The Pharmacist Activist

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"My conscience is clear, but that does not make me innocent. It is the Lord who judges me."

1 Corinthians 4:4

Editorial

The Change Healthcare/UnitedHealth/Optum Cyberattack Crisis:

Pharmacy Associations Must Estimate the Costs of the Damage and Take Legal Action!

"Health care providers losing up to $1B a day from cyberattack" by Tina Reed (*Axios Vitals*; March 11, 2024).

"Hacker forum post claims UnitedHealth paid $22M in ransom bid to recover data" by Raphael Satter (*Reuters*; March 5, 2024).

Even the word "Crisis" does not begin to capture the damage of the cyberattack resulting from reduced cash flow, the disastrous financial impact, the risk of closures of smaller healthcare providers (e.g., independent pharmacies, physician groups), the inconvenience and expense of cumbersome workarounds, and the anticipated additional loss of revenue when funds again become available because of paperwork errors and lack of prior authorizations.

On Tuesday March 12, leaders from the U.S. Department of Health and Human Services (HHS), the White House, Department of Labor, and the health care community convened "to discuss ways to mitigate harms to patients and providers caused by the cyberattack" on Change Healthcare systems on February 21, 2024. The 7-page press release issued on March 12 by the HHS Press Office (media@hhs.gov; 202-690-6343) that includes a brief (approximately 1-page) summary of what Administration Agencies and Officials have heard, stated, and urged, and with whom they have communicated. Almost 2 pages of the release are devoted to listings of the 11 Administration participants and the 36 Stakeholders who had participants in the "roundtable" and

Contents

who can now claim they "had a seat at the table." Almost 2 and one-half pages are devoted to a self-serving summary of "HHS Actions on Change Healthcare to Date" that are dominated by steps to address, assess, engage, communicate, and coordinate with Stakeholders. Nine "Key Actions" are described, three of which involve hosting or participating in roundtables and briefing Congressional staff "on the scope of the incident and the Department's response." The other six key actions include statements about the submission of claims, requests (my emphasis) for accelerated or advanced payments, and recommendations for insurance plans and Medicare Administrative Contractors as to how to best respond. Those who read the press release also have the opportunity to learn of Administration offices/agencies, officials, and programs, as well as their abbreviations/acronyms, with which we were not previously familiar.

The American Medical Association has asked the Biden administration to make emergency funds available to physicians who are victims of the cyberattack. Some have urged that the federal government declare a state of emergency to make government resources available, particularly to healthcare providers who risk financial consequences that may force closures. Unlike a tornado, hurricane, or other natural disaster for which consequences are very visible and publicized, the Change Healthcare cyberattack is essentially unknown to those who are not directly affected, but the consequences are no less damaging than those of a natural disaster.

The response of the pharmacy organizations is too weak and too courteous (e.g., "please do this," "please consider this action"). There is speculation that the cybersecurity systems of Change Healthcare/UnitedHealth/Optum were inadequate with the consequence that they were more vulnerable to the cyberattack that occurred. This should be confirmed through whatever means are necessary, including the recruitment of whistleblowers.

Some may think that Change Healthcare/UnitedHealth/Optum are the primary victims of the cyberattack. This is WRONG! It is patients, pharmacists, and other healthcare providers who are the primary victims. Change Healthcare/United Health/Optum will survive the cyberattack and continue as highly profitable organizations. Some pharmacies and other healthcare providers will NOT financially survive! Apart from the cyberattack, UnitedHealth and Optum policies and actions have been very damaging and destructive for pharmacies as a consequence of abysmal compensation and the extraction of DIR fees. Pharmacies that are not in complete compliance with terms of the "agreements" with these entities are at risk of being excluded from their pharmacy networks. However, in the aftermath of the cyberattack, it is Change Healthcare/United Health/Optum that are not in compliance, and have violated provisions of the agreements with pharmacies. The current crisis provides a rare opportunity for Pharmacy to seize the offensive!

