Improving Pharmacist-Physician Communication: Report of a Pilot Workshop

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Professional communication between pharmacists and physicians often leaves one or both participants feeling dissatisfied with the interaction. A two-hour workshop for junior pharmacy students on strategies to improve pharmacist-physician communication was developed at the University of New Mexico Health Sciences Center. Students were asked to analyze several scripted pharmacist-physician interactions and cite examples of “good” and “bad” communication. The workshop was generally well-received by the participating students who reported that it provided them with helpful strategies for effectively interacting with physicians.

INTRODUCTION

There seems to a consensus feeling that communication between pharmacists and physicians is often sub-optimal(1-3). Reasons for this are complex, but the end result is a working relationship that can, in many instances, be less than satisfactory. The real danger, of course, is that an impaired working relationship between two such essential health care professionals carries with it the potential for adverse effects on patient care and patient outcome.

In a pilot effort to bridge the “communication gap” between pharmacists and physicians we organized and ran a two-hour workshop on “Improving Pharmacist-Physician Communication” for junior pharmacy students at the University of New Mexico Health Sciences Center. The workshop was part of a required two credit course on communication in different pharmacy settings. Prior to attending this workshop, the students had attended three lectures on interpersonal communication and barriers to effective communication. The following is a description of the workshop as well as an assessment of this session by the students who participated.

METHODS

A physician (RHR) and pharmacist (BLS) collaborated to develop three “cases” depicting pharmacist-physician interactions. For each of the cases scripts were written to illustrate examples of “good” and “bad” physician-pharmacy communication. Each script was a page or less in length and could be acted out in two to three minutes (see Appendix). The situations depicted in these scenarios were designed to reflect common issues in pharmacist-physician communication, including: (i) the need for mutual professional respect; (ii) strategies to avoid confrontation; and (iii) collaborative problem-solving.

After each scenario was presented the students were asked to individually list specific examples of “good” and “bad” communication on the part of the “pharmacist” and also on the part of the “physician”. A ten-minute general discussion (led by a pharmacist and a physician) followed each of the scenarios, and the students’ comments were summarized on a flip chart. Emphasis was placed on “negative” communication that could have been re-phrased and thus turned into “positive” communication. A five-minute summary was used to conclude the workshop, emphasizing the major points which the students themselves had made during the session. Finally, the students were asked to complete a one-page workshop evaluation form.

RESULTS

Students’ Comments About Positive and Negative Communication in Scenarios

Table I illustrates what students perceived as the principal positive and negative aspects of pharmacist-physician communication in each of the scenarios. One of the major points noted by students was whether the pharmacist or physician had appropriately introduced himself/herself. Another feature commented on by the students was the pharmacist’s or physician’s apparent motivation for initiating the pharmacist-physician encounter: Was the interaction initiated out of concern for the patient and/or quality of care or did the interaction occur because of concerns about costs or litigation? A third characteristic mentioned by the students was the communication style of the health care professional, i.e., was the health care professional rude and condescending or was he/she helpful, pleasant, and professional?

The students also felt that the pharmacist’s preparation prior to initiating the interaction was an important aspect of the scenario. Did the pharmacist know the patient’s name and history? Was the pharmacist prepared to suggest therapeutic alternatives to the physician? Was the pharmacist prepared to help the physician prescribe within the hospital’s formulary?

Another facet of the scenarios noted by the students was whether the health care professional clarified information or asked the other person to clarify information. Students also noticed when the pharmacist asked a leading question. Finally, students expressed concern about Scenario IV because the problematic prescription was not changed even after the physician and pharmacist interacted.
Table 1. Student comments about positive and negative aspects of pharmacist-physician communication during the six workshop scenarios

