label and that it is your job to find the problem. First examine the written prescription and "set in your mind" how the label should read. If you check the product the other way, and read an incorrect label first, it might "set in your mind" that the label is correct.
5. Always provide thorough patient counseling before the patient leaves the dispensary. In this case, if the pharmacist had explained that hydrochlorothiazide is a diuretic used to manage high blood pressure, the error may have been caught. Likewise, if the pharmacist had prompted the patient to answer why the medication was prescribed, the error may have also been caught.