Our professional associations should not be asking, requesting, or begging for actions that may or may not be taken, or even have to wait for responses that will certainly be insufficient. Our associations must identify the specific resolutions, actions, and compensation that are necessary, DEMAND that they be met, and immediately pursue a class action lawsuit to recoup the billions of dollars that pharmacies/pharmacists have lost as a consequence of the cyberattack that may have been preventable!

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Pfizer Greed, Deception, and Fraud

I just became aware of a lawsuit filed in November, 2023 by the Attorney General of Texas against Pfizer for misrepresenting COVID-19 vaccine efficacy and conspiring to censor public discourse. I have summarized the major points and examples below, but encourage you to access and read the entire 54 pages. I accessed it via Google using the entry, Pfizer Vaccine Petition Filed – Texas Attorney General. WARNING: Be prepared for shock, revulsion, and nausea/vomiting! A high dose of an antiemetic may be necessary.

The statements, allegations, and excerpts include the following:

Pfizer claimed that its COVID-19 vaccine was 95% effective. This represented a calculation designated as "relative risk reduction." When it began making these claims, Pfizer possessed on average only two months of clinical trial data from which to compare vaccinated individuals and unvaccinated individuals. The total reduction in risk was actually less than 1% because very few people (less than

1%) in either the placebo or treatment group qualified as experiencing COVID-19 (a defined COVID-19 case).

Pfizer's own data show that 119 individuals had to be vaccinated to prevent one COVID-19 case, the definition for which was the presence of at least one of several COVID-19 symptoms (i.e., a symptom that typically does not represent a need for hospitalization) plus a positive COVID-19 test. These data identify the number needed to treat (NNT) to prevent one negative outcome.

Pfizer created the impression that its vaccine provided durable and sustained protection when, at least initially, it was not possible to know how effective the vaccine was beyond two months. The FDA found that only 43.9% of vaccine recipients in the clinical study completed at least two months of follow-up after receiving the second dose.

Pfizer exploited public fears by insinuating that the vaccine protected against transmission of the virus, and that vaccination was necessary to protect loved ones from contracting COVID-19.

Pfizer claimed that the vaccine included protection against variants of the virus, including the Delta variant that was emerging as the dominant form.

Pfizer conspired to censor the vaccine's critics by accusing them of spreading "misinformation," labeling them as "criminals," and requesting social media platforms to silence them.

On July 22, 2020, Pfizer announced that the company and the U.S. government had entered into a $1.95 billion supply agreement under which Pfizer would provide 100 million vaccine doses upon Emergency Use Authorization (EUA) approval, with the government having the option to acquire up to 500 million more doses.

Pfizer CEO Albert Bourla stated that the vaccine creates immune responses that are able to kill the virus and that the vaccine can neutralize the virus. However, Pfizer measured efficacy only against symptomatic COVID-19, and not whether the vaccine neutralized or killed the virus.

On November 9, 2020, Pfizer issued a press release that included a statement from its CEO that the clinical trial's efficacy data provided initial evidence that the vaccine had the ability to *prevent* COVID-19, a statement that some viewed as a message that the vaccine would end the global pandemic.

FDA and the CDC identified serious risks for myocarditis and pericarditis following administration of Pfizer's vaccine including some cases that required intensive care support.

There were 38 deaths during the clinical trial and the majority of deaths were in individuals who had been vaccinated (21 vaccine recipient deaths versus 17 placebo deaths). Many of the deaths of the vaccinated were a result of cardiac conditions. However, the FDA ultimately concluded that it was "unlikely" that the vaccine caused any deaths.

A CDC analysis demonstrated that vaccinated individuals caused a significant outbreak of symptomatic COVID-19 among other vaccinated individuals at multiple large public gatherings in Massachusetts.

Although there was not data to support effectiveness of a vaccine booster dose, the FDA, under political pressure from the White House, granted approval for Pfizer's EUA amendment for booster shots for a massive percentage of the population. Two top FDA vaccine officials resigned as a result of the White House pressure.

