A Day in the Life of a Corporate Retail Pharmacist

It was the Tuesday after Memorial Day and my fourth consecutive 13-hour day in the pharmacy. Having just passed the boards, I landed a job as a floating staff pharmacist. It was my first time working at this store and my third store in as many days. I did not know what to expect except that, as usual, I would be the only licensed pharmacist working here today. This fact struck me as a microcosm of my profession's ineffectualness—an ineffectualness resulting from misaligned objectives and poor processes of care, afflicting first pharmacists and, ultimately, patient care.

Today's store was small and old, the mirror against the wall a vestige of the soda fountain of years past. The fibrous carpet, with its familiar gray-square pattern, was the same as that at the two megastores where I worked over the weekend. Familiar, too, was the impending tumult of the day, which was as disruptive to the 20-year veteran pharmacist who managed this store as it was to me.

Arriving at the pharmacy, I entered the alarm code and raised the dusty gate. I prepared the cash register and logged into the ancient computer system, wondering when the pharmacy technician was due to arrive. Fifty new refill requests awaited. I preferred to arrive early for busy shifts, especially on a Tuesday after a holiday, but it was against corporate policy.

I answered the telephone. "Jim, this is Rocco. I need my orange pills and my inhaler," the caller said.

"Sir, Jim has the day off. I'm filling in for him. Let me see whether I can help you. What is your last name?"

He hung up. I answered a second call. It was the practice nurse from one of the local primary care providers responding to a question left on voicemail the previous evening. Prescriptions with pending problems are conventionally left in plain sight, but I found no note or other evidence of the situation. Perhaps the permanent pharmacists would have known of this issue, though not through any evident record-keeping system. No two systems were alike.

"I'm sorry, but I'll have to call you back," I said.

She hung up, wasting no time on pleasantries. My anxiety grew.

Standing alone in the pharmacy, I turned my attention to the now 60 prescriptions waiting. I spent the next 10 minutes processing the prescription orders, overriding the many warnings that popped up on the computer screen, thinking of the alarm fatigue that my colleagues at the hospital experience with medical equipment. The whirling of the laser printer drowned out the overhead music.

The first technician arrived 15 minutes late and began counting tablets on a small plastic tray by using a spatula that resembled a butter knife. Meanwhile, I was caught in a proxy battle with an insurance company. They no longer paid for olmesartan. A patient would have to use an alternative drug that her insurance company now preferred.

I called the physician's office to request a substitution, cursing the fact that I could not make the substitution without a physician's approval. After waiting on hold for several minutes, I left a message requesting a prescription for valsartan. I made a note to call the customer, who had not yet learned that her prescription was changing.

The technician was also on the telephone, and four customers arrived at the counter in rapid succession. The first woman tapped her keys on the counter, apparently to ensure that we noticed her. I smiled at her while my anxiety mounted.

After hanging up the telephone, I greeted the woman at the counter. She handed me a prescription for isotretinoin, for which the Food and Drug Administration required a special program for therapeutic risk management. I had to call a telephone-based registry system before filling the prescription.

"I have a new insurance card," she said, handing me a card that had no information that could be used for billing a pharmacy claim.

"You should have received a separate card for your pharmacy coverage," I told her. "Do you have it?"

"I didn't get it."

"I'll call the insurance company," I said.

"How long will it take?"

"About 30 minutes."

"But your advertisement says that prescriptions will be filled in 15 minutes or less."

She was right.

"I'm sorry, but that is not feasible at the moment. I'll finish it as soon as possible," I said.

She walked away with an angry look. I didn't notice, but that day I had not yet used any knowledge of pharmacotherapy that was the focus of my training.

The next customer was an overweight, out-of-breath woman in her mid-70s named Mrs. da Silva, who arrived with her daughter. Mrs. da Silva was a regular customer who spoke only Portuguese. Translating, the technician told me that Mrs. da Silva was just discharged from the hospital for what I inferred was an acute myocardial infarction. I had no access to her actual diagnosis or medical records. Mrs. Da Silva handed me 12 prescriptions written by the hospital's housestaff.

In subsequent moments, I prioritized the filling of Mrs. da Silva's prescriptions; her pale appearance suggested that she would be better off resting at home than sitting on a bench next to the pharmacy. The chaos of the routine prescription-filling circled just beyond my attention.

As the technician translated, I began counseling Mrs. da Silva on the importance and logistics of taking the medicines. I realized quickly that she learned very little about

the medications from her doctors at the hospital, which came as no surprise. During the inpatient rotations of my training, I learned how hectic hospital life could be for medical interns and residents.

Then, a second technician whose arrival I barely noticed interrupted to tell me that I had to take an urgent telephone call from a cursing customer. The caller was a man irate about the copayment for the prescription that his daughter had just picked up. When I returned to the counter, Mrs. da Silva was gone. I contemplated calling her when she arrived home but was interrupted by a beeping noise indicating that a car was at the drive-through pharmacy window.

"She just wanted to go home," said the technician who had translated.

I do not know why I allowed my conversation with Mrs. da Silva to be interrupted except that a typical day at a corporate pharmacy involves being understaffed and overworked, resulting in the need to address one urgency after another. Technician help is scarce, not because there are too few technicians but because corporate overseers allocate staffing resources.

Moreover, prompt responses are expected in retail, even if I have no influence over the physician's choice of drug or the insurance company's coverage policies. The large corporate pharmacies limit staff in favor of profit and promise convenience instead of health care. I also know that continuity of care after discharge from the hospital is imperfect and that community pharmacists are the most accessible health care providers.

As a community pharmacist, I cannot be expected to be a patient's primary care provider; indeed, physicians must follow their sickest patients closely. However, it seems that improving the patient-centeredness rather than profit-centeredness of pharmacy care would prevent lost opportunities for patient–provider dialogue, such as that with Mrs. da Silva.

Reflecting on the reasons why I went to pharmacy school, I recall that in my precollege years I had simply wanted a future career where I could help people. Although I considered a range of options, the college of pharmacy's recruitment materials touted the effect that one could have after completing the required doctoral-level training. Perhaps in a different practice setting that effect could be realized.

I spent the remainder of the day filling the 400 prescriptions that were waiting for my attention, talking to customers and physicians' offices on the telephone, and answering routine questions at the counter, all the time being rushed by the incessant flow of work. Yet, when I walked away from Mrs. da Silva, I knew that I had missed the most important opportunity that day to provide real pharmaceutical care.

Several months later, I was back at the same pharmacy working with the same technicians when Mrs. da Silva's daughter came in to tell us that her mother had died. With sad eyes, she told us that it was unexpected, because Mrs. da Silva had made a promising recovery from the first heart attack.

When I opened her pharmacy record to document that she was deceased, I noticed that Mrs. da Silva had never refilled her 12 prescriptions. My heart sank. To this day, I wonder whether Mrs. da Silva died of a diseased heart or a broken pharmacy system.

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Ann Intern Med. 2013;159:366-367.