Volume 1, Issue 4

July 2016

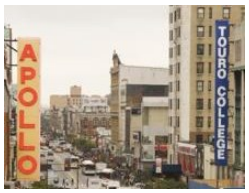
NYS-ACCP Insider

Touro College of Pharmacy—New York

Special points of interest:

- TCOP-SCCP student chapter highlights
- Clinical Spotlight
- Post-graduate training: resident spotlight
- Student legislation
- New drug updates
- Clinical practice updates
- "Phundamentals"

TCOP-SCCP Student Chapter Highlights

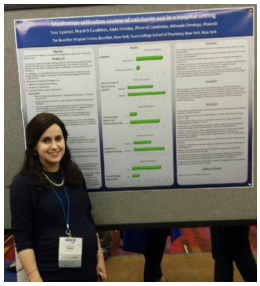


Touro College of Pharmacy's Student Chapter of Clinical Pharmacy (TCOP-SCCP) was first introduced to TCOP in the spring of 2015 by dedicated students who envisioned a bright future as clinical pharmacists. The main focus of our organization is to introduce students to clinical pharmacy and patient-directed research. In so doing, our student chapter aims to invite speakers, participate in various community outreach events, support student research and participate in local and national ACCP activities.

At one of our meetings titled "What are all of these certifications and how do I get there", three TCOP professors, Dr. Shinkazh, Dr. Berrios-Colon, and Dr. Huggins discussed the benefits of various certifications available to pharmacists (e.g. BCPS, CACP, CDE, BC-ADM, CGP and BCACP), as well as the steps needed in order to obtain and maintain them. In another monthly meeting, TCOP-SCCP hosted an event called "Life After Touro" where Touro Alumni spoke about how they obtained their residency positions and shared their experiences upon graduation. They advised students to make the most of their clinical experiences, get involved, seize opportunities and be proactive. TCOP-SCCP also collaborated in another event with the St. John's University student chapter titled "CDTM and NYS Current Pharmacy Legislatives". The guest speaker Dr. Monica Mehta spoke about NYS pharmacy legislative issues and how we as pharmacists can get better involved in helping to improve our practice. She spoke about current legislative bills, one of which aims to ensure that pharmacy technicians go through appropriate certification requirements and another would allow pharmacy interns to immunize patients.

TCOP-SCCP members were given the remarkable opportunity to participate in community service events where classroom experiences came to life. In a joint collaboration with St. John's University, both student chapters participated in an event hosted by the American Diabetes Association (ADA) called "Feria De Salud Sobre la Diabetes", in an effort to raise diabetes awareness in a Bronx Hispanic community. In another ADA event, TCOP-SCCP participated in the Step Out Walk, an event committed to educating the community on the risks and prevention of Diabetes. In collaboration with other TCOP student organizations, our chapter helped to raise and donate over $1800 to this cause. During the Walk, SCCP members also participated in the Wellness Village. At all of these events, students counseled patients, distributed educational pamphlets and flyers, and performed blood pressure and blood glucose screenings as well as diabetes foot exams.

TCOP-SCCP participated in the "We are Harlem Day, Health Expo" at Harlem Hospital where students were able to counsel over 100 patients on numerous medications, error prevention, and medication adherence. As an organization, TCOP-SCCP strives to educate and provide care to the underprivileged in our community by providing proper healthcare related education and support. SCCP chapter members participated in numerous events at the Iris House, a center dedicated to supporting those struggling with HIV/AIDS. The Iris House is recognized for sponsoring events that allow TCOP-SCCP members to monitor blood pressure, perform medication counselling, and promote healthy lifestyle modifications. These events provided excellent practice experiences to students and helped to improve the wellness of individuals of diverse ages and backgrounds on different disease states.



Following our first year of being an ACCP student chapter, we were fortunate to send some of our student members to ACCP's 2015 Global Conference in Clinical Pharmacy, where one of our members and now graduates, Sora Vysotski presented her research poster titled: Medication Utilization Review of Caclitonin Use in a Hospital Setting. TCOP-SCCP also participated in ACCP's Clinical Skills Challenge as well as the Clinical Research Challenge competitions.

