**Lecture 10 Dr. Haider Raheem**

**Case Studies in Pharmacy Ethics**

**CASE 1: Managing Dental Pain**

Ian Jones, Pharm.D., could tell just by looking at Jerry Rudolph’s face that he had just been to the dentist. Mr. Rudolph and Dr. Jones knew each other not only as pharmacist and patient, but as members of the same health club. Mr. Rudolph’s speech was slightly slurred as he presented a prescription to Dr. Jones. Mr. Rudolph stated, “I just had a root canal, and my mouth is still numb. I can’t talk very well yet. The dentist said the stuff he used to numb my mouth will last a long time, maybe up to 6 hours. What’s the prescription for anyway? I wasn’t paying much attention when I left the dentist’s office.”

Dr. Jones replied, “The prescription is for Tylenol #40, which is a combination of Tylenol and codeine, a narcotic analgesic. It’s for pain relief.”

Mr. Rudolph remarked, “I didn’t ask for anything for pain. I’m not sure about taking strong pain medication when I really don’t need it. Would aspirin or something else over the-counter work just as well? Are there any side effects from codeine?”

Dr. Jones believes that pain and pain relief are completely subjective. Yet he doesn’t like to encourage the use of narcotic analgesics until it is clear that the pain will not be relieved by non-opiate analgesics. He feels this is especially true in the case of dental patients who have received local anesthetic agents with a long duration of action. Should Dr. Jones encourage Mr. Rudolph to try aspirin, acetaminophen, or ibuprofen to relieve the pain?

**Commentary**

As in Case 1 there appear to be possible differences in value judgments about how to treat pain from a tooth extraction. Similar questions arise about what constitutes a side effect and how to determine just how bad the side effects could be. Mr. Rudolph seems to believe he will not need what he considers to be strong pain medication. Of course, the anesthetic has not worn off yet, but he may well know from past experience that he can tolerate the anticipated level of pain. The judgment that he will not *need* the codeine is actually a judgment that he prefers the risk of pain controlled only with non-narcotic analgesics to pain controlled by a narcotic.

Dr. Jones apparently views these trade-offs differently. He believes he is in a position to know not only how much pain Mr. Rudolph is likely to experience, but also whether the risks of the narcotic would be justified in his case.

Attitudes about pain vary tremendously from one culture to another and from one individual to another. Some people are averse to using “strong,” or narcotic, medication in part because of the psychological connotations of using narcotics. They may believe that the risk of addiction, no matter how small, is not worth it. They may also ground their judgments in even deeper cultural attitudes about the meaning of pain and its control. Moreover, in some cultures pain is perceived as affording some advantage, as a warning of an underlying problem or as a character-building experience in which the sufferer learns to cope. For other cultures and ethnic groups, pain is something to be expressed openly. This generates an attitude of sympathy while providing a rationale for explaining unusual behaviors related to pain.

In addition, there are those who hold the worldview that pain makes no sense (other than, perhaps, as a signal of a potential medical problem). According to this point of view, humans should have dominance over nature and make use of technology to suppress suffering. The dentist in this case seems to gravitate toward this view,\ while the patient is more cautious.

In effect, Dr. Jones is being asked to arbitrate a debate about which of these two worldviews is more appropriate for treating someone experiencing dental pain. Surely, there is no reason why the dentist’s view is necessarily the more correct. Some would be inclined to say that these issues are simply matters of taste, that there is no “right” answer. In that case, the pharmacist is being asked as a friend to give counsel on a matter of personal preference, a role he might want to take on as a friend but surely not as a pharmacist. Even if we want to view the question of whether or not to fight pain aggressively as having a correct answer, it is not the sort of issue about which any medical professional—dentist, physician, or pharmacist—can really claim to have expertise. It is a question of aesthetics, of what kind of lifestyle is best. It may also be a question of what kind of lifestyle is ethical.

**CASE 2: Use of Generic Drugs**

Sandra Kelly, Pharm.D., was impressed with the professionalism of her new employer, Mark Pierce, the pharmacist/owner of Midtown Pharmacy. Dr. Pierce took the time to counsel patients about the side effects of medications and often stepped out from behind the counter to assist a customer in selecting a nonprescription drug product. However, Dr. Kelly noted that Dr. Pierce seldom asked patients if they preferred generic or brand-name medications. Dr. Kelly had strong negative feelings about the bioequivalence of some generic drugs to innovator drugs, in particular, drugs with a narrow therapeutic index. Her suspicions had been fostered by several pharmacy school instructors who emphasized their personal biases against using generics for critical-dose drugs, such as immunosuppressive agents. One instructor went so far as to say, “A good pharmacist would not dispense generic drugs for critical dose drugs.”

