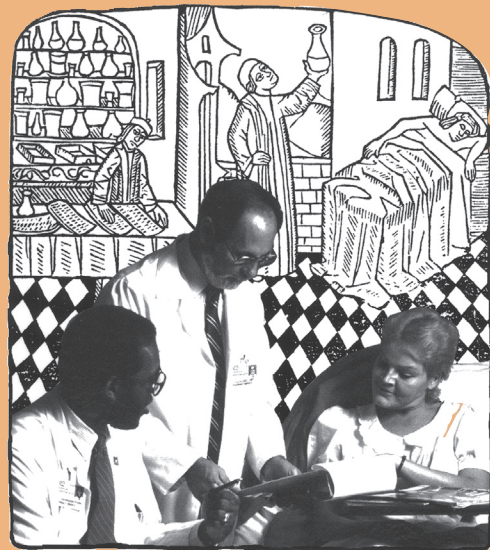


Foundations of Ethical Pharmacy Practice

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of
Ethical Pharmacy Practice**

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On the cover: The “triad of medical care” has been the basis for the ethical relationship between the pharmacist, the physician, and the patient for centuries. In the background is an early depiction of the triad from Book 7 of the encyclopedia *On the Properties of Things* by Bartholomew the Englishman, published in Westminster about 1495. The foreground is a photograph of a contemporary triad (courtesy of the Department of Veterans Affairs).

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Chapter 2

Foundations of Ethical Decision Making

America's pharmacists have long sought to maintain ethical standards as an integral part of their emerging professional character. The recent shift toward a more patient-centered practice of pharmacy has presented practitioners in all practice settings with a variety of new challenges. Expanded patient contacts have resulted in improved patient care, more rational drug therapy, and higher rates of compliance; however, these intensely personal, even intimate, contacts have increased the pharmacist's exposure to ethical and moral dilemmas. Moreover, the issues underlying these dilemmas tend to be more complex and significant than the product-centered problems faced by earlier generations of practitioners.

All persons draw upon a wide range of experiences and influences that converge to form their personal value system. The influences of our parents, friends, teachers, religious leaders, and others all combine to forge a basic value system that continues to expand during our years of pharmacy education and practical experience and into our professional practice. Our professional decisions flow from this unique, highly complex set of values we have acquired. How do our value system beliefs influence professional decision-making in pharmacy practice?

If we highly value interpersonal relationships with our patients, we might make decisions that enhance these relationships rather than conform to a formal statement contained in a professional code of ethics. Some pharmacists may value bureaucratic rules designed primarily for internal efficiency rather than the values associated with good patient care and refuse to continue maintenance therapy to an indigent patient because of certain third-party program constraints. Other pharmacists, placing a higher value on altruism, may circumvent these rules or even risk loss of reimbursement for their professional services by providing this therapy.

What are the agreed-upon personal values or ethical practice standards of American pharmacy? Can we identify time-honored moral principles and widely recognized ethical theories that apply to all generations of pharmacists in all practice settings? Are there commonly identified virtues so associated with the practice of pharmacy that they are embodied in every "ethical" pharmacy practitioner? Are the ethical norms reflected in pharmacy's code of ethics defined by a national body representing pharmacists, by pharmacy faculty in the classroom, by pharmacy-preceptors in the experiential program, or is ethical conduct merely what most pharmacists informally agree is "right" or "proper." Consider the following practice situation:

Situation 2.01: Invoking the Conscience Clause

A pharmacist working at a student health center pharmacy on a large campus refuses to fill a prescription for four oral contraceptive tablets once he realizes that the tablets are intended to be used for “morning-after therapy,” explaining that his religious beliefs do not condone abortion. “You may have a right to your religious beliefs,” the young woman counters, “but you don’t have a right to refuse to fill my prescription.”

Is the pharmacist acting ethical in this particular practice situation? Where do we turn for reasonable standards to affirm an ethical stance—broad ethical theories established over the years? Sets of humanistic virtues? Basic human rights and duties? A code of ethics?

Traditional Ethical Theories Applied to Pharmacy Practice

In the early 1930s, modern ethical theories were classified into two basic types of ethical theory that are still serviceable today: *consequentialism*, an ethical theory concerned only with the outcomes or consequences of actions, and *nonconsequentialism*, an ethical theory based upon the actions themselves without particular regard to their consequences. To a consequentialist, an action becomes “right” or “wrong” in terms of the benefit or harm the patient—and all others concerned—might derive from a given action. Following this line of reasoning, lying to a patient would be permissible, even laudable, if it resulted in some benefit to the patient or others. This rather paternalistic approach to patient care is the major principle underlying the Hippocratic Oath and many other codes of professional conduct that have been developed by pharmacists and physicians during the last 150 years.