<table>
<thead>
<tr>
<th>Comments</th>
<th>N (percent)</th>
<th>Comments</th>
<th>N (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician</strong></td>
<td></td>
<td><strong>Physician</strong></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>more patient than pharmacist</td>
<td>18 (21)</td>
<td>identifies self</td>
<td>26 (30)</td>
</tr>
<tr>
<td>asked to speak to another pharmacist</td>
<td>18 (21)</td>
<td>responsive to information given</td>
<td>21 (24)</td>
</tr>
<tr>
<td>introduced self</td>
<td>14 (16)</td>
<td>admitted lack of of knowledge</td>
<td>8 (9)</td>
</tr>
<tr>
<td>concerned about patient’s well-being</td>
<td>13 (15)</td>
<td>concerned about information presented</td>
<td>7 (8)</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td></td>
<td><strong>Negative</strong></td>
<td></td>
</tr>
<tr>
<td>condescending/rude</td>
<td>13 (15)</td>
<td>did not change prescription</td>
<td>24 (28)</td>
</tr>
<tr>
<td>accused pharmacist of being wrong</td>
<td>5 (6)</td>
<td>not aware of patient</td>
<td>10 (11)</td>
</tr>
<tr>
<td>impatient because put on hold</td>
<td>5 (6)</td>
<td>not prepared</td>
<td>8 (9)</td>
</tr>
<tr>
<td><strong>Pharmacist</strong></td>
<td></td>
<td><strong>Pharmacist</strong></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>informed physician about medication</td>
<td>5 (6)</td>
<td>identifies self</td>
<td>48 (55)</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td></td>
<td>offered further help</td>
<td>18 (21)</td>
</tr>
<tr>
<td>rude/short</td>
<td>37 (43)</td>
<td>professional</td>
<td>15 (17)</td>
</tr>
<tr>
<td>inappropriate use of putting someone on hold</td>
<td>34 (39)</td>
<td>explained the situation</td>
<td>15 (17)</td>
</tr>
<tr>
<td>uncaring</td>
<td>9 (10)</td>
<td>informative</td>
<td>12 (14)</td>
</tr>
<tr>
<td><strong>Scenario II</strong></td>
<td></td>
<td><strong>Scenario V</strong></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td>Physician</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>concerned about patient’s well-being</td>
<td>24 (28)</td>
<td>identifies self</td>
<td>39 (45)</td>
</tr>
<tr>
<td>thanks pharmacist</td>
<td>7 (8)</td>
<td>pleasant/polite</td>
<td>20 (23)</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td></td>
<td>showed concern</td>
<td>17 (20)</td>
</tr>
<tr>
<td>impatient</td>
<td>28 (32)</td>
<td>explained the problem to pharmacist</td>
<td>16 (18)</td>
</tr>
<tr>
<td>rude</td>
<td>25 (29)</td>
<td><strong>Negative</strong></td>
<td></td>
</tr>
<tr>
<td>did not identify self</td>
<td>18 (21)</td>
<td>did not change prescription</td>
<td>22 (25)</td>
</tr>
<tr>
<td>swore</td>
<td>14 (16)</td>
<td>not prepared</td>
<td>8 (9)</td>
</tr>
<tr>
<td><strong>Pharmacist</strong></td>
<td></td>
<td><strong>Pharmacist</strong></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>identifies self</td>
<td>26 (30)</td>
<td>identifies self</td>
<td>38 (44)</td>
</tr>
<tr>
<td>very professional</td>
<td>13 (15)</td>
<td>suggests alternative therapies</td>
<td>18 (21)</td>
</tr>
<tr>
<td>clarified information</td>
<td>10 (11)</td>
<td>rude</td>
<td>45 (52)</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td></td>
<td>suggests that price more important than quality</td>
<td>16 (18)</td>
</tr>
<tr>
<td>asked a leading question</td>
<td>15 (17)</td>
<td>unprofessional</td>
<td>12 (14)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>not helpful</td>
<td>11 (13)</td>
</tr>
<tr>
<td><strong>Scenario III</strong></td>
<td></td>
<td><strong>Scenario VI</strong></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td>Physician</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>identified self</td>
<td>34 (39)</td>
<td>identifies self</td>
<td>22 (25)</td>
</tr>
<tr>
<td>asked pharmacist to clarify informa</td>
<td>24 (28)</td>
<td>professional</td>
<td>15 (17)</td>
</tr>
<tr>
<td><strong>Pharmacist</strong></td>
<td></td>
<td>fosters teamwork</td>
<td>9 (10)</td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>identified self</td>
<td>34 (39)</td>
<td>identifies self</td>
<td>34 (39)</td>
</tr>
<tr>
<td>called about potential drug interaction</td>
<td>11 (13)</td>
<td>offers to help physician with non- formulary form</td>
<td>21 (24)</td>
</tr>
<tr>
<td>had good intentions</td>
<td>11 (13)</td>
<td><strong>Negative</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>did not identify self</td>
<td>11 (13)</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>rude</td>
<td>39 (44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not prepared for conversation with physician</td>
<td>34 (39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>did not explain in professional manner to physician</td>
<td>34 (39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>motivation wrong (mentions lawsuit)</td>
<td>21 (24)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Students’ Evaluation of Workshop**

