The Individual Pharmacist and Refusal to dispense

By

Jesse Shuster

For quite some time pharmacists have had the right to refuse to fill a prescription because it was illegal, harmful to the patient, or posed a potential for a serious drug interaction. Obviously, this can be seen as a positive since the pharmacist is acting in the best manner towards the patient’s safety. What if the pharmacist is presented with a perfectly legal, harmless prescription without any drug interactions? Is there any reason that the prescription should not be filled? The refusal to fill such prescriptions has been happening for quite some time. Prescriptions calling for oral contraceptives, hormones which stimulate anatomical changes, abortive medications, emergency contraceptives, drugs with the intent to end a patient’s life and so on have been given to pharmacists leading, in some cases, to the patient being turned away without the prescription and no drug, a scolding about morals or a questioning of the patient’s character. Such situations bring to the forefront the clashing of autonomies. The autonomies involved are the patient’s, the prescriber’s, and the pharmacist’s. There are certainly other factors involved and they will be addressed along with the dueling autonomies. There are two classes of medications that have a lot of controversy associated with them and have been in the news quite a bit recently. The two classes of drugs are those that are used for emergency contraception and physician-assisted suicide (PAS). Prescriptions for these drugs will be the focus as there are many factors to consider since these prescriptions can produce an ethical dilemma for the pharmacist.

These two types of prescriptions have an almost identical core to their utilization, that being life and choice to end it or its potential in a timed manner. When speaking of emergency contraceptives, the definition of when life begins is open to interpretation. Depending on when a person believes life or pregnancy commences will alter the definition of the particular drug’s intent (i.e. as a contraceptive versus as an abortive medication). With such a fine line it is hard to make such a distinction either way. Regardless, it does involve a person making the choice to end a life or the potential of the creation of life. When speaking of a drug or drugs for the purpose carrying out of PAS, the patient has decided to end their life because of a terminal condition, amongst other things.

I will at this point state where I stood regarding both issues at a time before my research. Regarding emergency contraceptives, if I were to be presented with a prescription for such a product, I would simply tell the patient that I would not dispense the product to her and tell her where a pharmacy is that might be able to oblige her request. Without looking into the patient’s reasoning of wanting to use the product, the dispensing of the product is something that I do not want to be apart of. I do respect the
individual’s choice but as mentioned, I would rather not be a part of this situation. My response towards a case involving a prescription for PAS would be more difficult to make. The reason for being more difficult is that the patient making the decision is the one affected. In the case of the emergence contraceptive, the patient may not be the only person affected since there is the possibility of another life or the potential for another life that is not being considered in the decision. With that, a patient presenting me with a prescription for the purpose of PAS is a person who has come to a decision regarding their own life and are enduring a great deal of pain, amongst other things, towards an inevitable end. This case has much more substance to lean towards dispensing such a drug. But ultimately, I believe I would not dispense the drug and yield the task to someone else who has the authority.

Both scenarios are very difficult ethical dilemmas. I have pondered what I would do if the patients in these scenarios were a loved one. If a relative of mine was the victim of rape and was likely to become pregnant, what advice would I give to her? In this case I would leave the situation up to her and respect her decision. I would, however, tell her my thoughts and talk to her about the available resources to help her make an informed decision. Regarding the other scenario, if someone in my family had a terminal illness and despite adequate drug therapy, was still experiencing intolerable pain and was asking for a solution involving a means to end the suffering, I think I may respect that decision and allow it to be carried-out if it were legal. No one wants to see their loved ones in pain constantly, only to die at an unknown point down the road. I must mention that if I were the person with the terminal diagnosis and incurable pain, I would choose to live. I try to be a strong person who has strong faith and a high regard for hope. To explain my case of situational ethics regarding not dispensing the drug to carryout PAS and allowing it to be carried-out for a loved one, it is because it is something I do not want to be involved in directly. One of the reasons I want to be a pharmacist is that I want to help better my patient’s health and well being. So dispensing a medication that does not accomplish this, is something I find not right for me to do. I would like to be involved in the prevention and cure of diseases not involved in dispensing drugs that end life or it’s potential.