Overall, it has been a rewarding experience to be a TCOP-SCCP member. We plan to further expand and develop our chapter by reaching out to more students at TCOP. In the following year we plan to participate in more events and workshops, do more fundraising, and continue to be involved in our community. In the meanwhile, our chapter will work to promote clinical pharmacy and the benefits of joining ACCP to our students at TCOP.

-Reshma Lakhram and Sanjay KC, PharmD Candidates, TCOP Class of 2017

Clinical Spotlight: Rebecca Cope, PharmD

Assistant Professor of Pharmacy Practice, Touro College of Pharmacy, New York

Dr. Rebecca Cope grew up in a small town near Saratoga Springs, NY and attended pharmacy school at Albany College of Pharmacy and Health Sciences. She served as the Chief Pharmacy Resident during her PGY-1 residency training at The Brooklyn Hospital Center in Brooklyn, NY before going on to complete a PGY-2 in global health and underserved care at the University of Pittsburgh Medical Center/University of Pittsburgh School of Pharmacy in Pittsburgh, PA. Her clinical focus is primary care in limited resource settings and underserved patient populations. Dr. Cope has spent a significant amount of time working in HIV primary care settings, as well as doing medical work in Honduras and Malawi. Her current specialty area is ambulatory care, where she continues to work in an HIV primary care center and as a consultant in the area of Hepatitis C treatment.

What made you interested in the path you chose?
I became very passionate about global health and working in underserved areas as a high school student when I began volunteering in a medical clinic in Honduras during my summer breaks. I met a pharmacist who encouraged me to pursue an education in pharmacy, and I did so with the intent of asking myself "How can I use pharmacy practice to advance the world?" When I was a P3 student I began taking a serious look at how I could merge my career with what I was most passionate about. I was thrilled to discover there were options for residency training which would allow me to become a strong clinician, while still maintaining my other interests and preparing me for a career in academia. I chose my residency programs carefully to prepare me as an ambulatory care pharmacist who has a high level of experience in diseases disproportionately affecting underserved patient populations, such as HIV and HCV, as well as an in-depth understanding of how social determinants impact health.

Are you board certified? Is there an importance in getting board certified?
I am in the process of becoming a board certified ambulatory care pharmacist (BCACP), and I also plan to pursue certification as a practicing HIV pharmacist (AAHIVP) within the next year. I do think board certification is important, particularly as pharmacists continue to advocate for the expansion of our role in direct patient care. Board certification is a necessary part of the credentialing process which allows us to showcase our knowledge and skillsets within the various specialty areas of pharmacy practice.

Have you or are you currently working on any special project(s) that are pharmacy related?
I recently hosted a physician from the NYC Department of Health and Mental Hygiene at my CDTM clinic as she is working on an initiative to expand pharmacist integration into hypertension management in the NYC area. It was the physician's first time learning about and seeing how CDTM with a clinical pharmacist works. I am excited to see what will come out of the initiative, and how pharmacists in many different practice settings could contribute!

What are your day to day tasks and what do you love most about your current daily duties?
I work in a variety of interdisciplinary or pharmacist-run ambulatory care clinics throughout the week. For example, I may be in the HIV Primary Care Clinic in the morning and then spend the afternoon seeing family medicine patients referred to me through CDTM agreements for chronic disease state management. Whichever setting I happen to be in, my goal is always to optimize medications by thinking about indication, adherence, efficacy in regards to the patient's chronic disease state goals, and safety. Each patient visit must be documented and billed. I am also an assistant professor at Touro College of Pharmacy and a faculty member for the pharmacy residency program at The Brooklyn Hospital Center. My day-to-day responsibilities also include teaching and working with pharmacy students/residents under my preceptorship. What I love most about my position is A) building relationships with my patients as I care for them over time and B) exposing pharmacy students to clinical pharmacy practice, often for the first time.