The nonconsequentialist, on the other hand, looks at the action itself as either right or wrong, without regard to outcome. Following this line of reasoning, lying to a patient is wrong by definition, whether or not the lie might ultimately “benefit” all concerned parties. Pharmacists who deeply believe in nonconsequentialism are devoted to being faithful to the patient above all other considerations and are therefore disposed to tell the truth in even the most sensitive situations. These pharmacists would speak frankly, but kindly, to terminal cancer patients who are apparently unaware of the seriousness of their condition, confident that they are being faithful to them. In contrast, pharmacists who believe in consequentialism must struggle deciding whether the false serenity resulting from lying to these same patients would be more beneficial than any anguish resulting from telling the truth. To the pharmacist guided by nonconsequentialism, this dilemma is simply not an issue. Nonconsequentialism tends to be less paternalistic by allowing its proponents to focus upon a more objective goal—telling the truth becomes a “good” that outweighs the consequences associated with telling the truth or the patient’s ability to handle the truth.

In applying these theories to ethical dilemmas, many philosophers appeal to widely accepted moral standards in their quest for acceptable outcomes. These standards include *beneficence*, the principle that guides the actions and behaviors of practitioners toward beneficial patient outcomes, and *nonmaleficence*, the principle that urges practitioners to avoid actions and behaviors that might bring harm to their patients. Pharmacists demonstrate beneficence whenever they provide critically needed prescription drugs to their patients in emergency situations without regard to possible legal consequences. Pharmacists who refuse to fill a prescription order because of their concern for patient safety or well-being observe the principle of nonmaleficence.

Character and Virtue in Professional Pharmacy Practice

A second possible conceptual basis for ethical practice in pharmacy involves studying the underlying virtues of its practitioners and the traits of character most often associated with these virtues. *Virtue* is often defined in terms of traits of character that are valued as a human quality; by looking at the virtues of individuals, we are able to gauge their character, and can better understand the attitudes with which they approach moral decisions. “If a virtuous person makes a mistake in judgment, thereby performing a morally wrong act, he or she would be less blameworthy than an habitual offender who performed the same act,” ethicists Tom Beauchamp and James Childress declare. While society can forgive a virtuous person who makes a poor ethical choice on occasion, it is much less forgiving of errors made by persons it considers nonvirtuous or patent scoundrels. Such virtues as *faithfulness*, *fortitude*, *tenderness*, and *compassion* have been associated with—and in some cases driven—the moral motivations of health-care practitioners for centuries.

The premise that the virtuous person will make morally defensible decisions, of course, may be incorrect: a physician who purposefully avoids telling a patient he has a terminal illness out of a sense of compassion may violate that patient’s right to self-determination; a pharmacist who tolerates the potential dangers associated with a drug-impaired colleague out of a sense of loyalty or faithfulness may neglect his ethical duty to keep patients from harm. This distinction has profound implications for health-care practitioners: because virtues are held by individuals, they reflect the unique beliefs of individuals. This means that practitioners can not only hold different virtues, but can assign different levels of importance to the same virtue. Pharmacists who hold justice as a primal principle guiding their practice will provide professional services without regard to external constraints placed upon those services. Such pharmacists will provide their professional services in an equitable manner without regard to the age, sex, or appearance of their patients, or even their ability to pay for their services. Other pharmacists, guided by a different primal principle, such as steadfastness, might refuse service to a certain class of clientele or refuse to fill welfare prescriptions or extend credit, but still might be widely regarded as virtuous practitioners who can always be depended upon to be helpful and supportive to their patients.

The Role of Virtue in Pharmacy Practice

What virtues do present-day pharmacists find to be the most important in their practice? Certainly, virtues such as honesty, dedication, carefulness, and dependability command consideration.* Three of the listed values more universally important are *altruism*, *equality*, and *justice*.

Altruism: A concern for the welfare of others. The pharmacist, with commitment, compassion, and generosity gives full attention to patients, assists other health-care personnel in providing medical care, and is sensitive to social issues.

