The Pharmacist Activist

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"Show me your ways, O Lord, teach me your paths; guide me in your truth and teach me, for you are God my Savior, and my hope is in you all day long." Psalm 25: 3-4

Editorial

The Value and Need for Meetings of Pharmacists

The APhA Annual Meeting in Phoenix

I have often stated my hope that every student pharmacist could attend a national pharmacy meeting. In addition to being a value-added addition to the curricular and college experience, the educational, professional, and social opportunities of pharmacy meetings are energizing and motivating in a manner that increases enthusiasm for and pride in our profession. Although many student pharmacists have enjoyed and benefited from this experience, most have not. I and others have not done enough to achieve that "hope," but I continue to view it as an important goal and encourage the leadership of colleges of pharmacy and the national pharmacy associations to actively explore this possibility. The locations and dates of national meetings must be confirmed several years in advance. One strategy for a college of pharmacy that is located in or near a city in which such a meeting is scheduled could be to not hold classes or exams on those dates, collaborate with the association holding the meeting to provide sponsorship, transportation and expenses for its students, and require (with exceptions for special circumstances) students to attend. I view this as an initial strategy that does not preclude consideration for making these arrangements for traveling to a national meeting in another city. I anticipate that the colleges of pharmacy which do this will add value to their program (and recruitment initiatives), and establish a model that other colleges will emulate.

The restrictions and cancelations of "in-person" meetings and other programs resulting from the COVID-19 pandemic have increased the difficulty in maintaining the recognition of the value of such gatherings. Some have adapted so quickly and effectively to remote and virtual means of communication and conducting business that they now view participation in and travel to "in-person" meetings as costly, inefficient, inconvenient, and unnecessary. I do not underestimate the value of remote and virtual communication, but these approaches must be used to enhance rather than replace the benefits of gathering in meetings.

The APhA meeting

Upon arriving at the hotel in Phoenix, I was greeted by multiple pharmacy friends from around the country in the lobby before I

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even joined the line to check-in and obtain my room. The hallway and mealtime discussions with previous and new pharmacy friends are always a highlight of my attendance at professional meetings. I made the observation to some that my APhA meeting would not be complete without visiting with them.

There were dozens of educational programs on timely topics and, for many, the most challenging decisions to be made during the course of the meeting were which program to attend when several of interest were held concurrently. The plenary sessions included presentations from APhA leadership and opportunities to learn from and be inspired by the accomplishments and perspectives of those who were being honored with awards. The House of Delegates conducted the business of the association that included the review of current policies and the consideration of new policies. And the exhibit program facilitated discussion and learning about new products and services, as well as other pharmacy and healthcare organizations and programs.

The APhA has recently committed extensive time and resources to acquire confidential and anonymous reports about positive and negative pharmacy workplace experiences with the use of the Pharmacy Workplace and Well-being Reporting (PWWR) digital tool. The aggregated data that is being collected is to be "used to help educate the pharmacy community and leaders about the meaningful, measurable, and actionable changes that are needed in pharmacy practice." There were several programs regarding these issues and the data collected to date, which is an important, although belated, initial action. However, this was also the only part of the overall meeting about which I heard significant frustration voiced by those who attended. There was disappointment in the typical format used in considering these topics that included a presentation regarding the information obtained to date and discussion among members of a panel, with very little time available for attendees to share their own experiences or ask questions. Some were "turned off" by a statement at the beginning of at least one program to the effect that, because of antitrust laws and concerns, the names of specific pharmacy employers can't be mentioned during the discussion or the meeting would not be continued. This generated skepticism as to what, if any, constructive actions would be taken if the employers about whom the greatest concerns exist, can't be specifically identified. It is likely that this restriction exists on the advice of APhA's legal counsel, but I do not expect any pharmacist to be satisfied by that explanation. For those who have any question with respect to the identity of the employers with the worst workplace conditions, I can help by providing a short list that includes but is not limited to CVS, Walgreens, Rite Aid, etc. But just don't tell anyone you heard that at an APhA meeting, or even in a summary of it!