Now that you are no longer in the classroom, how would you recommend keeping up-to-date on new guidelines?
I am a long-time subscriber to Physician's First Watch through NEJM, which provides a brief daily summary of breaking research and medical updates. I highly recommend subscribing. Specifically for ambulatory care, I love participating with ACCP's ambulatory care PRN, including their listserv, newsletter, and twitter feed (my favorite!). One last resource is the website iforumrx.org, which is also specifically for ambulatory care pharmacy practice. This website publishes written commentaries and podcasts on clinical trials relevant to ambulatory care, in addition to housing many guideline summaries and clinician resources.

What advice would you give to a pharmacy student planning on doing a residency?
While I would advise taking the opportunity to network and build connections with many people, I think it is important to identify one person who you view as a mentor and can guide you through the residency process. Career and life lessons are meant to be shared. I would not be the clinician, researcher, or person I am today without my own mentors, who continually take the time to share their experiences and perspective with me as I progress forward.

-Interviewed by Ilona Zakharyeva, PharmD Candidate, TCOP Class of 2017

Post Graduate Training: Resident Spotlight

David M. Salerno, PharmD
PGY2 Pharmacy Resident—Solid Organ Transplant
New York – Presbyterian Hospital
Columbia University Medical Center, Weill Cornell Medical Center

What made you interested in Clinical Pharmacy?

I became interested in clinical pharmacy during my advanced practice experience rotations in my final year of pharmacy school at Rutgers University. I was fascinated by the complexity of patients and how their specific clinical situations never seemed to fit the guideline recommendations learned during pharmacy school. It was very apparent to me that I would require advanced training under the guidance of clinical experts in order to provide optimal patient care. My interest in transplant started in pharmacy school during the one lecture provided about immunosuppressive medications. I had a chance to explore solid organ transplant further during PGY1 residency at Hackensack University Medical Center and instantly knew this was the career choice for me.

What is your current practice and/or role?

I am currently a PGY2 pharmacy resident in solid organ transplant at New York-Presbyterian Hospital in New York, NY. I rotate through all of the respective transplant disciplines between Columbia University Medical Center and Weill Cornell Medical Center in New York City, providing advanced pharmacotherapeutic recommendations to the multi-disciplinary transplant teams. Transplant pharmacy is unique in that a pharmacist is required to be part of the transplant multidisciplinary team and participate in all phases of patient care including the pre-, peri- and post-operative phases.

What type of person do you think would best be suited for practicing in your specialty?

The type of pharmacist that would be most successful in my particular specialty would be a person who is interested in immunology and providing care for a diverse group of patients in various care settings (from ambulatory care clinics to medicine and surgical intensive care units). In addition, a successful transplant pharmacist may be required to have organ-specific knowledge to provide care to kidney, pancreas, liver, small bowel, heart, and lung transplant recipients. Finally, a transplant pharmacist needs to enjoy interacting with and teaching patients about their medications.

With your specialty practice, where do you see your specialty going in the future?

Transplant pharmacy is a growing specialty that is rapidly advancing. There are greater than 100,000 patients waiting for organs within the United States, with a relatively stagnant donor pool. Clinical research and drug development will be key to optimize the outcomes of patients successfully transplanted. Pharmacists will play an integral part in managing a transplant recipient's immunosuppression, concomitant medications, and various primary disease states that burden all patients, irrespective of transplant. In addition, there is a tremendous opportunity for pharmacist-led research to advance practice.

What advice do you have for pharmacy students interested in pursuing a career in clinical pharmacy in your area of specialty?

Most successful residents are those pharmacy students who were very well-rounded in pharmacy school. Residency is composed of various daily activities, a handful of longitudinal requirements, and a variety of responsibilities. Learning to manage your time and try new experiences to develop your skillset will require a lot of practice. Diversifying yourself during pharmacy school to get an idea of what you are interested in will provide you with incite about career direction and plenty of experiences to share with residency interviewers. This advice applies to transplant pharmacy, as a great candidate for a PGY2 in transplant will have a variety of experiences throughout all phases of care to be successful.

How do you stay current and up to date with guidelines, research, and treatment options?

One of the more unique ways I stay up to date is by utilizing Twitter, not as a social application, but instead to follow transplant-specific journals. Each journal provides updates about clinical questions, new publications, and upcoming continuing education events to be involved in. Additionally, following specific organizations, for which you are a member, is another avenue other than email that can provide rapid updates when email becomes too cumbersome.

