
Ethical dilemmas in pharmacy

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Author's abstract

Results of surveys in which pharmacy students and pharmacists responded to ethical dilemmas are discussed. Respondents indicated a high level of concern about patient welfare and patient rights in dilemmas involving conflicts with socio-economic issues, and with peers and physicians. Conflicts that might arise as the roles of pharmacists change and the health-care systems evolve are also discussed.

Introduction

Ethical dilemmas occur when there are disagreements on ethical behaviour or application of ethical principles. Ethical dilemmas can occur between pharmacists and clients, pharmacists and physicians, and among pharmacists because the values, sense of justice and fairness of each party may differ. Each party might espouse a different principle, such as a utilitarian view versus the respect for the individual. In health care, ethical dilemmas most often affect physicians, but in an increasing cascade other health-care providers, such as pharmacists, are facing situations in their practices that are causing ethical dilemmas. Within one generation our health-care systems have gone from relatively simple systems to very complex ones. The problem of legal liability, real and perceived, affects the actions of physicians and pharmacists as each tries to maximise patient care and minimise legal liability. Collegial relationships become strained under certain circumstances. The cost of insurance has risen for everybody and astronomically for some physicians, making risk-taking even more hazardous.

The geometric increase in information about diseases and their treatment and electronic technology has caused a problem between physicians and pharmacists. There is a problem of flow of information between professionals and between professionals and patients. Who tells what to whom and how much information is shared? Consideration of duty to inform, rights of patients, confidentiality, and truthfulness become increasingly difficult to respond to.

Key words

Ethical dilemmas; pharmacy; level of ethical reasoning.

Since the interrelationship of physicians and pharmacists has become greater, it has become important for each to understand the other and to complement each other if there is to be efficient and effective patient-care. It is the purpose of this paper to update ethical issues faced by pharmacists and their responses to some of these dilemmas.

Students in a school of pharmacy and pharmacists in the State of Virginia have been surveyed as to their responses to certain ethical dilemmas (1,2). Both third-college-year (first professional year) and fifth-college-year (third professional year) students were queried. Responses by mail from a random sample of pharmacists were solicited and a limited response rate of around 30 per cent was obtained. Thus the results should be regarded as indicative rather than conclusive and other surveys are desirable. The dilemmas used in the survey were those reportedly experienced in practice by pharmacists, those discussed in the literature (3,4,5,6), at a national meeting (7) in the United States, or in various codes of ethics in pharmacy. The responses to the multiple-choice questions were analysed and grouped, based on similarity of responses by the three groups.

Results

A large majority in all three groups chose alternatives which showed a high degree of caring for patients and patient rights, overriding economic issues or conflict with the letter of the law. For example, there was an 88 per cent overall agreement among the three groups polled on four questions that dealt with the right of sixteen-year-old persons to buy condoms or oral contraceptives and receive advice without confidentiality being violated. Although there was general agreement among the respondents, pharmacists felt the strongest that prescription files were confidential (85 per cent, against 59 per cent for the students). In response to six questions involving different situations with welfare patients, 88-97 per cent indicated that they would give equal treatment to all clients. Seventy-eight per cent also agreed that advertising to the public would be acceptable.

The use of placebo products presents a difficult situation for both physicians and pharmacists. Placebos are both a form of therapy and a form of

deception. The dilemma involves not telling the truth for the patient's benefit. The physician initiates the action and the pharmacist is expected to go along with the deception. What happens when the patient asks for further information or suspects the prescription is for a placebo? About 70 per cent of the responses of all three groups were similar – referring back to the physician or supporting the physician's perceived intent. Spontaneous written comments indicated that placebos are rarely seen in community practices so that the issue of placebo products may be more of a dilemma in teaching hospitals.