Equality: Assurance that the patient has the same rights, privileges, or status in all cases and is treated with fairness and tolerance. The pharmacist provides services based on needs, relates to others

*A list of values appropriate for pharmacists, including commitment, generosity, tolerance, empathy, integrity, kindness, and rationality is presented in table form in Robert A. Buerki and Louis D. Vottero, *Ethical Responsibility in Pharmacy Practice*, 2nd ed. (Madison, Wisconsin: American Institute of the History of Pharmacy, 2002), p. 36.

without discrimination, and provides leadership in improving access to health care.

Justice: Upholding moral and legal principles with integrity and a keen sense of morality. The pharmacist acts as a health-care advocate, allocates resources fairly and reports incompetent, unethical, and illegal practices.

As the process of professionalization within the practice of pharmacy and the goals of modern health care have become more fully realized, society appears to have identified a number of specific virtues within contemporary pharmacy practice. For example, the Gallup Poll tells us that over two-thirds of Americans rank nurses and pharmacists as the most respected of all health-care professionals on the basis of honesty and ethical standards. While the underlying reasons for these high ratings remain somewhat of a mystery, Americans evidently feel very comfortable entrusting a portion of their health-care needs to their pharmacists. What values do pharmacists need to consider in resolving the following dilemma?

Case 2.01: Acting as the Patient's Advocate

Mrs. McGuire is 70 years old and hospitalized due to severe and debilitating back pain. She is a former employee of this urban tertiary teaching hospital, where she is now a patient and therefore knows many of the employees. Because of her previous relationship with the head of the pharmacy department, she placed a call to the pharmacy identifying an urgent need to speak to William Johnson, the department head, because "I need someone to serve as my advocate while I am in the hospital." Bill Johnson remembered Mrs. McGuire as a pleasant person, but somewhat dogmatic and demanding. He assured her he would confer with the pharmacist in charge of her therapeutic regimen and "look out for her." Within 24 hours Johnson had met with both Mrs. McGuire and the charge pharmacist. Mrs. McGuire was outraged because she was being denied the kind of pain medication that she was used to taking. "This new stuff doesn't work and I won't take any more of it." When Johnson investigated further he discovered that the charge pharmacist had refused to dispense opioids for Mrs. McGuire, prompting the prescribing physician to make a regimen modification that resulted in the unwanted drug. "As my advocate, Dr. Johnson, I want you to set this straight!" The charge pharmacist, an experienced and capable Pharm.D., quietly defended his position to Johnson by claiming it was his duty to protect Mrs. McGuire from the potential harm that is inherent in opioid use. Does Dr. Johnson face an irresolvable moral dilemma? Where is the harm, if any, resulting from the pharmacist's refusal to dispense the requested opioid?

Commonly Held Virtues among Pharmacists

While pharmacists have displayed a wide range of virtues in their practice, most of these virtues can be discussed under three broad categories: *fair dealing and equity*, *patient-centered services*, and *faithfulness*. It is significant that all three of these virtues have been incorporated in nearly every version of the Code of Ethics of the American Pharmaceutical Association.

Fair dealing and equity. Pharmacists have traditionally taken great pride in being fair and equitable in both their professional and their business dealings with patients, other pharmacists, and physicians. The 1852 Code of Ethics of the American Pharmaceutical Association enjoined pharmacists to "discountenance quackery" in their dealings with customers and avoid "dishonorable com-

petition” in their relationships with each other. Business intrigues with physicians were held not only as “unprofessional and highly reprehensible” and “unjust to the public,” but “hurtful to the independence and self-respect” of both parties. It seems clear that the framers of this Code wished to see pharmacists held to a higher standard of personal behavior than other mid-nineteenth-century American shopkeepers. Indeed, a preoccupation with fair business dealings seems to be a hallmark of most early codes of pharmacy ethics. Later versions of the Code (1922, 1952) continued to stress adherence to fair business practices, banning such seemingly unsavory practices as filling coded prescriptions, imitating labels of competitors, filling orders intended for competitors, or soliciting professional practice through advertising. The 1981 version of the Code enjoined pharmacists to “seek at all times only fair and reasonable remuneration for professional services” and never engage in financial practices that may cause “financial or other exploitation in connection with the rendering of professional services.” In contrast, the 1994 Code of Ethics for Pharmacists simply states that “a pharmacist acts with honesty and integrity in professional relationships.”