Membership

Readers of *The Pharmacist Activist* include pharmacists who are among the most actively involved in our profession and you may be wondering why I identified the general programming of the APhA annual meeting with which you are already very familiar. My reason is that the large majority of pharmacists in the U.S. have never been to an APhA annual meeting or a national meeting of any other pharmacy organization. The number of pharmacists who are members of APhA is a small minority of the total number, and the membership of any other national pharmacy association is even smaller, but my focus for now is on APhA.

I would like to think that most pharmacists would agree that it is important, and probably essential, that there is an organization that represents and is an advocate for the entire profession of pharmacy. However, if that observation is accurate, why does the membership of APhA include only a small minority of licensed pharmacists? The consideration of this question is beyond the scope of this commentary, but I would contend that every pharmacist should be a member of APhA as a responsibility of our citizenship in our chosen profession. Given the membership dues and participation of only a small minority of pharmacists, the most probable current reality is that it is remarkable that APhA accomplishes as much as it does. However, member pharmacists should expect accountability from leadership, explanations for decisions and actions for which there may be differences of opinion, and even the consideration of a more effective national organization structure for our profession (although I have almost given up on the latter).

Some pharmacists are of the opinion that most physicians are members of the American Medical Association (AMA) and that the AMA has much greater strength and political and other influence than pharmacy and APhA do. However, that is not the case, and medicine and the AMA experience most of the same challenges that exist in pharmacy. Some consider the professions of dentistry and nursing to be more effective than pharmacy and medicine, primarily because dentistry has been able to avoid control by health insurance companies and government agencies, and because a much higher percentage of nurses are unionized than the members of other professions. What can pharmacy learn from dentistry and nursing?

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The Consequences of COVID and the Deception of the Three-Letter Giants

The COVID-19 pandemic has resulted in millions of deaths, as well as a bitterly divided world that searches for solutions and answers. Those who do not support, or even question, the agenda and mandates of those with authority are ostracized as conspiracy theorists or purveyors of misinformation. However, after three years of deaths, devastation, mandates, and closures, the deception of the three-letter giants is being exposed.

It started with the CCP (Chinese Communist Party). It is highly likely that gain-of-function research at the WIV (Wuhan Institute of Virology) resulted in the construction of a virus with a spike protein that escaped and rapidly spread with deadly consequences. The CCP denied the probable origin of the virus and refused access to important information, destroyed records and potential evidence, and silenced its members who had suspicions and questions.

Three years of pandemic have not resulted in "evidence" for the origin of the virus or, according to some, even a "consensus." The reality that the CCP will not permit access to pertinent information must be recognized. In the absence of "evidence" for the WIV origin, or any other origin of the virus, reason must prevail. There are sufficient reasons for a consensus that the virus originated in the WIV and that the "leak" of the virus caused the pandemic. The burden of proof of another origin must be accepted by the "lab leak deniers."

The WHO (World Health Organization) would not challenge the CCP's explanations and refusals, and compromised its commitment to health by succumbing to politics. USA government leaders and officials of the NIH, CDC, and FDA quickly became accomplices of the WHO. Government leaders imposed mandates for masking, closures of businesses and schools, and restricted gatherings and travel without supportive evidence for its actions or even attempts to assess and differentiate the level of risk from exposure to the virus of a population representing the entire spectrum of age, risk factors, diversity, and responsibilities. Increased compensation was provided when COVID-19 was identified (accurately or not) as related to illness and death, resulting in erroneous statistical data. Fraud involving billions of dollars was rampant.

The NIH was exposed as covertly and indirectly providing grant funding to WIV to support its gain-of-function research, and it attempted to discredit the voices of reason which supported the Great Barrington Declaration. The FDA and CDC collaborated in approving and promoting the use of vaccines prepared using a new promising but incompletely tested technology (Pfizer and Moderna vaccines) with very limited data to support effectiveness and essentially no data regarding short-term and long-term safety. Notwithstanding the value of the vaccines for many, limitations and risks were unknown and/or understated, and the FDA's and CDC's actions were used to support government edicts and mandates that required immunization for employment, travel, and other responsibilities. COVID-19 vaccine has been added to the childhood immunization schedules in spite of the fact that the risk of serious infection in children is extremely low. Experience (but not yet evidence) to date suggests that the vaccines may reduce the risk of serious complications of COVID-19, do not prevent infection or transmission, provide only a brief period of protection (e.g., several

months) that new and resistant strains of the virus can escape, and have had a temporal association with serious events such as clotting, myocarditis, stroke, and sudden unexpected death.

