

scriptions with categories of conditions (or symbols for organ systems) that the physician simply ticks off<sup>2</sup> (e.g., “cardiovascular” or “neurology or mental health”). The vast majority of prescriptions are for conditions that are unlikely to generate privacy concerns for patients, such as hypertension, diabetes and gastroesophageal reflux. Stating the indication for the prescription will also provide important information for patients, many of whom have difficulty keeping track of which prescription is for which medical condition.

Bhanji’s concerns about the legal and ethical protections for electronically stored medical information and about the possibility that commercial interests will hijack electronic prescribing for mass marketing have received widespread attention. They should not stop us from proceeding with important advances in managing health information; similar concerns in other sectors have not prevented us from now routinely making electronic transactions involving important personal information.

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## Prescribing powers for pharmacists

At a time when the impact of diagnostic error on patient safety is finally being appreciated, the news that pharma-

cists in Alberta will be allowed to diagnose medical conditions<sup>1</sup> will generate alarm and some despondency among researchers in this area.

There is now abundant evidence that delayed or missed diagnoses are widespread and that in more than 50% of such cases there are serious adverse outcomes. They are the primary source of litigation against both family physicians and emergency physicians.<sup>2</sup> Not infrequently, apparently simple presentations of illness turn out to be incipient catastrophes. Dissecting aortas present as constipation; subarachnoid hemorrhages as muscle tension headaches; acute myocardial infarctions as stomach upset; and meningitis, encephalitis, cavernous sinus thrombosis, peritonsillar abscess and epiglottitis as the common cold. It is extremely easy to be fooled, and one is more easily fooled when one fails to elicit a history of the presenting illness and a relevant past medical history and to perform a physical examination. The money that pharmacists will have to pay for \$2 million in personal professional malpractice insurance<sup>1</sup> will be well spent.

Besides this overarching safety concern, the other major problem is the potential for conflict of interest: pharmacists have a commercial interest in what they prescribe. Pharmaceutical companies will certainly waste no time in “detailing” pharmacists. Sadly, physicians have adapted poorly to the variety of creative, insidious and sometimes unethical marketing practices that the pharmaceutical industry has used to influence them.<sup>3</sup> Human nature being what it is, pharmacists will be especially vulnerable in this regard owing to their proximity to the patient-medication interface.

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## Preventing adverse drug events

I read with interest Alan Forster’s article on preventing adverse drug events after hospital discharge.<sup>1</sup> In the 2 cases he outlines, it is likely that the involvement of a hospital pharmacist would have helped to prevent the adverse outcomes described.

The pharmacists in our small community hospital, which serves a largely geriatric population, offer a service that helps to minimize some potential problems with medications at discharge. For many patients, the pharmacists create a “discharge medication profile,” which is reviewed with the patient or their family members or both at discharge. These profiles are typically provided for patients who take more than 5 medications on a chronic basis, for whom several new medications have been prescribed, or whose medication types and dosages have been changed during their hospital stay.

To create the profile, the pharmacist completes a table that includes all current medications, directions, times to take each medication, the medical condition for which each medication is prescribed and any special instructions, all in easy-to-understand language. The pharmacist ensures that the patient has any new prescriptions that are required and will contact the prescribing physician if the prescriptions have not yet been written. The pharmacist also informs the patient which medications he or she should stop taking or take differently at home. The pharmacist may liaise with the patient’s community pharmacist to arrange dosette or blister packing or to update him or her about medication changes.

The discharge medication profile is an accurate and legible medication list that can be used by other health care providers, such as home care nurses and community pharmacists. A copy is sent to the patient’s general practitioner