Often times, health professionals find themselves faced with situations that are difficult to handle based on one’s own morals and intuition. As with any other health profession, whether it is physical therapy, occupational therapy, etc., pharmacy, over time, have adopted and adapted to a set of ethical codes that are used to distinguish the prevailing view of what is ‘right’ and ‘wrong’ in society. For pharmacy in particular, the American Pharmaceutical Association (APhA) is the first and only national professional association that has developed a unique code of ethics and offers a full membership to all practicing pharmacists in the United States. In this paper, I will examine the evolution from apothecaries to pharmacists; explore the history of ethics in pharmacy, as well as introduce a case study adapted from the Moodle website and challenge the questions presented with my knowledge and research. Topics covered in the case study will include controversial topics and a pharmacy student’s knowledge on emergency contraception, in particular, Plan B. To wrap things up, I will also be introducing Oregon’s Death with Dignity Act (1997) in controversial terms with Plan B laws.

Long ago, as early as the 12th century, apothecaries were designated as our modern day pharmacists. Back in the day, the term ‘apothecary’ represented anyone who owned a shop or store that carried nonperishable commodities including spices, drugs, dried fruits and preserves (Smythe, 1). According to Harold Gill, it was not until the end of the 18th century that the professions of apothecary and physicians were clearly distinguished (Smythe, 1).
In Europe, between the mid 14th to about the mid 17th century, better known as the period between the Middle Ages and Renaissance, apothecaries were a community’s source of remedies and treatments. When presented with a written prescription, apothecaries immediately set themselves to work behind a dimly lit counter. Behind that counter, they would grind seeds and herbs together with the aid of a mortar and pestle; the end product would ultimately correspond to the remedy listed on the written prescription. In simpler terms, apothecaries were responsible for dispensing herbal remedies that were prescribed by trained physicians (Smythe, 1). Additionally, in areas where physicians were not as accessible, apothecaries were also responsible for diagnosing illnesses and generating a treatment plan for their patients (Smythe, 1). Prior to gaining their right to practice and dispense herbal remedies, apothecaries were required to attain their license to practice via seeking what were then known as Guides. These Guides were responsible for the proper licensing and periodic policing of their members (Smythe, 2).

In terms of locations and settings, apothecary shops differ dramatically from modern day pharmacies. In a typical apothecary shop, one could expect to find a room lined with endless jars filled with prepared medicines and herbs. In another room, they could expect to find the actual preparation of the remedies that takes place. Adjacent to that room, there would be another room solely for consultations between patients, apprentices and apothecaries. Lastly, surrounding the apothecary shop, one could expect to find themselves standing in a garden surrounded by medicinal herbs that are commonly used in the apothecaries’ practice (Smythe, 2). Some herbs that are commonly found within an apothecary shop included: ginger, galangal, saffron, cubebs, pepper, cloves, cinnamon and nutmeg (Smythe, 2). In comparison, our modern day pharmacies
consists of one or two rooms and are filled with limited rows of medications that are already synthesized and ready for distribution.

The evolution of apothecaries to modern day pharmacists had several similarities and differences. In particular, the varying factors and duties between the two professions were made distinguishable during the 18th century and onward. Today, a typical pharmacist is expected to administer prescriptions according to a doctor’s written instructions and assisting customers with issues within their expertise. As opposed to apothecaries, pharmacists are not allowed to prescribe drugs or diagnose patients whatsoever. Instead, they are given limited power to dispense and offer generic medical advice.

As you can see, the progression from apothecaries to pharmacists has changed dramatically from the 18th century into our current 21st century. Apothecaries are a term used in the past and pharmacists are now recognized in the present. We no longer focus heavily on traditional medicine; however, instead we focus generally on modern day treatments. Herbal remedies, as seen in the old apothecary shops, are still used today in the sense that herbal pills (i.e. cough drops), lotions (i.e. aloe vera gels), and essential oils could still be purchased over the counter. Currently, pharmacists are required solely to dispense the medication and offer medicinal advice; they are no longer required to prescribe the medications as apothecaries were once required to. Pharmacists are also no longer required to manually formulate herbal spices using a motor or pestle; instead, there are now broader categories of the professions which include compounding pharmacists, who are expected to complete that task.