I will dissect the ethical dilemma and the rights of both the patient and pharmacist involved for emergency contraception and PAS. Starting with emergency contraception, the main factors are autonomy, beneficence, nonmaleficence, and fidelity. These do not apply to both parties however. The patient has autonomy. She has a right to legal, FDA approved drug. With respect to the pharmacist, he/she has the right to choose whether to dispense the drug or not based on personal beliefs.¹ That is the pharmacist’s autonomy. The next issue is beneficence. The pharmacist has the duty to do good towards patients. In this situation it can be seen that the act of beneficence is being accomplished towards the patient if the pharmacist dispenses the medication. Nonmaleficence, however, can be said to occur since harm is being done to the unborn depending on the definition of life and when it begins. If the pharmacist does not dispense the medication he/she compromises the patient’s autonomy and violates the fidelity with that patient. Patients trust that pharmacists will dispense the medications
they need when they provide a valid prescription, when a pharmacist refuses, that fidelity is violated.

The situation is very similar when dealing with the dispensing of medication for PAS. Again autonomy reigns supreme. The patient has a right to the choice that he/she makes because of his/her prognosis. If all therapeutic means have been exhausted and the patient, going through agonizing pain towards an oncoming death, is requesting a sooner end, is it wrong to oblige the request? It is certainly a difficult predicament. Advocating death is uncalled for, but in this situation is it that horrible? It has been determined that the patient cannot be cured and will, in the not too distant future, succumb to the ailment he/she is afflicted with. Why allow the pain to go on? If it does go on, the patient and family members suffer. If a peaceful death is allowed does that not bring peace? But, who has to become involved for such a request to be fulfilled? That would be a physician to prescribe the medication and very likely a pharmacist to dispense the medication. Do not these people have a say? They do. Focusing on the pharmacist, he/she has that covenantal relationship with patients. But, pharmacists, like physicians, take a similar oath regarding harm in which they pledge to not cause harm to their patients. The harm, obviously, would be death inflicted upon the patient. But considering the situation, it is more difficult to refuse the request for medication for PAS. With that, the issues of beneficence, nonmaleficence, and fidelity are at the forefront along with autonomy, leaving the pharmacist in an ethical dilemma. If a pharmacist dispenses medication for PAS would not it be a violation of beneficence? It must be even though the patient is requesting that that be the goal. If a pharmacist dispenses the wrong medication for a patient and the patient subsequently dies, then here too, it is a violation of beneficence. To look at this situation differently, what if the medication dispensed did not produce death but an unwanted coma? Could this be said to be nonmaleficence since while trying to do good, the pharmacist produced a harm by inducing a coma and not the desired outcome? I do believe that to be the case. As was the case with emergency contraceptives, the pharmacist violates the fidelity with the patient if he/she refuses to fill a legal prescription for PAS.

The literature on these situations is numerous and growing as the outcome of new legislations (e.g. morning-after pill now OTC). With the immense availability of literature, there are positions at both ends of the spectrum supporting the patient’s autonomy at one end and supporting the pharmacist’s autonomy at the other. With that, it is best to take into consideration both sides with an open mind. From this, the incidence of bias is reduced but the final decision is ultimately made by the individual.

In paper by Elizabeth Fenton & Loren Lomasky, they provide five statements that are against a pharmacist having the right to refuse to dispense emergency contraceptives and evaluate its validity.2 Starting with the first statement, it states, “Pharmacists acting in their professional capacity are not judges, legislators, or ethics review committee members. Their job is knowledgeably and effectively to fill prescriptions. Refusal to do so on non-medical grounds violates a standard of professional accountability.”2 The authors, justly, give more respect and value to the pharmacists and insist that they are professionals, and like other professionals are
allowed to select or decline clients based on how they feel necessary. It is very important that this is made known. Given a pharmacist’s professional nature they are allowed to exercise decisions regarding the selection of clientele. The second statement involves the nature of emergency contraception, that being an emergency:

“Although it is not incumbent on the population at large to render emergency assistance to those who will otherwise suffer significant harms, the same is not true for those possessing unique professional qualifications. So, for example, in case of medical emergency, physicians may be obliged to provide services. By parity of reasoning, pharmacists may justifiably be held to a requirement of performance when prompt receipt of medication is essential.”

