

UNDER MY SKIN

Why Are You Prescribing That, Doc?

"I've had this groin rash for weeks," says Harry. "Dr. Skimpole's tried different creams." Harry dumps tubes from a plastic bag onto his lap. The first is ketoconazole, the second fluocinonide, the third mupirocin.

Good question: What was the doctor thinking?

Better question: What was the patient thinking?

Did Harry ask, "Gee, Doc, you gave me a fungus cream, then you switched to a steroid, and now it's an antibacterial. Do you have any idea what this is?" Harry did not ask.

I am constantly impressed, even amazed, at how often patients fail to ask doctors what we're doing and why. A college student has been on minocycline for 2 years, with no discernible effect. Has he asked his doctor, "Why are we staying with the same thing if it's not working?" He has not. Neither has his mother.

Of course, some people do ask. I don't mind explaining what I'm doing, and I often do so at length—until, not infrequently, I see the patient's eyes glaze over with the unspoken plea, "Could you please just give me the prescription so I can go?"

This lack of inquisitiveness crosses so-

cioeconomic lines. College professors and working stiffs seem equally unlikely to challenge therapeutic decisions by asking doctors to explain and justify them. I use the word "challenge" advisedly.

If we were presenting on rounds, we would expect our attending physician to have us explain our treatment plan and to ask, "Why are you doing this, and how will it work?" When patients ask questions like these, they feel more like a challenge than a request for information: "So how do I know you know what you're doing, Doc?"



BY ALAN
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Not many patients are aggressive enough to do that. Thank heavens.

We are trained to make the right diagnosis and prescribe the best treatment, based on the best available evidence. I am all for this and do it whenever possible. But in daily clinical life, the diagnosis is often unclear, treatment options are fuzzy, and evidence for efficacy is limited. The old maxim goes, "Life is short, the art long, opportunity fleeting, experience treacherous, judgment difficult."

This remains largely true—treatment algorithms, decision trees, HMO guideline report cards, and doctor-quality assessments notwithstanding.

It's a relief, then, when patients cut us

slack and don't demand detailed explanations for many of the decisions we make. This comes in handy when we either don't have explanations or, for one reason or other, can't put them across.

I am not referring to high-stakes diagnostic and therapeutic challenges such as exotic diseases, medical mysteries, or excruciating end-of-life issues. Such situations generate learned musings on the dynamics and ethics of doctor-patient communication. The examples I have in mind are more homely, even trivial: the kinds of things, in other words, we deal with every day.

Consider Archie, a 3-year-old with infantile eczema. His mother insists that Archie "has been treated with everything" and that "nothing works." In this case, Archie has indeed been treated appropriately with a series of steroids and nonsteroids: hydrocortisone, desonide, pimecrolimus, and so forth. Because the diagnosis is clear, it seems reasonable to assume that what Mom means by "nothing is working" is that nothing has worked completely or fast enough or has prevented the rash from coming back elsewhere.

My own approach in such cases is to tell Mom, "I have a new and different cream that I'm convinced is just right for Archie." I ask that she apply it everywhere necessary twice a day, without fail, for 10 days and return. It works, of course, because she ac-

tually uses it long enough to see a result. Now she'll be better able to grasp the need for ongoing, intermittent treatment.

But what if she had asked me at the first visit: "I've already used a class 6 steroid, Doctor, and it says here on my Palm that the one you're giving me is just another class 6 steroid. What is the basis for predicting that your steroid will be more efficacious than the ones that have failed?"

Good question. To answer it, I would have to admit that the cream isn't objectively stronger, but she'll be more likely to stick with it because of my professional authority and calm reassurance. How would that go over?

Only she doesn't ask, not because she is uninterested or unintelligent, but because medical care is about more than patient autonomy and reportable outcomes. Among other things, it's about hope, fear, and trust.

Imagine dreaming that every day you have to justify every one of your clinical decisions to an attending or an administrator. Then picture waking up in a cold sweat, relieved that you're not in training anymore and that you still have some clinical independence.

Cherish it. It's shrinking. ■

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GUEST EDITORIAL

The Bright Side of iPLEDGE

While the transition to iPLEDGE has certainly been painful, with a remarkably steep learning curve, things are getting better. The iPLEDGE call center, which was woefully understaffed and provided inconsistent information early on, has reduced phone waiting times to less than 3 minutes. The information is not only more accessible now but more accurate. I actually had a wonderful conversation with an extremely helpful woman at the call center recently—and I admit I wasn't very nice when I initiated the call.

We've had some time now to get used to iPLEDGE and to voice our concerns. It was already getting easier, but it turns out that our complaints were heard by the Food and Drug Administration and are being addressed.

On Oct. 6, the rules were relaxed. Males and females of non-childbearing potential no longer need to follow the 7-day rule for picking up prescriptions. If they forget or lose a prescription, they aren't closed out of the system for the rest of the month. Females of childbearing potential will still have to accomplish their tasks within 7 days of the office visit. A small but significant step. (See article, p. 2.)

What else is in the plus column regarding iPLEDGE?

We now have just one risk management program instead of four, which reduces confusion.

The responsibility for abiding by the rules is now spread among all interested parties, including patients and pharmacists. Medicolegally, we're on better footing than we ever were before.



BY HILARY E.
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Women of childbearing potential can no longer claim that they didn't hear you say they shouldn't get pregnant or that they didn't understand that they should be on two forms of birth control. Now, every month they are taking an online test in which they attest to the fact that they are doing what you told them to do.

College kids now need to transfer to a local doctor.

They can't stay on the drug without coming to see you on a monthly basis. I think this is good news. I don't think that kids who went far away to school were getting particularly good care. This increased our legal exposure as well.

For females of childbearing potential for whom the 7-day rule still pertains, the system allows us to hold prescriptions hostage

until they comply with our medical instructions. We no longer have to say, "Look, I told you three visits ago that I wanted you to get liver function tests" or "I needed to speak to your psychiatrist or perhaps to your mother." To which they would reply, "I forgot, I forgot, I forgot."

With iPLEDGE, there's no more forgetting. They've got 7 days to do what I think is important for their health or I won't push the confirmation button. In other words, no more Dr. Nice Guy.

I've cracked down on everything. There are no more prescriptions written in hallways. Patients have to come in for visits every month. Everything goes according to the rules, no one takes advantage of me, and I am actually getting paid for what I do.

I see a lot of benefits to this program, and apparently I'm not the only one.

Lest you think your colleagues have given up on the drug, be aware that the iPLEDGE database now contains 26,127 registered prescribers, including nurse practitioners and physician assistants.

There has been a lot of grumbling, but people are still prescribing isotretinoin. Since the program was launched at the end of 2005, there has actually been about a 40% drop in prescriptions. I'm rather encouraged that that number isn't higher. You'll recall there was a 23% drop with the implementation of the SMART program.

Dermatologists still realize isotretinoin is a hugely efficacious drug, the only one that targets all four pathogenic factors underlying acne. No one seriously argues against isotretinoin using efficacy arguments because it's the best drug we have for our most difficult acne patients.

Will we ultimately have fewer prescribers, as some people decide the program is too burdensome for them? Maybe.

Will we have "isotretinologists" who commit to treating patients who need and deserve this drug? Undoubtedly. I wholeheartedly volunteer to be one of them. I love this drug, and I love using it. I love the look on patients' faces as they get better.

Will there be fewer patients who agree to take isotretinoin? Maybe, but perhaps they were patients who didn't belong on the drug to begin with: irresponsible patients, difficult patients, and patients who are uncomfortable taking the drug at all.

In the long run, I think this is a program we can live with. We might even find it better than what we had before. ■

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