

COVER STORY



The Pharmacist Who Says No to Drugs

Armon Neel tells patients how to save money and lives

BY BILL HOGAN

Ruby Gifford has come to see Armon B. Neel Jr. out of fear and perhaps desperation. Gifford, 86, hasn't been feeling well lately, and the list of symptoms that have prompted her to come to Neel's office in Griffin, Ga., might mark her as a hypochondriac in the eyes of many doctors. The problems run from dizzy spells and falls to osteoarthritis and back pain, from uncontrolled high blood pressure and erratic pulse rates to anxiety and depression. Then there are the skin rashes, hives and other allergic symptoms that seem to have come out of nowhere.

Gifford's 60-year-old daughter has brought her to the Wednesday morning appointment, and the two wait anxiously in Neel's conference room, where he meets with patients. Neel, however, isn't a doctor. He's a pharmacist whose specialty is determining whether people are taking the right medications—and in the right doses—for what ails them. Neel, 66, hasn't worked behind a prescription counter since the early 1970s, when he gave up dispensing drugs for a career that would often put him on a collision course with the doctors who prescribe them.

"If I could find out what's causing

all these allergies," Gifford begins. (Her name has been changed in this story to protect her privacy.)

Neel asks to see the blood pressure log she's been keeping at his request, along with all the medications she's been taking. Gifford reaches down, produces a freezer-size Ziploc bag that's bulging with prescription drugs, and places it on the table. Then comes another Ziploc bag, this one full of over-the-counter medications.

Neel quizzes Gifford about the prescription drugs, one by one. "What about that?" he asks. "How did that one do?"

He then asks Gifford about Ultracet, a pain medication that she's taking. "I never have headaches," she says. "My aches are all from falls."

"Tell me about the falls," Neel says. "Tell me how long it was after taking this pill that it happened."

Neel gently guides Gifford through the entire inventory. He explains that Aldactone, the blood pressure medication she's been taking, isn't the drug of choice in her case and may in fact be responsible for some of her other health problems. As he looks through Gifford's records, he sees that her doctor, in attempts to control her hypertension, has tried four different



Armon Neel helps admit a new patient at Pine Hill nursing home in Byromville, Ga.

ACE inhibitors, two beta-blockers and two alpha-blockers. Nothing has worked, and Gifford has had allergic reactions to all of them. Neel seems stupefied.

"There wasn't a need to go to the second one after the first one did you harm," he says. "They're in the same family. You need a calcium channel blocker instead."

Next, Neel zeroes in on Mobic, the NSAID (nonsteroidal anti-inflammatory drug) that Gifford's doctor has prescribed for her osteoarthritis. "There are certain drugs you just don't give old people," he explains, and NSAIDs are among them. It turns out that the doctor has ordered

yet another NSAID, in the form of Voltaren eye drops. “There’s a newer product that’s better than this,” Neel says.

Gifford seems relieved but at the same time disturbed. “I don’t want to go back to this doctor,” she says. “She never checked anything before she gave it to me.”

Neel promises to put everything in a written report by the end of the week. “Some of these things,” he says, pointing to all the medications spread out on the table, “we might just chuck in the trash can.”

Neel hits the road later in the day to make his way to two nursing homes in rural Georgia, where he will review the charts of dozens of residents and carry on his crusade against the overmedication of geriatric residents in long-term care facilities. Neel does this two or three days a week, nearly every week, and has been doing it since 1968. He’s one of a few thousand consultant pharmacists nationwide who specialize in identifying, resolving and preventing medication-related problems that affect, and afflict, older people.

“You see so many cookie-cutter approaches to taking care of old people,” Neel says. “Almost 100 percent of the people I see as outpatients are overmedicated, because the ones I see are the ones who are having problems. If I go into a long-term care environment, it’s about 80 percent.”