Pfizer took actions to intimidate and silence persons who spread factual information and concerns about vaccine efficacy. One of the individuals Pfizer tried to intimidate and silence was journalist Alex Berenson who had voiced concerns/criticisms that were valid at the time he made them and have been corroborated by subsequent data and analyses. Pfizer succeeded in having Berenson censored and derided as a "conspiracy theorist."

On August 24, 2021, former FDA Commissioner Scott Gottlieb who was subsequently appointed to Pfizer's Board, complained directly to Twitter about Berenson's comments that were being "promoted on Twitter." Gottlieb claimed that these comments were the reason "why Tony (presumably Anthony Fauci) needs a security detail." On August 28, Berenson tweeted that Pfizer's vaccine "doesn't stop infection or transmission" and that it has only a "limited window of efficacy." Gottlieb emailed this tweet to senior Twitter employees and, later that same day, Twitter permanently suspended Berenson's account. Soon after his suspension, Berenson created another account on Twitter. On August 29, Gottlieb emailed Twitter to flag this new account, telling Twitter that it "seems he switched accounts on you." (Editor's note: Alex Berenson has filed a lawsuit against Albert Bourla and Scott Gottlieb).

In August 2021, former FDA Director Brett Giroir tweeted that "#COVID19 natural immunity is superior to #vaccine immunity, by a LOT," and stated "no science justification" exists to demand proof of vaccination from an already infected person. On August 27, Gottlieb quickly flagged Giroir's tweet to his Twitter contacts. Gottlieb emphasized that Giroir's comments would "drive news coverage" and noted that Giroir's tweet would be "corrosive" to the public's confidence in Pfizer's vaccine. Twitter responded by flagging

Giroir's tweet as "misleading."

On November 9, 2021, Pfizer CEO Albert Bourla charged that persons who spread so-called misinformation concerning COVID-19 vaccines are "criminals" who have literally "cost millions of lives." On the same day, Pfizer tweeted a message with the clear implication that persons questioning the efficacy of Pfizer's vaccine are spreading "misinformation."

Pfizer received approximately $12 billion for the 600 million doses it provided under the initial supply agreement with the government, which ended in October 2021. In June 2022 Pfizer and the U.S. government announced a new supply agreement covering 105 million additional doses. Pfizer raised the price of its vaccine by over 50% for this sale, receiving $3.2 billion.

Pfizer increased its financial revenues in 2021 by $38.4 billion, nearly all of which represented proceeds from the sale of its COVID-19 vaccine.

Pfizer officials have characterized those who challenge the claims for the vaccine as "criminals." Actually, it is Albert Bourla and Scott Gottlieb who are criminals and they must be prosecuted! Because of its false claims, Pfizer must be required to return the funds paid for its vaccine to the government and to consumers who have paid for it!

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Another Pfizer Outrage – Paxlovid

I Would Only Dispense a Pfizer Product When No Other Acceptable Alternative is Available!

In a recent discussion with my local independent pharmacist (and former student), I was shocked by his statement that he loses money on every prescription for Paxlovid. When Paxlovid received full FDA approval and was no longer covered by the Emergency Use Authorization, the wholesale acquisition cost (WAC) for a 5-day course of treatment is $1390. As an example, my pharmacist shared that the compensation he received for the most recent prescription for Paxlovid he dispensed was $146 less than his acquisition cost (that is slightly lower than the WAC). It is outrageous that Pfizer and the PBM administering the patient's prescription plan receive such exorbitant income while the pharmacist loses money.

Why should a pharmacist dispense a medication for which he loses money? My independent pharmacist has a commitment to serve his patients who trust him and his colleagues, value their services, and may purchase other products while in the pharmacy. He also recognizes the importance of initiating treatment with Paxlovid as quickly as possible. At the other extreme, Pfizer gives priority only to the revenue and profits it receives regardless of the expense/loss incurred by patients and pharmacists. Pfizer has a program available in which pharmacists can reduce their financial loss when dispensing Paxlovid. However, it should not be necessary to use an additional mechanism to receive reimbursement that can be cumbersome and time-consuming.