Ninety-five students attended the workshop and 87 completed the evaluation form, for a response rate of 92 percent. One section of the evaluation form consisted of four statements with which the students were asked to indicate their level of agreement or disagreement on a five-point Likert scale (“strongly agree”; “agree”; “unsure”; “disagree”; “strongly disagree”). In another section of the evaluation form the students were asked to comment on what they perceived to be the “strengths” and “weaknesses” of the session.

**Likert-Scale Responses to Evaluation Form Statements**

The results of the Likert-scale section of the evaluation
form are summarized in Table II. For purposes of analysis, “strongly agree” and “agree” responses were combined, as were “strongly disagree” and “disagree” responses. “Unsure” was left as a third, separate category. Overall, the students rated the session quite highly, with “positive” responses ranging from 90.8 percent (79/87) to 96.6 percent (84/87) for the four statements presented.

**Comments About Session’s Strengths**

Comments regarding the session’s strengths focused on several areas, including the opportunity to voice one’s own opinion, the opportunity to directly hear the perspective of a practicing physician, and the perception that watching and discussing the scenarios made for a more engaging learning experience than a traditional lecture. Representative comments included:

“Role-playing allowed students to better visualize and analyze situations which might occur.”

“Interactive and humorous.”

“Actually ‘walking through’ the scenarios was good.”

“Put pharmacists and physicians on same level. We tend to perceive physicians as ‘unapproachable’ but actually each individual physician is different.”

“Good to have a physician present his point-of-view.”

“Student input was encouraged.”

“Entertaining, got everyone involved.”

**Comments About Session’s Weaknesses**

Comments regarding the session’s weaknesses pointed out that some of the scenarios seemed redundant and that, overall, the scenarios could have been more realistic (and perhaps even more confrontational). Representative comments included:

“A little extreme, inflated.”

“I didn’t feel I learned anything new.”

“Needed more suggestions regarding MD-pharmacist confrontations.”

“The emphasis seemed to be on maintaining the MD’s ego.”

“The issues were real, but the way they were presented wasn’t. The situations were often too bipolar.”

“At some points seemed as though we were beating a dead horse.”

**DISCUSSION**

Several citations in the literature have expressed the concern that pharmacist-physician communication if often less than ideal(1-3), and that interactions involving these two groups of health care professionals have the potential of provoking frustration or even anger. Of note, the need to improve pharmacist-physician communication appears to be an area of concern not only to health care professionals in the United States but also to their counterparts in Great Britain(4,5) and Australia(6,7).

Numerous barriers to effective pharmacist-physician communication have been described. Some of these barriers have a fascinating historical context. As Hall(8) and Cowen(9) point out, in the nineteenth century physicians usually dispensed medications out of their own offices; therefore, in days gone by, the physician and pharmacist were one and the same. The rise of pharmacy as a separate discipline thus posed a threat (primarily but not exclusively economic) to practicing clinicians.