Patient-centered services. The 1922 Code of Ethics defined the pharmacist’s relationship to the public in terms of “safeguarding the handling, sale, compounding, and dispensing of medicinal substances.” The pharmacist was exhorted to “hold the health and safety of his patrons to be of first consideration” and “regulate his public and private conduct and deeds so as to entitle him to the respect and confidence of the community in which he practices.” As the focus of pharmacy practice began to shift from product-centered to patient-centered values, the 1981 Code urged the pharmacist to “render to each patient the full measure of professional ability as an essential health practitioner.” The 1994 Code of Ethics for Pharmacists states that “a pharmacist promotes the good of every patient,” a broader standard that places “concern for the well-being of the patient at the center of professional practice.” Today, the tensions that emerge from attempting to balance the human and patient-centered values of a health profession with the very real and practical demands of the business world test the value system of even the most dedicated pharmacist.

Faithfulness. The 1922 Code of Ethics calls upon the pharmacist to “enlist and merit the confidence of his patrons,” adding that once this confidence is established, it should be “jealously guarded and never abused by extortion or misrepresentation in any other manner.” The Code further considered the knowledge and confidences associated with the ailments of a pharmacist’s patients as “entrusted to his honor,” exhorting the pharmacist to “never divulge such facts unless compelled to do so by law.” By 1969, the Code carried this appeal to faithfulness beyond mere compliance with the law noting that the pharmacist “should not disclose such information to anyone without proper patient authorization.” In studied contrast, the 1994 Code of Ethics for Pharmacists recognizes the pharmacist-patient relationship as a “covenant,” and places further emphasis on faithfulness by emphasizing that “a pharmacist focuses on serving the patient in a private and confidential manner.”

Ethical Principles Applied to Pharmacy Practice

Within the last two decades, the conceptual foundation for evaluating outcomes within the tenets of consequentialism has been expanded to include other ethical principles beyond beneficence and nonmaleficence. These newer principles press the practitioner-patient relationship beyond these traditional ethical guidelines to include such additional principles as *justice*, strategies or acts that ensure the fair allocation of goods and services; *autonomy*, strategies or acts that respect the self-determination of other persons; and *fidelity*, strategies or acts that stress faithfulness and promise-keeping.

Pharmacists driven by *justice* attempt to treat all their patients with equanimity and fairness, regardless of circumstances or the likelihood of their patients benefitting from a certain therapy or even being able to pay for it. Pharmacists who respect the *autonomy* of their patients will never attempt to interfere with their patient’s right of self-determination or influence the patient’s decisions by withholding or shading drug product information that might result in a patient’s noncompliance or discontinuing needed therapy. Finally, pharmacists who display a strong sense of *fidelity* will always maintain their patient’s diagnoses, laboratory test results, prescription records, and other clinical information in the strictest confidence. These pharmacists also display their faithfulness by embracing related virtues such as *truthfulness* as an integral part of their covenant with their patients and strive toward absolute honesty and promise-keeping. What ethical principles are observed or compromised in the following situation?

Situation 2.02: Injecting Personal Values into Patient Counseling

A pharmacist receives a prescription for a fertility drug from a Medicaid recipient with four young dependents. The pharmacist grudgingly fills the prescription, but counsels the patient on the advisability of submitting to a tubal ligation.

Rights and Duties in the Practice of Pharmacy

The most emotionally charged conceptual basis for ethical pharmacy practice lies in the realm of human rights and professional duties and the inherent tension that can exist between these concepts. The importance of human rights as reflected in the tenets of liberal individualism has emerged as a

driving force in American society. During the last two decades, societal claims to the right to know, the right to die, the right to privacy, and the right to health care has transformed nearly every aspect of personal and professional life. “Health care can no longer be a private matter to be purchased as any other market commodity,” bioethicist George H. Kieffer declares. “Rather, health care must be considered a necessary *social* resource like education or police protection.” In response to this societal mandate, nearly every institution and professional association within the health-care field has embraced the notion of “patient rights” to some extent. The American Hospital Association’s vaunted “Patient’s Bill of Rights” (1992), for example, attempts to articulate specific rights that hospitalized patients might claim, suggesting that the physician is required, by claim of right, to involve his patients in nearly every aspect of the decision-making process associated with their therapy. This new claim—and the underlying respect it may command as either a “natural” or “bestowed” right—moves the physician-