In the area of professional standards, there is a consensus for self-policing in dealing with a potential malpractice situation of another pharmacist, with 62–70 per cent of the respondents indicating the matter should be referred to the licensing authority. There was also general agreement on charging a lower price for generic drugs, giving the client the savings. Patient welfare was again demonstrated when, on a case involving a severe overdose of a barbiturate in a child, there was agreement not to fill the prescription even though the physician indicated the prescription was correctly written.

It seems that with experience comes: greater respect for patients and a better balance of appropriate action; more reasoned responses, and an understanding of physicians' rights and responsibilities and of economic realities. The younger students seem to have a more conservative and legalistic approach to dilemmas, which is not unexpected. The more experienced pharmacists are most likely to fill prescriptions based on their experience with particular patients and physicians, for example use of mild tranquillisers. In several dilemmas fifth-year students and pharmacists agreed more closely on the actions to take and differed from the third-year students. The more experienced respondents were more likely (95 per cent as contrasted to 66 per cent) to refill prescriptions for small amounts of medications for clients if the physician could not be reached. They were also more likely to fill prescriptions for dose regimens and therapeutic uses for non-federally approved uses or fill prescriptions for clients who owed money to the pharmacy. The more experienced respondents also seemed to have a better sense of degree of urgency in filling prescriptions.

Students indicated that they would be more likely to try to sell generic over-the-counter drugs than pharmacists (68 per cent in contrast to 42 per cent) because their schooling made them more comfortable with the quality of today's generic drug products than older pharmacists who may have had negative experiences earlier in their careers. Pharmacists seemed more oriented to brand-name products, in part due to different emphasis during their education.

There were a series of dilemmas where there was a gradation in responses in which first professional year (third-college-year) students gave a response at one level, the third professional year (fifth-college-year) students a response at a middle level and the

pharmacists at a third level. Pharmacists were less willing to do counselling of patients than fifth-year students. Third-year students indicated the greatest willingness to do counselling. Students are now better trained in oral communication skills than their predecessors and in their college training they are given more time to counsel patients. Pharmacists (65 per cent) said that they would be more willing (trend up from 16 per cent) to fill a prescription with a potential drug interaction after consulting with the physician. The more experienced pharmacists would more likely fill a prescription for a drug known to cause drowsiness to a public bus driver after warning the patient whereas students would consult with the physician. Yet pharmacists much more than students would consult the physician in a suspected suicide due to hoarding of drugs.

Pharmacists were more adamant about separating business affairs and professional affairs and exhibited high ethical standards on business practices. To be sure, more often than not, the prescription was filled but only after the pharmacists seemed satisfied that the patients' rights were protected. The pharmacists' approach was more pragmatic, which could be due to realities of practice. There was an increasing trend from students to pharmacists with over three quarters of the pharmacists indicating they would avoid conflict of interest on approval of drugs by a hospital pharmacy and therapeutic committee and by not participating in a questionable business deal involving a physician-owned nursing home.

Discussion

Given the limited response rates definite conclusions cannot be drawn. However, certain important trends are suggested, including a very positive attitude by pharmacy students and pharmacists towards the welfare and rights of patients and an ability to separate economic interests and professional judgements. Kohlberg (8) divided human ethical behaviour into six stages. In stage one the aim is to avoid punishment and achieve gratification; in stage two one exchanges power and favours rather than considers loyalty and justice; in stage three there is confusion between social approval and right and wrong; at stage four there is an orientation towards law and order; stage five involves general principles of human rights; and at stage six behaviour acknowledges the rights of individuals. Dolinsky and Gottlieb (5) indicated in their study that 37 per cent of the pharmacists' responses were at Kohlberg's stages of 4–6. The survey results discussed in this paper also showed that pharmacy students and pharmacists responded at the higher stages of Kohlberg 40–50 per cent of the time. Their actions appear to have observed the admonition: Above all do no harm. In a study of pharmacy students, pharmacists and clients Stroman (9), and in a study of nurses and nursing students (10), similar results were found. Students are learning and gaining experience with which to make ethical decisions. They are learning that a

textbook drug interaction may be uncommon in general practice and that individual characteristics of patients and individual prescribing habits of physicians may result in dilemmas for the inexperienced.