Another major barrier to communication (and a paradoxical one at that) is the prescription script. Traditionally, this has been the major means of communication between physicians and pharmacists(7) and still remains a cornerstone of the physician-pharmacist communication process. The difficulty, of course, is that the prescription is a one-way, rather than a two-way, form of communication. To many physicians, however, the prescription slip is the only way they have ever communicated with pharmacists, and their training and practice has not enabled them to see pharmacists in a broader consultative and collegial role.

As Albro(2) has pointed out, physicians and pharmacists often have different agendas and concerns, related in part to differences in training but also due to differences in professional roles and responsibilities. The recent emphasis on controlling health care costs (e.g., by using the least expensive medication among those which are effective in a given clinical situation) has cast these different perspectives into even sharper focus: physicians are understandably more comfortable prescribing medications they are familiar with — and whose effectiveness they have confidence in(2) — rather than medications recommended by someone perceived as an “outsider” who does not have the same degree of direct clinical responsibility. Pharmacists, on the other hand, must wonder why some physicians persist in prescribing costly medications when less expensive agents would achieve the desired clinical outcome.

Lastly, the fact that physicians and pharmacists have traditionally been trained in relative isolation from each other(10) undoubtedly contributes to a lack of collegiality in later years. Herrier and Boyce(11) have recommended that pharmacists become “bilingual,” i.e., conversant in the patient problem-focused language used by physicians as in the drug-focused language traditionally used by pharmacists.

Numerous attempts to improve pharmacist-physician communication have been described. Some of these efforts have emphasized the benefits of increased pharmacist-physician interaction both during training(12) and clinical prac-
tice(4,13,14). Other efforts have focused on collaborative pharmacist-physician projects such as educational drug fairs(15), a joint approach to improving the prescribing of generic drugs(16), the innovative use of informational pharmacist-generated computer messages(17), and a regional pharmacist-physician task force(18). Common threads uniting all of these varied efforts include the importance of mutual respect and the recognition that excellent interprofessional communication can only serve to enhance patient care. If anything, one suspects that the importance of effective pharmacist-physician communication will become even more widely recognized in the future, as an increasing percentage of Americans join managed care organizations with restricted (and often changing) formularies.

This article describes our attempt to effect improvement in pharmacist-physician communication by developing a workshop on this topic for junior pharmacy students. This workshop featured brief case “scenarios” illustrating examples of “good” and “bad” communication; in addition, we attempted to make the workshop as interactive as possible by asking the students to analyze each of the scenarios in turn, first individually and then as a group. Emphasis was placed on defining the components of an effective pharmacist-physician encounter, including a brief introductory statement, an organized approach, a non-confrontational style, the need to speak the physician’s language, and the importance of focusing on quality of care issues. In addition, the session provided an opportunity for the two workshop leaders (a physician and pharmacist, respectively) to role-model a respectful, participatory style; the aim was to demonstrate how health care professionals with different training and from different backgrounds could effectively work together to reach consensus on issues of substance.

Overall, the students were quite positive in their assessment of the workshop; their comments indicated that this session was an effective and efficient means of developing practical strategies to improve pharmacist-physician communication.

We believe our next step is to begin to integrate medical students and pharmacy students (along with nursing students) in a course which examines the roles and responsibilities of different health care professionals; we are hopeful that mutual understanding and respect, nurtured early on, will result in improved working relationships among our students during the remainder of their training and in the years beyond.

Am. J. Pharm. Educ., 61, 359-364(1997); received 1/21/97, accepted 10/14/97.