Dr. Kelly asked Dr. Pierce why patients weren’t routinely given the option to choose between generic and brand-name drugs. Dr. Pierce stated, “There is a sign on the cash register in the pharmacy that tells patients to ask about generic drugs. If they don’t request one, I’m not going to encourage the patient to choose a brand-name product. We make a larger profit on generics, so I prefer dispensing them whenever I can.” In addition to her general concerns about the effectiveness of generics, Dr. Kelly is uncomfortable with the specific practice of not giving patients a real choice. The sign on the cash register is not very large. Should she comply with the pharmacy’s informal policy that encourages the use of generics, or should she let patients know they have a choice?

**Commentary**

Once again the problems of this case may appear to raise questions of medical science. Dr. Kelly and her instructors in pharmacy school have been impressed by the pharmacological data reportedly showing inconsistent bioequivalence of generic drugs as compared with name brand medications. Furthermore, Dr. Kelly’s instructors went so far as to make a value judgment on the quality of the pharmacist, suggesting that a bad pharmacist dispenses generics for critical-dose drugs. However, even if one assumes that there is less consistency in generic compounds as well as a greater risk of getting an ineffective dose, it does not automatically follow that the patient should prefer the brand name compound.

If through careful consideration of the pertinent research on the efficacy of generic drugs Dr. Kelly concludes that one can buy greater reliability by paying a higher price, she still must consider whether it is wise to spend more money for the extra margin of advantage from the brand name drug. The answer will depend on how one perceives the value of the extra benefit from a brand-name drug as compared with all the other things one might do with the extra money.

Choosing how to spend one’s money is clearly not a question of medical science. It is a question of values. Different patients are likely to make different value judgments. If a patient is quite wealthy and has a high degree of concern about the effectiveness and safety of the drug being taken, it would certainly be understandable for that patient to spend the extra money to achieve an additional level of safety. This would to some degree depend on how important the hoped-for benefits would be. It may be more reasonable to take some risk with a generic drug for a headache than for the control of seizure activity.

However, those for whom the “alternative costs” of brand-name medications are high—those with less disposable income who are less concerned about the effectiveness of the medication probably would prefer the generic. The value trade-off is in large part not medical. If one assumes that the generic drug is supposed to have met some minimal standards in the manufacturing process, the risk may be less than Dr. Kelly fears.

But Dr. Pierce seems to be engaging in evaluative judgments as well. He simply may not share Dr. Kelly’s concern about the risks of filling prescriptions with generic drugs. His may simply be a different value judgment. There is a complicating factor, however. Dr. Pierce admits that the profit on the generic is greater. Insofar as the patient is maneuvered into the drug preferred by the pharmacist for reasons of personal profit, the case begins to raise ethical as well as nonethical questions. When the right of the patient to be informed and to choose among alternatives is violated by the pharmacist, the problem is no longer simply one of nonmoral value preferences. It is to cases that will help distinguish between ethical and nonethical evaluations that we now turn.

**CASE 3: A Medication Error on the Oncology Unit: Who Has the Final Word?**

Since Edward Strunk, Pharm.D., was a new clinical pharmacist on the oncology unit, this was literally the first time he had ever discovered a medication error. At first he wasn’t sure what to do. Dr. Strunk was in the process of reviewing the medical records of the patients on his unit and updating orders when he noted the error. It appeared that the physician had written an order for “L-PAM 2 mg.” Lorazepam, an antianxiety agent, was mistakenly dispensed instead of melphalan, an antineoplastic agent. The patient had received lorazepam for 6 days instead of the melphalan. “L-PAM” was the formal and correct abbreviation for melphalan, but lorazepam was often incorrectly abbreviated as “L-Pam” as well, which caused considerable confusion and in this case a medication error by the pharmacist who originally filled the prescription.

The physician had renewed the order for “L-PAM 2 mg.” After confirming with the physician that a mistake had been made, Dr. Strunk dispensed the correct medication. He also reviewed the medical record to see if the patient had suffered any ill effects from the lorazepam. It did not appear that the patient had suffered any adverse drug reactions. Yet Dr. Strunk wondered how one could measure the harm that was done by not receiving the appropriate antineoplastic drug, especially since the patient was diagnosed with ovarian cancer?

Dr. Strunk decided to approach his supervisor with his discovery. The clinical supervisor told Dr. Strunk that it was hospital policy to complete a medication error report but not to inform patients of errors such as this on the grounds that it would only upset the patients and undermine their confidence in the hospital and their caregivers. The supervisor claimed that the risk-management committee reasoned that it was morally unacceptable to disturb patients if they had not been injured. In this particular case, no one would ever know that an error was made, as the melphalan and lorazepam look remarkably similar, and the nurses recorded that “L-PAM 2 mg” was given to the patient. Dr. Strunk was troubled that the patient was unaware of the mistake and felt that she had a right to be informed. He was also not certain that the hospital’s policy was ethically sound.

**Commentary**

In this case, the hospital’s moral policy seems controversial. One could easily suggest that it is grounded in self-interest, since the hospital could be in serious legal trouble if the patient learned of the error. Assume, however, for purposes of discussion that Dr. Strunk is convinced that the hospital’s policy is, in fact, believed by administrators and the risk management committee to have a moral, rather than a self-serving purpose—that they really believe it would be unethical to upset patients. This, after all, is a long-standing interpretation of the Hippocratic Oath’s imperative to do whatever is believed to benefit that patient.