Typically, medication levels in nursing homes can be cut in half or better. “If I can get the drug therapy management correct,” Neel says, “there are fewer hospital stays, fewer hospital admissions, lower labor costs involved in care and a better quality of life for residents.”

Neel is a rebel with a cause—namely, advancing the idea that pharmacists must serve and protect the people who take the medications they dispense. “I get paid by the patient,” he says, “not the doc.” The way he sees it, pharmacists are often a patient’s last line of defense in a nation

of doctors who, more often than not, don’t know much about the drugs they are prescribing and the geriatric population they are treating.

The renegade streak goes way back. In 1963, just two years out of pharmacy school, Neel opened an apothecary shop in Griffin that, just like a doctor’s office, had a carpeted reception room and a separate consultation room. He also set up prenatal counseling programs as well as hypertension and diabetes clinics. Neel thought the new approach would earn praise; instead it drew ridicule from many of his peers.

In the late 1960s, Neel, at the request of a friend, started doing some clinical consulting in nursing homes, and what he saw both shocked and transformed him. “Here was a brand-new population of people, and nobody had any earthly idea how to take care of them,” he recalls. “Back then you’d see Mellaril [a powerful antipsychotic drug] brought in by the truckload. They used it as a chemical restraint. Nursing homes back then didn’t have a lot of help, so the best help they had was to drug the patients. I knew it wasn’t humane, and I fought it from day one.”

On Wednesday night Neel is driving to a mom-and-pop motel in rural Georgia that he has stayed in many times. It’s not far from a county-owned nursing home Neel counts among his six institutional clients.

The next morning at 9, Neel is stationed at a small desk near the nursing director’s office. He has brought along a notebook computer, portable printer and a supply of blank forms and printed materials. He knows just about everyone, it seems, by name.

The doctor who serves as the nursing home’s medical director doesn’t seem to care for Neel’s approach to a job—mandated by federal law—that others see as rubber-stamp work. The doctor doesn’t talk to Neel, choosing to deal with him mostly through the nursing staff.

Throughout the day Neel will type his medication-related suggestions on a form of his own design (printed on a pink slip of paper so as to stand out in the patient’s medical records) that directs the patient’s physician to check a box that says “Accept” or “Reject” before signing and dating it.

The medical director rejects, almost without exception, Neel’s suggestions. He evidently takes umbrage at being second-guessed by a pharmacist—something, Neel says, that’s not at all unusual. Neel finds the lack of engagement troubling. “He’s here once a month,” he says. “Maybe five minutes per patient. That’s all they’re required to do.”

Neel begins working his way through a tall stack of blue loose-leaf binders that contain the patient charts and other medical records. Today he’s reviewing the charts of residents who are taking nine or more prescription medications simultaneously.

It’s important on at least two counts that Neel—or someone like him—review the medications these people are receiving. First is safety. The risks of adverse effects expand exponentially with the number of medications “on-board,” partly because they indicate the presence of numerous diseases or other medical problems and provide an opportunity for both drug-disease and drug-drug interactions. Second is cost. “The rule of thumb,” Neel says, “is \$100 a drug.” That’s per patient, per month. Thus the cost of having someone on, say, 15 different medications—many of which may be unnecessary or even harmful—is \$1,500 a month, or \$18,000 a year.

First up today is the chart for a 68-year-old man who is on many drugs, including Nitrofurantoin, an antibacterial that’s prescribed for urinary tract infections. Neel enters the man’s age, weight, height and information from his blood work into a calculator programmed with certain formulas he uses over and over. Neel explains that toxic levels of the drug will build up in the man’s system because his kidneys aren’t as efficient as they used to be.

Why would a doctor prescribe it? “Because,” Neel says, “it works in young people.” (A new study in the *Archives of Internal Medicine* found that 20 percent of outpatients 65 and older were prescribed “at least one drug that should generally be avoided in elderly people.”)