References

APPENDIX. SCENARIOS USED IN “IMPROVING PHARMACIST-PHYSICIAN COMMUNICATION WORKSHOP

Scenario I
Physician phones pharmacist.
MD: Hello?
RPh: I’m really busy. Can you hold? (taps “hold” button, then reads magazine, drinks soda)
MD: Hello? Hello? (rolls eyes, shakes head, looks at watch) I can’t believe this.
RPh: (after 10-15 seconds, reconnects with MD) You still there?
MD: I’m here all right, but I thought you forgot about me.
RPh: Hey look, it’s busy here too, you know.
MD: OK, OK, whatever. I called because I have a real problem here. I prescribed simethacine for one of my patients with renal failure who has abdominal bloating, but the patient tells me he was given “Mylanta gas relief” instead.
RPh: So what’s the problem?
MD: So what’s the problem? Excuse me, but don’t you know that Mylanta contains magnesium, and magnesium-containing products are contraindicated in patients with renal failure?
RPh: (sarcastically) Well “excuuuse” me, but don’t you know that “Mylanta gas relief” doesn’t contain magnesium?
MD: What are you talking about? It’s called “Mylanta”.
RPh: I don’t care what it’s called. They can call it Mylanta, shmylanta, Irving. Fred ... I don’t care what they call it. It still doesn’t have any magnesium in it.
MD: Look, is there someone else there I can talk to?

**

Scenario II
Physician phones pharmacist.
MD: Hello?
RPh: I have a patient on the other line. Can you hold for a moment, please?
MD: Well, if it’s just for a moment.
RPh: It’ll just be a second, (taps phone button, then speaks into
phone again) That’s right, Mrs. Jones, it’s OK to take Septra even if you’re allergic to penicillin. Now, you’re not allergic to sulfas, are you? ... No? Then Septra should be ok for you ... You’re welcome. ‘Bye now. (taps phone button again) Hello?

MD: Gee, I thought you forgot about me.

RPh: I’m really sorry. I just had to clarify something for an elderly patient. How can I help you?

MD: Well, I’m concerned because I prescribed simethicone for a patient with renal failure, and he informs me that he was given “Mylanta gas relief” instead.

RPh: And you’re concerned about the magnesium issue?

MD: Exactly.

RPh: Well, let me check in the PDR for you. I believe there’s no magnesium in “Mylanta gas relief” despite the Mylanta brand name, (checks in PDR) Yes, that’s right. No magnesium.

MD: Well I’ll be durned.

RPh: Yeah, it’s really confusing for the drug companies to do that. I imagine they do it for marketing purposes.

MD: Well, thanks very much for your help.

**

Scenario III

Pharmacist dials physician’s office.

Nurse: (nasal voice) Dr. …………..’s office. Can I help you?

RPh: This is the pharmacist. Is Dr. ………….. there?

Nurse: (nasal voice) Just a moment, (pushes “hold” button) The pharmacist is left on “hold” for 10-15 seconds. She stews, looks at her watch, etc.

MD: Hello, this is Dr. …………..

RPh: Did your nurse forget to tell you I was on the phone? It didn’t sound like her elevator went all the way upstairs.

MD: That wasn’t my nurse. That was my wife.

RPh: Whatever. Anyway, you remember that prescription you wrote on that 45-year-old guy. What’s his name? (fumbling through stack of prescriptions)

MD: I don’t have the foggiest idea who you’re talking about.

RPh: I’ll find it in just a second, (continues to shuffle through prescriptions) here it is. Mr. Smith, the guy on Seldane and now you’re prescribing erythromycin.

MD: So?

RPh: So? Is what you just said, “so”?

MD: So what’s the problem?

RPh: The problem is that we must have a very bad connection ’cause I can’t believe I’m hearing you correctly.

MD: What did you just say?

RPh: Don’t you know that prescribing Seldane and erythromycin together is a big no-no?

MD: A no-no? What’re you talking about? What’s a no-no?

RPh: With malpractice being the way it is these days, Doc, I’d watch myself if I were you.

MD: Malpractice? Hey, I want to speak to your supervisor?

RPh: You’d probably be better off speaking to (name of locally prominent attorney).

MD: …………..? who’s …………..? (slams down the phone) Pharmacists! Who’s training them these days?