How do you stay connected with your mentors and professional pharmacy networks?

I stay connected with professional networks by getting involved in events that interest me. Working with pharmacists from other disciplines and locations will build your network. Additionally, I have tried to collaborate with former and current mentors of mine to continually show my skills. Pharmacy is a small world, and transplant pharmacy is even smaller.

-Interviewed by Thu (Misa) Nguyen, TCOP-SCCP President, Class of 2018

NYS Legislation: Pharmacy Lobby Day

At the crack of dawn, at 5:30 AM on April 12th, 2016, Touro College of Pharmacy (TCOP) students boarded two buses headed to Albany, New York State's Capitol, to lobby for advancing our profession of Pharmacy. Pharmacy Lobby Day is an advocacy day when pharmacy students, professors, and pharmacists meet public representatives to advocate and support legislation relevant to the field of pharmacy. Many New York State pharmacy schools were represented at this event, including Albany College, Long Island University, St. John's University, St. John Fisher College, and University of Buffalo. We were greeted in an auditorium by inspiring speeches from members of Congress and leaders from the Pharmacists Society of the State of New York (PSSNY). We were then split into groups of ten with other pharmacy schools and assigned one leader, a Pharmacist, to direct us through the process (totaling ~20 groups). The issues that we discussed with the legislators included:

Assemblyman Victor Pichardo of District 86 (Bronx) with P1 student from TCOP

Bill A9312-A: Allowing pharmacy interns to immunize adults
Bill A9529: Removing sunsets and authorize Certified Immunizers to administer all CDC recommended vaccines for adults
Bill A9424-A/S7201: Setting standards in law for fair pharmacy audits
Bill A4841/S1883: Recognizing and regulating pharmacy technicians

New York is one of 7 states that restricts pharmacy interns from administering vaccinations to adults, and with Bill A9312-A, this restriction could be lifted. In meeting with various Assemblymen, our group explained that pharmacy students complete CDC-approved immunization training, which provides the instruction to safely and effectively administer vaccines. This bill will allow for pharmacy interns to practice their immunization skillsets under the supervision on an immunizing pharmacist, as well as provide additional opportunities for citizens of New York to get vaccinated against preventable diseases. As an example, we shared that TCOP students participate in Health Fairs every season to screen the Harlem community for blood pressure, bone density, foot exams, and explained how much more of an impact there would be if pharmacy interns were able to administer vaccinations in such settings.

TCOP students with Assemblyman David Weprin of District 24 (Queens)

New York is one of the last states in the country to require certification for pharmacy technicians, and Bill A4841/S1883 will establish requirements for registered and certified pharmacy technicians. Currently, pharmacy technicians, as long as they are 18 years old, may be hired without any restrictions, or even a criminal background check. Having a certification process will require technicians to register with the Pharmacy Technician Certification Board (PTCB) and pass the certification examination in order to practice. This process aims to reduce medication errors and hospital costs. We were surprised that some of our representatives did not know the difference between a pharmacist and a pharmacy technician and we took the time to explain that pharmacy technicians are essential support staff, while pharmacists serve as the medication experts and pharmacy managers.

The Assemblymen with whom we met were all very receptive and had positive opinions about the bills we presented. They understood the current issues and expressed their support. It was a really great experience and we realized that collective action makes it easier to advance our profession and therefore contribute to the improvement our Healthcare System. The legislative process in New York is quite extensive. If a majority of the Senators approve the bills, they will be sent to the Assembly for further processing. We would expect to know the outcomes for these bills by February, 2017. To keep updated with the status of these bills, the bill numbers can be searched via http://assembly.state.ny.us/leg/.