The AMA (American Medical Association) took the unprecedented step of declaring that medications that were already approved by the FDA for treating other conditions must not be used for treating or preventing COVID-19 without FDA approval for that purpose. In taking that position, the AMA 1) betrayed the rights of its members and other health professionals to exercise their expertise and best professional judgment in caring for their individual patients, and 2) threatened the hospital privileges, certifications, licenses, and reputations of those who would not comply with its edicts.

Chain pharmacies such as CVS responded to the professional opportunity to immunize millions of individuals. However, their already understaffed stores were overwhelmed by the added workload without adequate support that 1) exacerbated stressful workplace conditions, 2) increased the risk of errors and harm for customers, and 3) exposed the primary motivation of the chains increase profits.

Pharmaceutical manufacturers must not escape attention because the long-term three-letter designation (PMA [Pharmaceutical Manufacturers Association]) for their trade organization was changed to PhRMA. Pfizer terminated the clinical trials of its COVID-19 vaccine as soon as it acquired enough data to meet the anticipated but insufficient FDA expectations to provide emergency use authorization and subsequent approval (continuing the trials might only reveal problems and limited effectiveness). As a consequence, the vaccine was widely used and mandated with limited knowledge of its value and no information regarding long-term safety. In the development of Paxlovid for the treatment of COVID-19, Pfizer also ignored the opportunity to evaluate nirmatrelvir alone (the active component against COVID-19), but rather included ritonavir (for only the convenience of less frequent administration) which interacts with so many common medications that the use of the most effective treatment is precluded in many individuals.

Many of the media giants such as CNN and NBC not only embraced but strongly promoted without questioning the agenda, narrative, and deception of government leaders and the three-letter giants. As recently as last month, the NYT (New York Times) sensationalized the suggestion that the pandemic's origin was linked to raccoon dogs, a possibility that has lost credibility as suddenly as it was unexpectedly "discovered."

The NFT (National Federation of Teachers) was very creative, but destructive, in its development of reasons for keeping schools closed and, in so doing, exposed its self-serving motivations. And almost all rejected the benefit of immunity to COVID-19 that many acquired without immunization.

Those who voiced concerns or even questions were rejected and accused of being anti-vaxxers, vaccine deniers, or vaccine hesitant, but continuing experience suggests that their concerns are well-founded. We are told that the use of vaccines and other interventions has provided more value than risk, and specific numerical estimates of "prevented" COVID-19 hospitalizations and deaths are provided. However, can attempted quantification of possible but unknown "outcomes" that may not or have not occurred have validity?

The devastating consequences of COVID-19, coupled with the resultant mandates and restrictions, have seriously damaged the credibility of government leaders and the three-letter giants, as well as the stature of "science" and "evidence." Will those who are responsible have enough integrity and courage to acknowledge and apologize for their statements and actions that are now recognized as inaccurate and/or deceptive?

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Leadership Wisdom and Perspectives

***Editor's note:** As a value-added feature of* The Pharmacist Activist, *I am pleased to start including commentaries prepared by pharmacist leaders and other experts in this issue and some future issues.*

By Daniel Hoffman*

During the past few years, Dan Hussar on these pages has meticulously documented how abusive practices by the big pharmacy chains have overworked their pharmacists, provided them with inadequate support staff, and instituted hurry-up quotas that make it nearly impossible to fulfill the professional duties of a registered pharmacist. This has not only led to steeply declining morale and high resignation rates among those pharmacists, but it also deprives the public of many valuable services traditionally provided by community pharmacies. Patient counseling on new medications, management of polypharmacy regimens and alerts on adverse drug-drug interactions are just a few of the services on which chain drug pharmacists have been forced to stint.

As an isolated phenomenon, this subjugation of chain pharmacists would be bad enough, but the reality is that many other health care professionals have been similarly oppressed and forced to limit the quality of their services.