When I learned the details of this situation, I communicated with executives of the American Pharmacists Association (APhA) and urged them to demand that Pfizer provide compensation to pharmacists for each prescription for Paxlovid in the amount of the WAC plus $50 for the professional services provided. I received no response from APhA leadership and began to wonder if they were ignoring my recommendation. However, to give them the benefit of the doubt, they probably feel that I have undervalued the services of pharmacists. I am, therefore, now recommending that APhA demand that Pfizer provide compensation to pharmacists in the amount of WAC plus $100 for each prescription for Paxlovid dispensed. Even the amount of $100 is much less than the amount per prescription received by Pfizer and the PBM. I look forward to a response from APhA leadership.

If I owned a pharmacy, I would only dispense a Pfizer product if no acceptable alternative is available. In the case of Paxlovid, there is only one other approved orally-administered alternative for the treatment of COVID-19 – molnupiravir (Lagevrio). Although Paxlovid and Lagevrio have not been directly compared in clinical trials, Paxlovid is considered to be more effective and is the preferred product. In other situations, however, there are products available from other companies that are similar in effectiveness and safety to the similar Pfizer product. For example, there are other COVID-19 vaccines and, for those who consider it important to be immunized, I would not use the Pfizer vaccine. Some other vaccines (e.g., influenza, pneumococcal) are also available from multiple companies, and I would not use the Pfizer product when an acceptable alternative is available.

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Media Coverage of Pharmacy Concerns is On-Target and Extensive

The extensive media coverage of pharmacy concerns is addressed in the November 2023 issue of *The Pharmacist Activist*, and in the concluding section of the February 2024 issue. Some pharmacists have been apprehensive that media coverage of medication errors and stressful workplace conditions will reflect negatively on the profession of pharmacy and individual pharmacists. However, the media investigations and commentaries have provided excellent coverage of the important concerns of pharmacists, and have accurately identified the individuals and organizations (e.g., chain executives, health insurance companies, PBMs, government agencies) that are at fault for the medication-related errors and risks. Almost all of the recent media coverage has been sympathetic and supportive regarding the risks for both patients and pharmacists, and very supportive of the need for reform.

The media are powerful allies in increasing awareness and actions of the public and legislators in a manner that our profession must utilize in improving the safety, quality, and scope of pharmacy practice and services. The following recent investigations and commentaries are exceptional in exposing the problems, and I urge you to access and read them in their entirety.

> "CVS pharmacist's death becomes cautionary tale of crushing stress at work" by Emily Le Coz (*USA TODAY* – online version published February 8 and print version on February 13, 2024).

Pharmacist Ashleigh Anderson had a heart attack and collapsed in the CVS store in which she worked in Seymour, Indiana. She died on September 10, 2021 at the age of 41. Investigative reporter Emily Le Coz's very detailed description of the tragedy and background circumstances identifies the horrific workplace conditions while also capturing Ashleigh's personal qualities of being "whip-smart, selfless, and dependable" and enjoying the respect of friends and family who described her as "the smartest person in any room." Ashleigh's family paid for a bright orange billboard on Interstate 65 in Indiana that "featured a photo of her along with the hashtag and a simple message: 'Your job can wait, your heart can't.'"

> "Father of CVS pharmacist who died calls company memo 'corporate garbage'" by Danielle Genovese (FOXBusiness – top headline on February 12 and published February 13, 2024).

Ashleigh Anderson's father Larry Anderson "told FOX Business that a CVS memo sent to staff last week acknowledging the *USA Today* report that exposed his daughter's death was 'corporate garbage' and nothing but 'damage control.'" The memo that was sent by CVS Chief Pharmacy Officer Prem Shah said that CVS was saddened by the death and that the company had been making investments to create a "positive work environment" that would include "enhancing technology to support patient safety, introducing digital innovations to help balance workload, and increasing wages." (Editor's note: The memo makes no mention of increasing hours of pharmacist and technician staffing). Larry Anderson noted that "the memo came almost two and a half years after his daughter's death, underscoring how it was 'nothing more than its attempt at damage control given the bad press that they have gotten.'"