<p>National Association of Boards of Pharmacy Pharmacy Patient’s Bill of Rights</p>
<p>Patient Rights/Pharmacist’s Responsibilities</p>
<p>Patients have the right to expect their pharmacist to:</p> <ol style="list-style-type: none"> 1. Be professionally competent 2. Treat them with dignity 3. Act in their best interest 4. Serve as their advocate 5. Maintain their medical records, keeping them confidential 6. Provide counseling 7. Have their prescriptions dispensed at a pharmacy of their choice 8. Monitor drug therapy . . . for safety and efficacy 9. Monitor their compliance and proper drug use
<p>Patient Responsibilities/Pharmacist’s Rights</p>
<p>Patients are responsible for:</p> <ol style="list-style-type: none"> 1. Providing personal demographics, medical history, and payment mechanism 2. Implementing the drug therapy program conscientiously and reporting their clinical responses 3. Cooperating with the pharmacist and authorizing [the release of] medical information necessary for the pharmacist to practice responsibly.

patient relationship far beyond the typical bounds of the paternalistic Hippocratic Oath. In 1992, the National Association of Boards of Pharmacy encouraged the promulgation of a “Pharmacy Patient’s Bill of Rights,” in acknowledgment of an “increasingly informed and cost-conscious public,” making specific reference to the “proliferation and complexity of drug therapy .” The document was developed to provide pharmacists with “a common reference to describe their covenantal relationship with the public” (see box p. 14).*

Rights may be defined as justified claims that individuals or groups can make on others or upon society. Rights emanate from two distinct sources: *natural rights*—such as the right to life, the right to freedom, and the right to die, which are inherent in the human condition, and *bestowed rights*—such as the right to a living wage, the right to privacy, and the right to health care, which must be granted by others—a government, institution, or individuals. Every right carries with it an obligation on someone else to behave in a certain manner. This obligation to perform some prescribed conduct is referred to as a *duty*. The natural right of freedom, for example, carries with it a corresponding duty to not abridge that freedom. The bestowed right of health-care assistance to the indigent through Medicaid implies an obligation on all health-care practitioners to provide that assistance in an equitable manner. In the practice situation previously presented, does the patient have a “right” to have her prescription filled? Does the pharmacist have a “duty” to honor the prescription and dispense the medication? Do rights and duty emerge in the following situation?

Situation 2.03: Rights vs. Duties in Pharmacy Practice

A doctor telephones a prescription for a powerful tranquilizer, but directs you to label the prescription with the name of a mild sedative because the patient is “frightened by the idea of taking tranquilizers.” The drug prescribed is the only effective therapy for this condition. Your state pharmacy practice act includes a strong prohibition against mislabeling.

During the later part of 2006, just months after the Food and drug Administration licensed a vaccine that is effective against human papillomavirus (HPV), lawmakers in several states proposed that vaccination with this vaccine be compulsory for girls entering sixth grade. Parents who objected to such action for their children would be able to opt out of the requirement under the same provisions that apply to other childhood vaccinations. HPV vaccine is a major public health breakthrough: it protects against the most common sexually transmitted disease in the United States, including the two strains of HPV that cause most cases of cervical cancer. The move to make the vaccine compulsory has ignited a number of contrasting stances that highlight unique ethical, as well as policy, issues. Health-care professionals who generally hold the values of patient autonomy and informed consent to be preeminent, tend to be skeptical about compulsory vaccination laws. Others might hold that minors have a right to be protected against vaccine-preventable illness, and society has an interest, even a duty, to safeguard the welfare of children who may be harmed by the choices of their parents or guardians. School-based laws such as these being proposed (or already adopted) have proven to be an effective and efficient way of boosting vaccine-coverage rates. A central ethical question surrounding this issue is whether a higher level of coverage justifies the infringement on parental autonomy that compulsory vaccination entails. Personal value systems that differ according to beliefs in community-based and individualistic values will lead to contrasting answers to this

*For the full text of the Pharmacy Patient’s Bill of Rights, see *ibid.*, pp. 216-17.

question. Pharmacists who are increasingly involved in administering vaccines will need to assume a justifiable personal stance on this issue.

Concluding Remarks

As we have seen, pharmacists and other health-care professionals employ a variety of theories and concepts to solve the ethical dilemmas they face in practice. Value-based professional decisions are the hallmark of a profession and values such as compassion, faithfulness, altruism, justice, and equality define the very essence of pharmaceutical care.