— Diana Duong, PharmD Candidate, TCOP Class of 2019

New Drug Updates: Idarucizumab (Praxbind®)

In October of 2015, idarucizumab (Praxbind®) was approved as the first reversal agent specifically for dabigatran (Pradaxa®).[1] In current practice, dabigatran is a medication used to treat and prevent deep vein thrombosis and pulmonary embolism, as well as to prevent stroke and systemic blood clots in patients with atrial fibrillation.[2] It achieves its anticoagulant effects by acting as a direct thrombin inhibitor. For patients taking dabigatran who are experiencing life-threatening or emergency situations and their bleeding cannot be controlled, idarucizumab (Praxbind®) is now an available drug that can be an important tool in managing these patients and neutralizing the anticoagulant activity. It is indicated for patients treated with dabigatran when reversal of the anticoagulant effects is needed for emergency and urgent procedures or in life-threatening or uncontrolled bleeding, including surgery.[1]

Idarucizumab is a humanized monoclonal antibody fragment that works by binding to dabigatran and its acyl glucuronide metabolites, which has a greater affinity than the binding affinity of dabigatran to thrombin. Since it is a specific reversal agent for dabigatran, it does not reverse the action of factor Xa inhibitor anticoagulants including apixaban (Eliquis®), edoxaban (Savaysa®), and rivaroxaban (Xarelto®).

Idarucizumab solution is available as 2.5 grams of Idarucizumab in 50 mL for intravenous injection. The recommended dose is 5 grams. Therefore, two vials of idarucizumab are given as consecutive boluses.

In clinical studies, 123 patients who were using dabigatran were assessed after they received idarucizumab due to uncontrolled bleeding or the need for emergency surgery . The anticoagulant effect of dabigatran was fully reversed in 89% of patients within 4 hours of receiving idarucizumab, followed by normalization of coagulation parameters.[4]

Three additional clinical trials were conducted in 244 healthy volunteers to help determine the adverse event and pharmacokinetic profile of idarucizumab. The most common side effects include headache (5%), fever (6%), hypokalemia (7%), constipation (7%), delirium (7%), and pneumonia (6%). At present, there are no black box warnings, nor contraindications for idarucizumab.[3]

Hypersensitivity reactions may occur with this medication and administration should be immediately discontinued if anaphylactic or other serious allergic reactions arise. There is also a risk of serious adverse reactions in patients with hereditary fructose intolerance. Because idarucizumab is formulated with 4 grams of sorbitol as an excipient, patients with hereditary fructose intolerance may develop serious adverse reactions, including fatal reactions. Therefore in these patients, the combined daily metabolic sorbitol/fructose load should be determined from all sources to prevent serious reactions occurring from idarucizumab.

Idarucizumab is the first reversal agent of its kind and can be useful when medically appropriate. However, the reversal of dabigatran effects can expose patients to the increased risk of blood clots and strokes from preexisting or underlying diseases, such as atrial fibrillation. Therefore, after a patient is administered idarucizumab, anticoagulant therapy should be restarted as soon as is medically appropriate based on the patient's underlying disease.

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2. Pradaxa [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc. October 2010.

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-Christopher Milan, PharmD Candidate, TCOP Class of 2017

Reviewed by Michele B. Kaufman, PharmD, CGP (Editor, Pharmacovigilance Forum, P&T journal)

Clinical Practice Updates: New Anthithrombotic Therapy Update for Treatment of VTE Diseases -

There are approximately 10 million venous thromboembolism (VTE) cases occurring globally each year. VTEs, blood clot formations in the venous system, are life threatening events. In these latest evidence based guidelines, the American College of Chest Physicians provide 53 updated recommendations for appropriate treatment of patients with VTE. Some recommendations are unchanged from previous guidelines, while others are updated, and still others are brand new.

WHAT IS UNCHANGED (Topics 2, 4-6, 13):

Topic 2: *Duration of Anticoagulant Therapy.*

First provoked and 2nd unprovoked VTE, with high bleeding risk, it is recommended to treat for 3 months,

Low/moderate bleeding risk or VTE with active cancer, the duration of treatment is lifelong.

Topic 4: *Whether and How to Anticoagulate Isolated Distal Deep Vein Thrombosis (DVT).*

If risk factors for extension are absent, treat with serial imaging for 2 weeks

If risk factors are present then treatment with anticoagulation (AC) is appropriate.

Topic 5: *Catheter-Directed Thrombolysis (CDT) for Acute DVT of the Leg.*

It is best to treat with AC, (ex: low molecular weight heparin (LMWH) or Fondaparinux) over CDT.