The above statement is certainly true but when dealing with the case of emergency contraception, it is hardly an emergency compared to the manner that is in the above statement. Pharmacists certainly do render their services in emergencies. The dispensing of medications in medical emergencies is one example. Another example is aid in disaster situations. Pharmacists have rendered their services in these types of situations as well, most recently in New Orleans. The authors also believe that the use of emergency contraceptives is not a type of emergency that requires immediate services, stating that the woman has up to 72 hours to retrieve the drug after unprotected intercourse. It could be seen that in rural areas this situation could escalate to something towards an emergency since access to a product could take time and possibly distant travel. Considering this, it still does not make the situation a full fledged emergency. With that, the dispensing of an emergency contraceptive is not necessarily imperative to warrant that a pharmacist dispense the medication without delay contrary to what is seen in the state of Illinois. The third statement is, “Emergency contraceptive relief is not abortion.” This is the one that has the most gray. Therefore, it is the most difficult to either refute or accept. It is dependent on definitions and an individual’s thoughts on these definitions. Lines have been drawn but people have held their beliefs. Both the FDA and NIH have reached a consensus on a definition of when pregnancy starts, that being when the implantation of a fertilized egg in the wall of the uterus has occurred. Even with this definition, certain people retain their beliefs and hold the belief that emergency contraception is a form of abortion. The fourth statement reads, “Refusal to provide contraceptive relief is tantamount to the infliction of harm.” This seems to be quite a bold statement. The authors refute the statement with the following, “By refusing to enter into a transaction that the other party desires, one thereby fails to provide a benefit but not to inflict a liability. If that were not so, then anyone who turns down an offer from a prospective buyer, seller, employer, or suitor is guilty of inflicting a harm on the disappointed party.”

The instance of refusing to sell an emergency contraceptive does not produce nonmaleficence since the patient remains the same without receiving the drug. In some cases harm can be inflicted when a pharmacist refuses to fill a prescription, while doing so the pharmacist berates the individual in an unwelcome manner. This is certainly uncalled for and can be very detrimental to the patient. But if the pharmacist simply refuses no harm is done. The fifth and final statement of the paper is as follows: “Declining to fill medically and legally
legitimate prescriptions shows disrespect toward women. Because women become pregnant and men do not, refusing them service is impermissibly sexist.\textsuperscript{2} John H. Fielder states that there is a saying that abortion would be a sacrament if men were the ones who get pregnant.\textsuperscript{3} This is quite a bold statement and I believe it to be a false one as well but the truth will never be known. Regarding the refusal, the fact behind the refusal is most likely, that the refusing pharmacist believes that an abortion will take place if the medication is ingested. The predicament that only women get pregnant is not the reason for refusing to fill the prescription.

What about the other people affected by the pharmacist’s refusal to fill a prescription for an emergency contraceptive? Not only is the patient affected, but so too is the physician. The physician is having his/her rights to prescribe medications hindered by a pharmacist who chooses to not fill a prescription. This situation has brought about disgruntled physicians wondering what is going on.\textsuperscript{4} It has escalated to the point that the American Medical Association (AMA) has called for a meeting with pharmacists to find a solution to this predicament.\textsuperscript{4} This has created an unwanted problem for physicians, because their patients are not receiving their planned out care.\textsuperscript{3} For the patients, they should have access to a drug that is legally available to them. This statement is affirmed by the vice-president of the American Society of Health-system Pharmacists (ASHP).\textsuperscript{5} But he also states that pharmacists have the right to remain true to their beliefs and conscience.\textsuperscript{5} So it is difficult to please both sides in the situation of emergency contraceptives.

The ASHP has published its decision on assisted suicide.\textsuperscript{6} In this statement the patient’s autonomy, confidentiality, and decision-making are said to be treated with respect by the pharmacist.\textsuperscript{5} The patient also has a legal right to choose or decline treatment.\textsuperscript{5} This choice opens the PAS two ways. One way would be to have the patient take something to end his/her life or to remove a life-sustaining device that would end his/her life. The pharmacist would only be involved in the former, which is the most common method of PAS.