The history of ethics in pharmacy dates back to the 1870’s when the first set of ethic codes was developed by the American Pharmaceutical Association (APhA). Founded in 1852, the APhA was the first established national professional society of pharmacists. APhA members
consisted of practicing pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and individuals who are interested in advancing in the profession. The mission of the APhA organization is to educate its members through information, education, and support. APhA also hopes that its members will ultimately be able to provide the necessary information to patients that will allow them to improve their health, wellness and quality of life by offering the optimal medication that best fits the patients’ needs.

In 1870, after many revisions and expansions, the APhA constructed and published the very first seven codes that would, in the end, provide the structure and foundation of an ideal pharmacy practice for the future generations. These first seven codes include (and I quote):

- “To improve and regulate the drug market by preventing the importation of inferior, adulterated or deteriorated drugs, and by detecting and exposing home adulteration.

- To establish the relations between druggists, pharmaceutics, physicians and the people at large, upon just principles, which shall promote the public welfare and tend to mutual strength and advantage.

- To improve the science and the art of pharmacy by diffusing scientific knowledge among apothecaries and druggists, fostering pharmaceutical literature, developing talent, stimulating discovery and invention, and encouraging home production and manufacture in the several departments of the drug business.

- To regulate the system of apprenticeship and employment so as to prevent as far as practicable, the evils flowing from deficient training and in the responsible duties of preparing, dispensing and selling medicines.
• To suppress empiricism (i.e., quackery) and to restrict the dispensing and sale of medicines to regularly educated druggists and apothecaries.

• To uphold standards of authority in the education, theory and practice of pharmacy.

• To create and maintain a standard of professional honesty equal to the amount of our professional knowledge, with a view to the highest good and greatest protection to the public.”

After a certain period of time, these original seven codes have been revised and modified in such a way that would best fit in with society’s view of an ideal professional practicing in the field of pharmacy during the year it was revised. Revised in 1952, 1969 and 1975, the codes now read (and I quote):

• “The pharmacist’s personal duty to maintain and utilize the best professional knowledge and skills; and to practice only in situations which allow him to do so.

• The need to practice in such a way as to bring credit to the profession of pharmacy; and to participate in the professional organizations.

• Put the health and safety of the patient first.

• Use only drugs of high quality and therapeutic efficacy.

• Seek fair and reasonable remuneration

• Respect the confidentiality of the patient

• Provide appropriate and never misleading information to patient.”

Without a doubt, pharmacy’s code of ethics is altered and will continue to change as each generation progresses. Periodically, the members of the APhA will gather together to discuss the current ongoing issues in a pharmacy practice and decide whether it is necessary or not for the
requirements or codes of the profession wishes to be altered and shaped into what society now view as ‘right’ and ‘wrong’. For pharmacists, these legalized codes often help ease the ethical dilemmas that often arise in part of a typical day in a pharmaceutical practice. As issues in the health care industries’ expand, old codes are being distorted and new codes are generated to increase clarity and to avoid ambiguity. In general, what started off as a mere code of ethics for pharmacists has later evolved into a list of code of ethics for both pharmacists and patient care. Built on from the original seven, the following is a list of recently generated ethic codes to avoid ambiguity in dispensing medications in a pharmaceutical clinic. These ethic codes are also used to state publicly what the principals are that forms the fundamental basis of the roles and responsibilities of active pharmacists. The ethic codes and principles are revised based on moral obligations and are established as a guide to lead pharmacists in the right path for their relationships with patients, other health professionals and society. Revised in 1994 by the APhA, these codes include (and I quote):

- “A pharmacist respects the covenantal relationship between the patient and pharmacist.
- A pharmacist promotes the good of every patient in a caring, compassionate and confidential manner.
- A pharmacist respects the autonomy and dignity of each patient.
- A pharmacist acts with honesty and integrity in professional relationships.
- A pharmacist maintains professional competence.
- A pharmacist respects the values and abilities of colleagues and other health professionals.
- A pharmacist serves individual, community, and social needs.
• A pharmacist seeks justice in the distribution of health resources.
• A pharmacist serves individual, community, and societal needs.”