Topic 6: *Role of Vena Cava Filter in Addition to Anticoagulation (AC) for Acute DVT/Pulmonary Embolism (PE).*

AT10 suggests against the use of an Inferior Vena Cava (IVC) filter in addition to anticoagulants.

Topic 13: *Thrombolytic Therapy in Patients with Upper Extremity DVT (UEDVT).*

Treat with AC (ex: LMWH or Fondaparinux over IV/SC UFH) over thrombolysis.

In patients with UEDVT who undergo thrombolysis, it is recommended to treat with the same intensity and duration of AC as in patients who did not undergo thrombolysis.

WHAT IS UPDATED (Topics 1, 7, 9, 10-12):

Topic 1: *Choice of Long-Term (first 3 months) and Extended (no scheduled stop date) AC treatment for the DVT of the leg or PE with and without cancer.*

AT10 suggests new oral anticoagulants (NOACs) over vitamin-K antagonists (VKA) for the treatment of VTE in patients without cancer.

NOACs have been associated with low rates of VTE recurrence (not statistically significant) and low rates of major bleeding (statistically significant with apixaban and rivaroxaban only), when compared with VKA.

NOACs demonstrate greater convenience for patients and healthcare providers, since no monitoring is required.

In cancer patients, AT10 suggests LMWH over VKA. If not treating with LMWH, AT10 has no preference for either NOAC or VKA.

In patients requiring extended therapy, initial AC choice of therapy may be continued.

Topic 7: *Compression Stocking to Prevent Post Thrombotic Syndrome (PTS).*

AT10 discourages the use of compression stockings to prevent PTS in patients with an acute DVT of the leg.

This recommendation focuses on prevention of the chronic complication of PTS. Therefore, it is still acceptable to use compression stockings for relief of PTS symptoms.

Topic 9: *Treatment of Acute PE Out of the Hospital.*

Patients who are at low-risk for PE, with adequate home circumstances, may be treated at home or be early discharged.

Topic 10: *Systemic Thrombolytic Therapy for PE.*

Acute PE with hypotension (SBP<90), no high bleed risk, thrombolytic treatment is suggested.

Topic 11: *Catheter-Based Thrombus Removal for the Initial Treatment of PE.*

Use systemic thrombolytic therapy using a peripheral vein over CDT.

If a patient has an acute PE associated with hypotension and who has: a high bleeding risk, failed systemic thrombolysis, shock that is likely to cause death before systemic thrombolysis can take effect (e.g. within hours), it is suggested to do a Catheter-Assisted Thrombus Removal (ex: MegaVac).

Topic 12: *Pulmonary Thromboendarterectomy in for the Treatment of Chronic Thromboembolic Pulmonary Hypertension (CTEPH).*

Treatment of choice is pulmonary thromboendarterectomy.

Clinical Practice Updates: Anthithrombotic Therapy Update for Treatment of VTE Disease - CHEST Guidelines 10th Edition (AT10)

(continued from page 6)

WHAT IS NEW (Topic 8, 3, 14):

Topic 8: *Whether to Anticoagulate Subsegmental PE.*

For patients with low risk for VTE recurrence, clinical surveillance is suggested.

For patients with high risk for VTE recurrence (risks include: hospitalization, reduced mobility, active cancer/chemotherapy, recent surgery, and low cardiopulmonary reserve), AC is suggested.

Topic 3: *Aspirin (ASA) for Extended Treatment of VTE.*

In patients with an unprovoked proximal DVT or PE, who stopped AC therapy, and have no contraindications to ASA, treat with: ASA 100mg daily to prevent recurrent VTE.

ASA is not intended for extended treatment, is a reasonable option only in patients who would otherwise not receive oral AC.

The treatment effect of ASA is much less than that achieved with VKA or NOACs (40% vs. 80%, respectively).

Topic 14: *Management of Recurrent VTE on Anticoagulant Therapy.*

In patients on VKA (in therapeutic range) or NOAC (compliant) treatment experience recurrent VTE patients, AT10 suggests switching to treatment with LMWH (for at least 1 month).