> "What's Gone Wrong at Pharmacies? A CVS Store in Virginia Beach Holds the Answer" by Catherine Dunn (*Barron's* – online version published February 9, 2024).

When pharmacist Victoria Ward resigned from CVS in 2020 after three years at the Virginia Beach store she sent a warning to the state's Board of Pharmacy that she was leaving her position because of "dangerous working conditions due to corporate greed which resulted in sweatshop conditions." In a follow-up investigation of the store a sample of 200 prescriptions reviewed by a Virginia inspector found a 37% error rate, with some of the errors having the potential to harm patients. "The investigation culminated in a $346,250 fine against CVS from Virginia's pharmacy board in March2022, as well as an indefinite probation for the Virginia Beach store. CVS has appealed the board's order."

In her very comprehensive coverage, reporter Catherine Dunn exposes how CVS prevents disclosure of information about errors. "CVS told the state inspector that it reports mistakes to a private entity called a patient safety organization (PSO). PSOs, authorized under a 2005 law signed by President George W. Bush, were created to encourage healthcare providers to report and learn from mistakes. As an incentive to disclose mistakes, the legislation granted confidentiality protections for information reported to a PSO….CVS in 2014 established a PSO called Enterprise Patient Safety Organization. During Virginia's investigation, CVS cited the confidentiality provisions of the federal law in declining to provide additional information about dispensing errors."

"Healthcare Insights: America's Retail Pharmacies – Patients and Pharmacists in Crisis" by John August (ILR Scheinman Institute on Conflict Resolution; Blog; February 18, 2024).

The Scheinman Institute at Cornell University is a preeminent institute focused on workplace conflict resolution and John August is the Institute's Director of Healthcare and Partner Programs. His experience and expertise in healthcare and labor relations acquired over a period of 40 years include service as the Executive Director of the Coalition of the Kaiser Permanente Unions. He led the Coalition as chief negotiator in three successful rounds of National Bargaining in 2008, 2010, and 2012 on behalf of 100,000 members of the Coalition. He is in a unique and authoritative position to analyze the crisis in the retail pharmacy workplace.

In his blog of February 18 he identifies the perspectives of frontline pharmacists and their increasingly demanding working conditions, citing the walkout of chain pharmacists and technicians in the fall of 2023, as well as the *USA Today* coverage of the circumstances and stress that contributed to the death of Ashleigh Anderson. He examines "some of the root causes of the deterioration in working conditions and the careers of pharmacists, leading to the rising incidents of prescription errors related to understaffing and workplace stress." His excellent coverage includes the increase in number of chain stores and the decreased number of independent pharmacies, the consolidation of wholesalers, and the dominant role of the three PBMs that "corner the market" for sales of drugs and create "a race to the bottom" in the reimbursement of drugs that has driven independents out of business while also reducing operating margins for even the large chains.

His analysis identifies the significant deterioration of safety and quality as a result of the understaffing and the fast pace of work that place patients at great risk. He further observes: "Enrollment in schools of pharmacy is dropping" and that, in combination with major indicators of burnout and undue stress, there is "a deterioration of one of the nation's proudest and most essential professions." John August recognizes the difficulty that pharmacists and other employees who work in small groups in tens of thousands of retail outlets have in gaining enough power to successfully respond to the challenges. He notes that traditional store by store organizing through the NLRB organizing model would take a very long time, and that other strategies should also be explored such as the creation of Standards Boards that would "oversee the establishment and enforcement of working standards and workers protections." He concludes his commentary with the following observations:

"The recent activism among pharmacists and pharmacy workers who are confronting their poor working conditions is based in the need to educate consumers and policy makers that if we want safe, high quality control of the dispensing of medicine to our communities, the industry itself must be transformed to accomplish that essential need.

And most would welcome the return of the neighborhood, locally owned pharmacy, too!"

"State of Ohio Board of Pharmacy Issues Decision in CVS Pharmacy #2063 Case" (Press release from the State of Ohio Board of Pharmacy; February 6, 2024).