With patient autonomy again at the forefront, it again can put the pharmacist in an ethical dilemma. The situation in which a patient might request PAS, is a time of great strife for the patient. Surprisingly, intolerable pain was not one of the top three reasons a patient requests PAS.\textsuperscript{7} This displays the patient’s strong view of autonomy since it was one of the top reasons for requesting PAS.\textsuperscript{6} Patients requesting PAS disliked being a burden on their caregivers and, probably because of their prognosis, just wanted to end their lives earlier than expected. Mrs. Steinbock in her paper, states that if we are to oblige the terminally ill’s request for PAS by respecting their autonomy, then why should it be limited to just the terminally ill and not to others who feel unbearable.\textsuperscript{6} Steinbock states that that is not the solution, but that a treatment for depression may be called for.\textsuperscript{6} Steinbock indicated that depression is a big factor in those who are terminally ill.\textsuperscript{6} Furthermore, Steinbock presents a case where antidepressants helped alleviate a patient’s symptoms. I think this is a positive step in helping patients who are terminally ill.
Another positive direction for helping patients, who are terminally ill, is increase knowledge in palliative care. Dr. Jeffrey Stephenson, a palliative care physician, wrote of such a need.\textsuperscript{8} When speaking of a possible law change back to a neutral stance regarding PAS, Stephenson states, “Those (Palliative care providers) who have most experience of caring for the terminally ill, however, come out most strongly against any change in the current law.”\textsuperscript{7} He continues by giving a great overview of what palliative care constitutes,

“Palliative care recognizes that each person has unique physical, emotional and spiritual needs, all of which need to be addressed. It aims neither to hasten death nor prolong life at all costs, but accepts that when a patient is dying the relief of suffering, be it physical, emotional or spiritual, takes precedence over both of these concerns.”\textsuperscript{7}

With palliative care, Stephenson believes when adequately given, it may not eliminate everything but it can alleviate many of the problems that a patient is going through.\textsuperscript{7}

Stephenson also discussed that if physicians where to respect patient’s autonomy, that physicians would be breaking the Hippocratic Oath, specifically the vow to do no harm. This also applies to pharmacists, as they have vowed to have a covenantal relationship with their patients and vow to do them no harm.\textsuperscript{9}

As mentioned above, a physician and most likely, a pharmacist have to be involved in the execution of PAS. This involvement can bring about psychological distress. Just the fact that someone has been involved in the death of someone whether voluntarily or not, can cause psychological harm. This has proven to be true for physicians, as a review article was published that evaluated the emotional and psychological effect on physicians from involvement in PAS and euthanasia.\textsuperscript{10} After the act of euthanasia or assisted-suicide, almost half of the physicians have reported emotional discomfort.\textsuperscript{10} Many physicians have reported that the great deal of emotional and psychological stress has forced them to take days off following PAS or euthanasia.\textsuperscript{10} The article states that physicians have felt pressured and intimidated by their patients and families of the patient to assist in the patients’ suicide.\textsuperscript{10} Another adverse effect that was produced for the physician was isolation.\textsuperscript{10} With all of these factors involved, it makes the situation of PAS such a difficult situation for both the physician and patient. I believe that a lot of these factors, although to a lesser degree, apply to a pharmacist who is called upon to dispense medication for PAS. Because of this, it presents the pharmacist with a difficult decision when presented with a medication for PAS.

Life is a valuable. To end it or its potential is something that can be viewed to be horrible. It also can be viewed as a relief. Situations involving prescriptions for emergency contraception and PAS can make pharmacists evaluate their views on life and where they stand. The pharmacist has autonomy and the pharmacist also has the duty to act in the patient’s best interest. The patient, with a legal prescription, has the right to have his/her prescription filled. But, because of what the nature of the drug is,
the pharmacist has the right to refuse based on his/her beliefs. It has been displayed that this creates a conflict and an ethical dilemma for the pharmacist. The key to getting through these dilemmas after evaluation and a decision is to respect the individual. As a pluralistic society, values and beliefs clash on a daily basis. It is in anyone’s best interest to respect differences and avoid altercations that come up when confronted with an ethical dilemma.

With regard to my stance on dispensing these medications, I remain on the side of refusing to fill prescriptions for emergency contraceptive and PAS. From my research, I found that not dispensing certain medications can take a toll on the physicians who have prescribed them. I see that pharmacists, from dispensing these medications, can also probably be affected psychologically in a negative way. I saw that there is a lot more to PAS than what I initially thought. From this, I think that more work and learning can be done to help improve end-of-life care and produce better outcomes for patients who are terminally ill. Education would also certainly help anyone presented with an ethical dilemma and allow him/her to make a decision that he/she is pleased with.

References

6 ASHP. ASHP Statement on Pharmacist’s Decision-making on Assisted Suicide. www.ashp.org/bestpractices/ethics/Ethics_St_Suicide.pdf.