If there is an irreversible reason for recurrent VTE (ex: cancer and patient is on AC) and AC cannot be increased (ex: due to bleeding), AT10 suggests inserting a Vena Cava Filter (last resort).

If the recurrence happened on LMWH (compliant and no risk of bleed), the dose of LMWH can be increased by a quarter to a third.

Of 54 recommendations included in the 30 statements, 20 were strong and none were based on high-quality evidence, highlighting the need for further research. Although it is a grade 2B recommendation, the use of NOACs as first line as opposed to VKA favors patient and provider convenience. Recommending shorter hospital stays (topic 9), categorizing patients into high/low risk categories (topic 8), and using aspirin as a protective agent (topic 3) are prominent changes. AT10's focus is more patient specific, which will hopefully prevent hospitalizations and VTE recurrences.

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--Roksolyana Filipchak, PharmD Candidate, TCOP Class of 2017

Reviewed by Nataliya Shinkazh, PharmD, BCPS, CDE

"Phundamentals"#2: The Mother Test

I have several friends whose mothers are actively dying or have steadily progressive chronic physical and/or mental disorders that have changed BOTH of their lives. Since I last felt my mother's touch over 56 years ago, I have led a life with a hyper-observant eye at how others interact with their mothers. It was on my first clinical rotation in my PharmD program that I witnessed a medical intern having to interact with a patient with a new terminal diagnosis. It was the first-time I heard a family member ask THE question: **"Doctor, if she was your mother, what would you do?"**

Over the years I have heard this question repeatedly and it has even been asked of me, most recently by one of the previously mentioned friends whose mother is in the care of hospice right now. This question has always intrigued me. These current "end-of-life" or "change-of-life" experiences of my friends PLUS some of my recent encounters with other members of my current health-system, other health-systems, insurers, government agencies and pharmacists in the community PLUS Mother's Day 2016 have catalyzed this essay. The New York Times published an article on August 1, 2013 by Dr. *Haider Javed Warraich*
"If This Were Your Mother Doctor…" (http://well.blogs.nytimes.com/2013/08/01/if-this-was-your-mother-doctor/?_r=0). Dr Warraich very efficiently summarized the intention behind, the utility of and the essence of this question. I encourage you to read the article AND the numerous replies (171 linked comments)! One brief statement encapsulated my thoughts:

> "by invoking the physician's parent, they hope to humanize the physician"

My recent encounters left me with evidence of the "culture of indifference" to which Pope Francis has frequently alluded to during his papacy. Would each of these people, performing their specific task, really respond in the manner that they did if the issue involved their mother? Their relative indifference to the human being involved or failure to act in accordance with this ethic (or even in some cases with "usual and customary professional care") is simply astounding to this hyper-observer.

Yes there are rules. Yes there are policies. Yes there are procedures. Yes, there are far more than enough of all of these. Are there not ethical practices anymore? Are all the distractions of modern communications, the disruptions caused by so many fingers in the health care pot, and the demands upper management places on most health care professionals to "get the job done and move on" (in order to meet some primarily financial metric) actually fostering this indifference? Isn't "The Mother Test" applicable in guiding most of our clinical/patient-oriented decisions? I am sure that in the thick of an over-booked day that I fail to meet this standard as I try to quickly and perfunctorily usher a patient who reeks of body-odor through a medication management encounter, in contrast to my protracted conversation with the sweet 97-yr-old grandmother who still works full-time and bathes regularly. Or as I attempt to negotiate, via an over-the-telephone interpreter, with a patient who is rightfully upset by the care she did or did not receive from another segment of our health system, how do we pause and step back to consider "The Mother Test" while in the "heat of the battle"? Is there a way to prepare ourselves? Has Pharmacy School prepared us? I don't recall having a class or any formal training in ethics in either my Bachelors degree or PharmD curriculum. Perhaps our best training may be taking the time on a regular basis to reflect upon our day, especially the difficult decisions contemplating our success or failure in the application of "The Mother Test".

-Gregory Szymaniak BSc, PharmD, BCACP

Questions? Please contact:
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