Today, there are codes of ethics not only for pharmacists, but also for pharmaceutical industries, physicians prescribing practices and the department of pharmaceutical research as well. Those four categories listed above are then broken down into subcategories which include: the normative principles of pharmacy ethics, the relationship between ethics and law, ethical decision-making and the counter-side conversation.

First, we will discuss the “the normative of pharmacy ethics”. This category is identified as the nonmaleficence, beneficence, and respect for patients, loyalty and distributive justice. Next, we have “the relationship between ethics and the law”. This category of ethics recognizes that pharmacists often face situations that would raise the concerns of both ethical and legal considerations. Subsequently, pharmacists would be found using the ethical decision making technique (also called the four-stage approach) to justify moral issues. They would gather the facts, identify the values of the situation based on the code of ethics developed between them and their patients, generate some possible options and select the most appropriate resolution. To provide the best pharmaceutical care, a pharmacist may also use a technique called the counter-side conversation in which, instead of lecturing a patient about what they believe is the best solution, a pharmacist would discuss with the patient in the form of a narrative and understanding process.

Currently, there are many ethical issues that have already arisen in the field of pharmacy that does not comply with the most current ethic principles listed above. While researching about the ethical issues in pharmacy, I came across the five different ethical principles that are commonly encountered within the profession. The categories of these ethical principals include:
autonomy vs. interference with the physician-patient relationship, veracity vs. social responsibility, confidentiality vs. verocity, nonmaleficence and the principle of justice.

In any given situation, often times more than necessary, doctors and pharmacists find themselves choosing the option of refusing to provide a patient with a full disclosure of information regarding any adverse effects of medications. This, of course, is against the code of ethics for pharmacists; however, pharmacists decide that this decision is the most beneficial to a patient’s well-being. The situation listed above is an example of “autonomy vs. interference with the physician-patient relationship”.

The next commonly encountered ethical dilemma is called “veracity vs. social responsibility”. In this case, pharmacists are called upon to provide certain drug information to be used for questionable purposes. A pharmacist is then faced with a predicament on whether they should tell the truth or to carry out their ‘expected’ responsibilities. An example to illustrate this ethical issue is when a potential employer decides to call up a pharmacist for information regarding an applicant, before a pre-employment physical, on the length of time marijuana remains detectable in the urine. Depending on an individual’s metabolism rate, marijuana is typically detectable anytime between 3-30 days of intake.

The third category mentioned is “confidentiality vs. verocity”. This is an ethical dilemma in which places the pharmacist in a difficult position. A circumstance that some pharmacists occasionally find themselves dealing with is when a parent decides to approach them and ask them to identify drugs that were found in the possession of a child to reveal whether or not the child is on birth control pills.

Next, we have the ethical issue of “nonmaleficence” which, in short, means to do no harm. The question behind this principle is, “Can a pharmacist conscientiously objet to dispense
a medication?” For instance, a pharmacist may be asked to dispense diethylstilbestrol, commonly known as the “morning after pill.” Can pharmacists say “no” due to cultural beliefs? Or are they required to dispense the medication? This has been a huge ethical issue that has been going on for several years. Based on my research, some states have legalized pharmacists to refuse to dispense Plan B based on moral and religious beliefs; however, they must direct the patient to a clinic where they will be able to obtain such medication. Further research will be conducted during the spring semester regarding this issue.

Finally, we have the principle of justice. The principle of justice is when pharmacists are being asked to ration the use of high cost drugs in an area of cost containment and limited resources. Are pharmacists allowed to do this? If an elderly patient (on medicare) walks in requiring a high cost biotech drug, should pharmacist ration between net revenue losses that might occur because of government issued insurance?