There are changes coming which will continue to modify the relationship of pharmacists and physicians. Consider the following: health-care delivery is becoming more centralised, in some instances national governments have taken control and in other instances mega-corporations control the delivery. In the United States insurance companies have merged with hospitals, other health-care facilities and drugstores to form a continuous chain of health-care delivery. Health Maintenance Organisations (HMOs) can consist of employer, insurance company, physician, and pharmacists. These systems have led to the depersonalisation of both clients and health-care practitioners. Physicians and pharmacists are now salaried employees of the same organisation. To whom are they responsible and what are they responsible for? This also means another party has been inserted into the health-care system; another party who has the power because it pays the salaries and bills. Organisational policies and politics further complicate disagreements among health-care team members and resolution of dilemmas.

We have become more knowledgeable about illnesses and our diagnostic technology is constantly becoming more sophisticated and giving more information. Our treatment modalities also are more specific, more potent, more complex and more costly. The bionic person is slowly being built. Computers store all the information, retrieve it, sort it, analyse it, and if programmed appropriately, will make recommendations. Professionals are becoming super-specialists – for example there are paediatric oncologists and paediatric clinical pharmacists – adding another layer of complexity in relationships and treatment of patients. As a result health care may be more effective but more individuals are involved. As knowledge increases and it becomes more difficult for individuals, even with computers, to keep up, other professionals are expanding their roles and status, and asking legislatures to redefine the scope of their practices. Roles begin to bump into each other, for example, physicians, pharmacists and nurses all giving patients instructions about medications or physicians dispensing and pharmacists prescribing. Pharmacists no longer rely on their physical skills in compounding but now dispense information and counsel patients. Some of these issues mentioned above have been discussed by Berns (3) in an article aptly entitled *Pharmacists and the Sword of Damocles*.

As pharmacists become more understanding of disease states and their treatment they also become more sensitive to mistakes of their colleagues, for example an elderly patient on digoxin and furosimide (4). This means there needs to be increased awareness and sensitivity to each other's professional obligations.

Since best patient-care is the common denominator, physicians must be more willing to share information and medical reasons for decisions. As team-care becomes more prevalent, decisions must be made as to who is responsible for different functions; there will be shared responsibility and an ethics of team-care. Discussions may have to include employers and insurance companies. Codes of ethics might have to be rewritten so they are more innovative and less restraining and deal more with ethical behaviour than economics, for example coercion by employers, reporting misconduct of peers (whistle blowers), and inappropriate prescribing (psychiatrist prescribing an antibiotic for an inflamed throat of a child). Stevens and Firth (11) reported that medical students and psychiatric residents seemed to behave at a higher ethical level than the Canadian Medical Association Code of Ethics requires.

The level of resolving ethical dilemmas was refreshing and encouraging, but as pressures increase for better health-care and lower costs there will be issues that require discussions and understanding. If we do not work together and complement each other's strengths we will find the legislative process will try to resolve our dilemmas, for example by laws governing advertising, by changing our roles, and by changing how and what to prescribe. Accountants will dictate how health-care is delivered if we hesitate or are divisive.

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News and notes

Feminist medical ethics

A special issue of *Hypatia: A Journal of Feminist Philosophy* on feminist medical ethics is to be published and the publishers are calling for papers to be submitted. They welcome discussions of 1) feminist ethics; 2) issues involving medicine and women's bodies (for example, new reproductive technologies, childbirth issues, unnecessary surgery); 3) feminist rethinking of other issues in medical ethics (for example, human experimentation, euthanasia). The Editor is Helen Bequaert Holmes and the Associate Editor is Laura M Purdy. Preliminary deadline for submissions: March 15, 1988. Send a self-addressed envelope for guidelines to: Helen Bequaert Holmes, 24 Berkshire Terrace, Amherst, MA 01002, USA. Phone: 413-549-1226.