"State of Ohio Board of Pharmacy Reaches Settlement Agreement with 22 Ohio CVS Stores to Resolve 27 Cases" (Press release from the State of Ohio Board of Pharmacy; February 29, 2024).

Contact person: Cameron McNamee (Media.relations@pharmacy.ohio.gov, 614-466-7322).

The Board of Pharmacy had initiated an investigation of CVS #2063 in 2021, and inspectors found "customers experiencing significant delays in obtaining prescriptions, phones not working properly, lack of appropriate drug security and control, and failure to provide a safe working environment for pharmacy staff." Following several hearings the Board issued a decision on February 6 that requires this CVS store to comply with the following terms of the Board's order:

An indefinite probationary period of at least three years;

Enhanced monitoring by the Board;

Payment of a monetary penalty of $250,000;

Ensure that sufficient personnel are scheduled at all times in order to minimize fatigue, distraction, or other conditions which interfere with a pharmacist's ability to practice with requisite judgment, skill, competence, and safety to the public; staffing levels shall not be solely based on prescription volume but, in determining the need for staff, consideration shall include any other requirements of the practice of pharmacy by pharmacy personnel during working hours;

Develop a process for its pharmacy staff to communicate requests for additional staff or reports of staffing concerns; such requests shall be communicated and documented in writing by the responsible person or pharmacist on duty to their supervisor;

The store's Responsible Person and/or Board-approved designated representative of CVS Health LLC, shall appear before the Probation Committee upon request;

The store shall not retaliate against or discipline a pharmacist, pharmacy technician, pharmacy technician trainee, intern, or any other employee who communicates a request for additional staff or reports staffing concerns or reports concerns related to working conditions or non-compliance with the Board's order to supervisor(s), CVS management, and/or the Board;

The store must process (have completed final verification and be ready for patient pick-up) all new and refill (not generated by an auto-refill program) prescriptions within no more than three business days of receiving the prescription; the store must process all refill prescriptions generated by an auto-refill program within no more than five business days of receiving the prescription or the auto-refill notice;

Pharmacists, pharmacy technicians, and interns should not be required to administer vaccines when only a single pharmacist is on duty, and in that pharmacist's professional judgment, the vaccine cannot be administered safely;

The store is required to bear any costs associated with the terms and conditions of the Board's order.

Continuing Board inspector investigations documented errors and violations in 22 other Ohio CVS stores. The allegations include improper drug security, dispensing errors, prescription delays, lack of general cleanliness, understaffing, and failure to report losses of controlled substances. On February 29, the Board reached a settlement agreement with CVS Health to resolve 27 cases pending against the 22 stores. As part of the settlement, the 22 pharmacies operated by CVS Health agreed to comply with the following:

CVS will pay the Board a monetary penalty of $1,250,000;

Eight of the 22 stores will be placed on probation for three years;

CVS will pay approximately $83,333 per year to the Board to cover the cost of enhanced monitoring by the Board, for a total additional penalty of $250,000;

CVS shall appoint an Ohio Compliance Liaison, who shall be a licensed Ohio pharmacist, to act as a channel for communications between the Board and CVS regarding compliance with state and federal pharmacy laws and rules;

CVS stores subject to this settlement shall voluntarily comply with several of the Board's proposed minimum standards rules (specifically identified) as drafted;

CVS will make changes to its current electronic recordkeeping system to address compliance with OAC 4729:5-5-04;

CVS acknowledges that virtual verification (a method of pharmacist dispensing that relies solely on images) is not authorized for use at any pharmacy in the state unless otherwise approved by the Board.

The Ohio Board of Pharmacy, as well as those in Virginia and California, are to be highly commended for their thorough investigations, perseverance, and battling their way through the disingenuous excuses (e.g., It was the pandemic's fault.) and deceptions with which CVS attempted to explain away so many errors and violations. These Boards have done the hard work in establishing model templates of investigations and actions that Boards of Pharmacy in other states must also use in preventing the continuation of the harm and risk for patients, pharmacists, and other pharmacy staff that are perpetrated by CVS and some others. However, the harm, fraud, and power of CVS and certain others must never be underestimated. The ill-gained profits of CVS enable it to achieve settlements for *billions* of dollars, so settling with the Ohio Board for several million dollars is no more than a "nuisance" cost of doing business for CVS.