**

Scenario IV

Pharmacist dials physician’s office.

Nurse: (nasal voice) Dr. …………..’s office. Can I help you?

RPh: This is ………….., one of the pharmacists from ………….. pharmacy. Can I speak to Dr. ………….. please?

Nurse: (nasal voice) Just a moment, (pushes “hold” button) The pharmacist is left on hold for 10-15 seconds.

MD: Hello, this is Dr. …………..

RPh: Dr. this is ………….., one of the pharmacists from ………….. pharmacy. I have a question about Mr. Smith’s prescription.

MD: Mr. Smith?

RPh: The gentleman you saw earlier today for sinusitis. I’m calling about the erythromycin prescription.

MD: Why? Is he allergic?

RPh: No, it’s not that. I’m not sure if he mentioned this to you, but he’s also taking Seldane and, as you know, there have been reports of interactions between Seldane and erythromycin.

MD: Really? I wasn’t aware of that.

RPh: Well, in the past few years, there have been reports of ventricular arrhythmias when the two were used together. Erythromycin affects the way Seldane is metabolized in the liver, so essentially using the two together leads to a Seldane overdose.

MD: Whoa. That’s pretty scary. I knew a Seldane overdose could cause ventricular arrhythmias, but I didn’t know erythromycin could contribute to that.

RPh: It’s also been described with ketoconazole and a few other anti-fungal meds.

MD: No kidding.

RPh: If you’d like, I could send you some information on it.

MD: That would be great. I could add it to my files. Thanks very much.

**

Scenario V

Physician’s pager goes off. He notes the number and dials the phone.

MD: Hello, this is Dr. ………….. Someone just paged me.

RPh: This is ………….. From the hospital pharmacy. Don’t you know we don’t carry amlodipine any more?

MD: I beg your pardon?

RPh: Amlodipine. We don’t carry it.

MD: Why not?

RPh: It’s too expensive.

MD: Well, I have a patient who’s been on other calcium channel blockers but developed edema. I thought amlodipine caused less edema than nifedipine or even dilatiazem.

RPh: Edema, shmedema. It’s not on the formulary.

MD: I don’t understand. It was on the formulary last month.

RPh: Not any more it isn’t. Not as of two weeks ago.

MD: What am I supposed to do now?

RPh: Were you prescribing it for hypertension?

MD: Yes I was.

RPh: What’s the matter with a beta-blocker?

MD: The patient has asthma.

RPh: Then what about a diuretic?

MD: He also has gout and hyperlipidemia.

RPh: Well, I guess you got a problem there, doc. I guess that’s why your parents shelled out the big bucks to send you to medical school, right?

MD: Is there someone else from the pharmacy I could speak to?
The P and T committee decided to take it off about two weeks ago but unfortunately we haven't gotten the memo out yet.

**MD:** Oh wow. The formulary around here changes so darn often.

**RPh:** Yeah. Frankly, it's confusing for us, too. The major issue is cost. Amlodipine is much more expensive than generic diltiazem or generic nifedipine.

**MD:** I understand that, but my patient didn't tolerate either of those because of edema, and I've read that amlodipine tends to cause less edema than either nifedipine or diltiazem.

**RPh:** That's true. Can I suggest a few other options?

**MD:** Sure. Go ahead.

**RPh:** You could leave the patient on diltiazem and add a diuretic for the edema.

**MD:** I'd prefer not to use a diuretic because he also has gout and hyperlipidemia.

**RPh:** What about an ACE inhibitor or a beta-blocker?

**MD:** The patient already has a chronic cough because of pretty severe asthma.

**RPh:** Well, another option would be to fill out a non-formulary request form.

**MD:** Under the circumstances, that's probably the best thing to do.

**RPh:** Do you have a form easily available or should I send one up?

**MD:** I would really appreciate it if you could send one up. I'm seeing patients in the clinic right now and I'm running a little late.

**RPh:** Sure. No problem.

**MD:** Great. Thanks very much for your help.