The next chart is for an 89-year-old woman who’s on 13 different prescription medications, including Zantac, which raises an immediate flag for Neel. There are no blood chemistry tests in her charts, but Neel quickly computes her probable renal clearance at 32.5 cubic centimeters a minute. “This tells me right off the bat she shouldn’t be taking it,” he says. He then types his suggestion to the doctor: “ZANTAC DOSE TOO HIGH/COULD LEAD TO ‘HEPATIC SHUTDOWN’ ... RESULTING IN SERIOUS PATIENT ADVERSE EVENTS.”

Neel opens the next chart, that of an 82-year-old woman who’s on 17 different medications, including, for type 2 diabetes, a prescription drug called metformin. He’s dumbfounded at first, then angry. He reads the suggestion slip he typed out a month and a half earlier: “PATIENTS WITH SERUM CREATININE CLEARANCE LESS THAN 60CC-M USE OF METFORMIN IS CONTRAINDICATED AND PLACES THE PATIENT AT HIGH RISK FOR LACTIC ACIDOSIS, WHICH IS FATAL IN MOST CASES.”

In a little while, Neel joins the staff for lunch in the cafeteria and spends much of the time soaking up details about residents that may prove useful in his work. On the way back from lunch Neel stops to visit with them in their rooms or in the hallway.

Neel rises early the next morning to drive to another nursing home about 20 miles south. There, too, he

has a combative relationship with the facility’s medical director.

As soon as Neel arrives at the facility, he searches out a 73-year-old resident who’s been there since February 1999. The man, who has advanced Parkinson’s, brightens instantly. When Neel first looked at his chart, the man was on 20 milligrams of the antipsychotic medication Zyprexa, a daily dose that by any measure is therapeutic overload; he’s down to 2.5 milligrams a day, and soon, Neel says, he may be off the drug entirely. The man’s old symptoms, among them nonstop yelling, have all disappeared, and now he sometimes comes to sit quietly next to Neel as he works.

The physician overseeing the man’s treatment told Neel and the nurses that he would never be able to walk again. But walk he now does—and walk and walk. He visits other residents in their rooms and likes to sit near the main nursing station—the hub of activity. “I gave him his life back,” Neel says matter-of-factly.

One problem, as Neel sees it, is that few of the 300 or so doctors who treat patients in the facilities he visits have a specialty in geriatrics. How many do? “Maybe two,” he says. “They’re not up to date with the physiology of the geriatric patient as it relates to the chemistry of the drug. That’s the easiest way to put it.”

Neel reviews a few more patient charts, producing more small pink suggestion slips, each numbered sequentially, as he goes. A little while back he passed the 300,000 mark.

At another nursing home, where Neel has known the medical director for some 25 years, the success of a collaborative approach is clear. “If I

Finding Help

The American Society of Consultant Pharmacists offers information at www.ascp.com, including a list of the 10 most dangerous drug interactions in long-term care. A companion site, www.SeniorCarePharmacist.com, lists potentially inappropriate medications for older people, and offers a questionnaire to assess your risk for medication-related problems and a search feature that can help you find a “senior care pharmacist” in your area. You may also contact ASCP at 1321 Duke St., Alexandria, VA 22314, (800) 355-2727.

write up a suggestion to paint the nose blue,” Neel jokes, “when I go back the next time, the nose is blue.” The daily cost per patient for drugs at the nursing home is down to \$7.22, the lowest in Georgia and just over half the statewide average.

Neel will be back in Griffin before suppertime, where he’ll finish the written report that he promised Ruby Gifford before leaving for a weeklong vacation with his wife, children and grandchildren. He doesn’t yet know that Gifford’s physician will be angered by her decision to seek out his help and will refuse even to read Neel’s 17-page report.

So Armon Neel soon will help Gifford find a new doctor. He isn’t one to pass the buck. “I’ve always gotten along well with old people,” he says. “They’ve always been special to me.” A mischievous smile breaks. “And I really like ’em now, ’cause I’m one of ’em.” ■