Memorandum concerning Nevada Pharmacy Alliance

To: Nevadans not wishing to die from "pharmacy misadventures"

Fr: B. Eliot Cole, MD, MPA

Re: Proposal of the Nevada Pharmacy Alliance to expand scope of pharmacist licensure

Da: October 14, 2024

Have you been to a chain or retail pharmacy recently? Have you noticed that in a shift, a typical chain or retail pharmacist fills 300+ prescriptions, answers telephone calls, administers vaccinations, performs med-med and med-supplement interaction checks, provides counseling, does some point of care tests, advises women about contraceptive options, may even oversee Medication Assisted Treatment for those with Opioid Use Disorder (OUD). Now, the Nevada Pharmacy Alliance proposes that pharmacist be allowed to order from a long list of Clinical Laboratory Improvement Amendments (CLIA) waved tests, provide interpretation, and render treatment by prescribing "drugs, drug categories or devices." No physical examination is required, no adequate history is obtained beyond whatever a person might tell the pharmacist, and no training is specified even though MDs and DOs were required to have no less than 8-hours of advanced federal training just to prescribe buprenorphine sublingual for the treatment of OUD according to the enabling federal Legislation, DATA-2000.

Step back for a moment and separate "access to care" from competence of care provided? Why did the Nevada Legislature 45 years ago decide that MDs had to receive no less than 3 years of post-graduate residency training to be eligible for Nevada medical licensure when most other jurisdictions only mandated an "internship" of one-year? At that time, Nevada was thought to have very poorly trained physicians, so having them become specialists was preferable to only being generalists. Why was a "face-to-face" interview required before two examiners of the Nevada State Medical Board in the specialty I claimed to have taken in residency to obtain a medical license in Nevada through the 1980s? I was told by one of my examiners it was to confirm "you are white and speak English."

Access to care in Nevada is still questionable, and unequally provided throughout most of rural Nevada. That said, having physicians prescribe and pharmacists dispense has been equivalent to two-factor authentication for decades. I write a prescription knowing what patients tell me, and I hope that a pharmacist with access to all of patients' medication history, will thoroughly check for drug-drug interactions, drug-supplement interactions, contraindications posed by medical conditions that were not reported to me as a specialist in Psychiatry. Having pharmacists first attempt to diagnose, then decide what confirmatory tests are warranted, before dispensing a medication with inadequate or no follow up care is below the acceptable standard of care for physicians. Sadly, I would expect Pharmaceutical Benefits Managers (PBMs) to love this idea, since it cuts out the physician, and allows them to enforce a more narrowly defined formulary. This will allow PBMs to enforce "step-therapy" and "prior authorization" that SB167 tried to negate in the 82nd Legislature.

In doing this real time "experiment" with Nevadans, we should prospectively define acceptable and unacceptable outcome. Acceptable might be careful identification of patients, reasons for seeking care, diagnostic methods employed, medications dispensed, and clear evidence that conditions under treatment were resolved and/or effectively managed to lessen utilization of higher levels medical intervention. Unacceptable outcome should be defined as unanticipated death, need for higher levels of medical intervention, delay in diagnosis or treatment with disease progression, outright harm from pharmacist misadventures, malpractice claims against pharmacists, and results of coroners' inquests.

I have worked on many treatment teams with PharmD colleagues, hospital based, and the care we collectively provided was superior to that I could provide alone. Treatment teams always bring a level of wisdom not seen in individuals, because in a world of one, you are mostly/always right. I applaud Drs. Stone and Orentlicher for thinking outside of the traditional box but need to stress that they may not have considered the "pine box" outcome I described above.

Do not grant Nevada chain and retail pharmacists the authority to practice medicine without supervision. Residents in all medical specialties are supervised until they complete all training, regardless of years involved. We can do better than this.