Currently 70% of physicians work for hospitals or corporate entities. Private equity firms have shelled out almost $1 trillion in recent years to acquire health care businesses in deals that are typically hidden from regulators. The results have been higher charges for physician services, more malpractice lawsuits, and increasing complaints about care.

Morale among practicing physicians has nosedived accordingly. Nearly half of all U.S. physicians claim they feel burned out, ten percent have thought about suicide and a majority plan to either leave their current positions or even the medical profession entirely.

The public suffers because physicians in practices owned by outside corporate entities such as hospital systems and private equity groups *charge more and spend less time with each patient*. Physicians in such settings are under greater pressure to see more patients and must follow more restrictive rules. The concentration of hospital and physician practice ownership into fewer hands inevitably increases healthcare costs across the board.

Also, as the duration of time spent with each patient has decreased, doctors more often write unwarranted antibiotic prescriptions for upper respiratory tract infections and co-prescribe opioids and benzodiazepines for patients with pain-related diagnoses.

The third leg of the therapeutic triad, nurses, similarly complain about being overworked and understaffed. Last September, 15,000 nurses in Minnesota *went on strike* to protest hospital understaffing that their union says has harmed patient care and exhausted health workers.

This country's expenditure of almost $4 trillion a year on health care, while the rest of the world combined spends only slightly more than amount, doesn't mitigate the adverse consequences for U.S. health care. Approximately 40 other nations have better outcomes.

If the U.S. doesn't produce good health care outcomes, the private corporations that make health care products generate most of their money here. The pharmaceutical industry earns almost 50 percent of its worldwide revenue in the U.S. and device makers make 40 percent of their money here. When it comes to net operating profits, approximately 75% of that derives from the United States. (As an example, see the annual report of AstraZeneca at https://www.astrazeneca.com/content/dam/az/Investor_Relations/annual-report-2021/pdf/AstraZeneca_AR_2021.pdf.)

This situation of speedup, overworking, and onerous conditions are not unique to health care professionals but also apply in many other areas of non-competitive, under-regulated capitalism.

Earlier periods of American history that were marked by the exploitation of workers achieved only checkered success at making the American political economy more humane and democratic.

The lesson from our history and its application to hard-pressed pharmacists working at the chain drugstores is that to achieve significant gains in income and working conditions, employees must do it for themselves by organizing and taking united action on their own behalf. Politicians, technocrats, the media, and activist reformers cannot do it for them.

My friend Dan Hussar believes that beleaguered pharmacists at places such as CVS and Walgreens should find ways to start their own independent pharmacies where they will be able to maintain professional integrity and properly serve the public. For a small segment, that may be a feasible course of action, but for the vast majority, independent pharmacy is an artifact of an obsolete past. Like vent windows in cars, water fountains on street corners and free sandwiches at taverns, most independent pharmacies will exist only as nostalgic memories.

Health care today accounts for almost 20% of the U.S.'s gross domestic product. As such it is a sector dominated by multinational manufacturers and payers, as well as providers owned by hospitals and private equity groups that each hold billions of dollars in assets. In this sector that caters to Wall Street's demands for quarterly returns, the hope of seeing independents as a substantial share of community pharmacies is quixotic.

Pharmacists must follow the lead of their colleagues among physicians, nurses, and graduate students by organizing, engaging in collective bargaining and, when necessary, striking.

Ever since the Progressive era (1890-1920), labor unions have been stymied by the reluctance of white collar, professional/mid-management/technical workers to join organized labor in the belief that unions are only appropriate for manual workers. As educated professionals, they have long considered themselves to be above the susceptibilities of rough-handed laborers because of their skills and the limited labor supply in their respective fields.

Such delusions are useful tools for hospitals and private equity groups seeking to wring more profit from their health care professionals. The U.S. is now a service economy, and the working class no longer toils primarily with shovels, wrenches, lathes, or stamping equipment. Increasingly they wear white coats.

In this new economy, I would ask Dan and his readers, "Which strategy is the better alternative, given the dispositions of community pharmacists and the health care economy?"

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