"Ohio board fines CVS $250K, places it on indefinite probation over understaffing at Canton store" by Marty Schladen (*Ohio Capital Journal*, February 7, 2024).

"CVS, Ohio regulator settle claims of critical understanding: $1.5 million settlement largest in Ohio history" by Marty Schladen (*Ohio Capital Journal*, February 29, 2024).

Investigative reporter Marty Schladen with the *Ohio Capital Journal*, and previously with the Columbus Dispatch, has for many years exposed the deception and fraud of the PBMs, and the errors and violations in CVS stores, and has also increased the awareness of the public and legislators of investigations by regulatory officials and the Board of Pharmacy. His investigative reports have been of great value in supporting the actions taken by Ohio officials, and have been recognized in previous issues of *The Pharmacist Activist*.

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Unionization of Chain Pharmacists

In the February issue of *The Pharmacist Activist*, I voiced my advocacy for the unionization of pharmacists employed in the largest chains, and identified what I view as the priorities in taking these actions. All of the responses I received to that commentary were supportive and informative, and contributed to my recognition that many others had reached this conclusion long before I did. What I have also learned during the last month has made me more aware of the importance of proceeding in an informed, cautionary, and deliberative manner in organizing pharmacists.

I noted in my February commentary that I had been made aware of the Doctors Council that is a national affiliate of the Service Employees International Union (SEIU). It is my understanding that the pharmacists who participated in the walkouts in the fall and who have worked with other colleagues in forming The Pharmacy Guild, have established a working relationship or affiliation with the International Association of Machinists (IAM) and Aerospace Workers Healthcare. Some other pharmacists are represented by The United Food and Commercial Workers International Union. A listing of unions whose membership includes pharmacists goes on, but I stopped searching when I realized that the "picture" of the unions representing pharmacists was starting to resemble the fragmented, compromised, and often ineffective organizational structure of the national professional associations of pharmacists. The profession of pharmacy must be on guard to prevent the same mistakes in new/expanded initiatives to organize employee pharmacists.

Perhaps the words "unions" and "unionization" are so widely perceived as being associated with wages, benefits, and strikes that they do not best serve the efforts to organize pharmacists whose highest priorities are patient and personal safety. There can also be a strong public perception that unions both favor and financially support political candidates and positions on issues with which some members of the union do not wish to be identified. Existing unions often have names or identities that are primarily associated with certain groups of employees, but which have had no or little previous identity or involvement with pharmacists or other healthcare professionals. Issues such as these raise questions as to whether a group of pharmacists who are affiliated or otherwise have an identity with a particular union can have an identity and autonomy that are exclusively focused on pharmacists and their goals. For example, rather than affiliating or being members of an existing union, could a large group of pharmacists contract with an established union or other organization for the provision of administrative and other services that would be needed for operations and communications? Could such a group of pharmacists acquire the size, recognition, and power necessary to attain its professional goals, or would it become just another national professional association of pharmacists?

As John August notes in his recent blog (identified earlier), organizing pharmacists who work in small groups in tens of thousands of retail outlets through the traditional labor organizing model will take a very long time. The window of time in which pharmacists can have an important role in improving patient safety with respect to the use of medications, and also "rescuing" our profession, may close before the to-be-established organization of chain pharmacists will have sufficient strength and influence to make a difference. John August also identifies as an option the creation of Standards Boards that would have enforcement authority, and this possibility should also be actively explored.

Nothing in this commentary should be misinterpreted as a reduction in my support and advocacy for uniting chain pharmacists in a union/organization that can achieve important and extensive changes. However, the myriad factors and questions confirm the importance of proceeding in a careful and deliberative manner in developing strategies and actions, while also recognizing the demand for urgency of actions as quickly as possible.

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