If the hospital’s position is intended to have a moral purpose, then there is a real conflict between the holders of two ethical perspectives. Here the issue is whether a pharmacist should treat the hospital as the legitimate source of morality. Presumably when Dr. Strunk accepted employment at the hospital he made at least an implied commitment to abide by its rules. To what extent does that commitment imply agreeing to accept hospital policy as a source of moral authority?

In this case, however, Mr. Strunk has real reason to believe that the hospital’s policy is unacceptable. Can he acknowledge his general obligation to conform to hospital policy and, at the same time, still claim that there is a source of moral obligation beyond the hospital where he works?

**CASE 4: Oral Contraceptives: The Pharmacist’s Refusal to Dispense**

Phil Schwartz, Pharm.D., had always been a little uneasy about the distribution of standard birth control pills. But now that he had finished rabbinical study, he was certain that it was wrong to dispense oral contraceptives. Dr. Schwartz works in a chain pharmacy that sells oral contraceptives. He is sometimes the only pharmacist on duty. He has discussed his unwillingness to dispense oral contraceptives with the pharmacist-owner. Dr. Schwartz argued, “You must concede that most women who take the pills are not told about the possibility that the pills cause the woman’s body to reject a fertilized egg. I refuse to distribute oral contraceptives. I believe I have the right to refuse to participate in a practice that I feel compromises my moral integrity and violates my understanding of rabbinical law.”

The pharmacist-owner responded, “I respect your right, but what about the rights of the patients that come into this pharmacy expecting to get a legally valid, therapeutically sound prescription filled? The Code of Ethics states that ‘ … A pharmacist places the well-being of the patient at the center of professional practice.’ Therefore, I believe that patients have the right to have access to appropriately prescribed medications regardless of your personal beliefs. Furthermore, you may have the law to contend with as well since the state is considering a law requiring pharmacists to fill all prescriptions.” What should Dr. Schwartz do when he is the only pharmacist on duty?

**Commentary**

Dr. Schwartz perceives correctly that oral contraceptives in some cases may function to block implantation of a fertilized ovum and that some Jews (as well as Catholics and members of other religious groups) find them morally objectionable for this reason. The pharmacist is caught between two possible sources for his moral position.

There is something special in this case, however. In the other cases it seems hard to defend the claim that a behavior is right simply because it is in accord with the code of ethics of the professional group, is a matter of public policy, or is the opinion of a physician, hospital, or patient. However, one might imagine that a believer in a particular religious or philosophical tradition might claim that he or she knows a behavior is right because it is held to be so by the tradition of which he or she is a member.

Actually, most believers in such traditions do not literally hold that a behavior is ethically right simply because their group says so. Rather they hold that their group has a legitimate claim to being able to know what is right what is God’s will, what is in the moral law, and so forth.

Thus being a Jew includes being committed to the view that the Torah and the Talmud provide a way of knowing what is morally right and that the interpreters of that tradition are authoritative in such matters. Likewise, Catholics, while respecting moral conscience, give prominent place to the teaching authority of the Roman Catholic Church. Protestants affirm that the Bible is the source of moral knowledge. Even those who subscribe to secular philosophical movements do so, in part, because they accept the movement’s claims about how moral positions can be known. To stand within one of these traditions is precisely to affirm its views about the source or grounding of morality. It is hard to imagine that Dr. Schwartz could say, “I am a Jew; in fact, I have undertaken rabbinical study, but do not consider the teachings of the tradition morally significant.”

Could one imagine him saying, “I am a pharmacist and a member of my professional organization yet do not consider its moral positions definitive”? The problem presented in this case from the point of view of Dr. Schwartz is determining the grounding or foundation of ethical judgments and which sources should be relied upon for guidance.

It is the nature of religious and philosophical systems that they claim to provide a systematic framework of moral insight for knowing what is morally right. This is not to say that those who do not subscribe to these frameworks believe they make legitimate claims to this status, but from the perspective of an adherent, by definition, those claims are accepted. Should Dr. Schwartz give similar status to the claims of his profession or of any other groups of which he might be a member? If his religious group gets this special claim, what does this mean for the pharmacist-owner, who appears to have reached a different moral conclusion? What about the conflict between refusing to dispense a medication on religious grounds and state law that explicitly requires pharmacists to fill all prescriptions? Several states have enacted laws regarding pharmacists who refuse to dispense oral contraception and emergency contraception. Some laws allow pharmacists to refuse to dispense on religious grounds, while others specifically require pharmacists to fill valid prescriptions. Should the owner in this case appeal to the professional code as having, for him, similar moral authority? What does this mean for potential patients who, perhaps based on their religious convictions, have concluded that oral contraceptives are acceptable or even morally necessary?