The ethical issues listed above are on-going situations that pharmacists typically encounter. Furthermore, pharmacists are also faced with existing situations where they are asked to disclose private patient information, whether it is from a child to a parent or from patients to hospitals. While researching through previous interns’ works, the Plan B pill (also known as the morning after pill) at this time is nonetheless facing some valuable ethical concern in the pharmacy profession in which it conflicts with individual morals and beliefs.

The following is my case study, adapted from Moodle, for the 2009-2010 school year:

“Mary is a pharmacy student on a rotation in a busy clinic downtown. Mary has worked with Dr. Jennings, her preceptor, for two weeks and gets on well with her. Alice, a patient presents to the clinic pharmacy to purchase Plan B (an OTC
emergency contraceptive) to Mary. Mary is a Catholic and believes emergency contraception is abortion and amounts to the killing of innocent human life. This has happened once before and another pharmacist was able to help the patient. Even though there are others in the pharmacy that could dispense the Plan B pill, Dr. Jennings decides it is time to teach Mary her duties and asks her to participate in the dispensing and consults for the drug. Mary is dumbstruck by this request.”

Case Analysis:

1. **Is Dr. Jennings reasonable in forcing Mary to participate in filling this script as part of her education?**

No. I believe that Dr. Jennings is not reasonable in forcing Mary to participate in filling this script as a part of her education. Personally, I feel that this one script that she chooses not to fill will not have a large affect in her education in any way because she is receiving the same education by filling other prescriptions.

According to the Code of Ethics for Pharmacists, it states the following:

- Each individual patient is the center of each pharmacist’s practice
- Pharmacists should be committed primarily to the welfare of individual patients
- **Pharmacists should recognize the differing beliefs and values**
- Pharmacists should respect each patient’s right to self determination
The third bullet in bold above acknowledges that Mary’s preceptor, Dr. Jennings, should recognize Mary’s differing beliefs and values with the filling of the Plan B emergency contraceptive pills.

According to the Pacific University Introductory Pharmacy Practice Experiential Series Manual, it states the following requirements of preceptors:

- “Preceptors may assign appropriate additional tasks, including but not limited to: learning the computer system, entering prescription and patient data, performing distributive functions, and/or counseling patients.

- Preceptors are required to direct and/or supervise all activities undertaken by students. They guide students through learning competencies and supervise the pharmacy-related tasks performed during IPPE (Introductory Pharmacy Practice Education). Additionally, they assess student performance following each experience. Their contribution in this manner is meaningful and is an important component of the School’s mission to graduate competent pharmacists prepared to deal with the demands and rewards of contemporary pharmacy practice.

- **Preceptors are expected to instill and demonstrate principles of professionalism and ethics.**

- Preceptors are responsible for clearly communicating student expectations regarding performance, appearance, attitude and method of practice.

- Preceptors should not assume student competency but determine it by reviewing the student’s performance through discussions and observation.

- Preceptors are expected to provide constructive criticism that is conveyed in private and in an appropriate manner (Shipman, et. al., 1-4).”
As indicated above in bold above, the student manual at Pacific University’s School of Pharmacy clearly states that preceptors are expected to demonstrate professionalism and ethics. By forcing Mary to participate in filling the script, her preceptor has, once again, neglected to comply with Mary’s differing beliefs and values.

On a side note, according to assistant professor Jeff Fortner of Pacific University’s School of Pharmacy, pharmacy students on rotations are not required to dispense any medications since only a pharmacist are legally able to do so; however, students are able to routinely help prepare medications for dispensing.

2. **Do pharmacists have an absolute duty to fill every safe and legally prescribed script?**

In short, no, pharmacists do not have an absolute duty to fill every safe and legally prescribed script.

According to the Code of Ethics in Pharmacy, the duties of pharmacists are to:

- Put the health and safety of the patient first
- Use only drugs of high quality and therapeutic efficacy
- Respect the confidentiality of the patient
- Provide appropriate and never misleading information to the patient
- A pharmacist promotes the good of every patient in a caring, compassionate and confidential manner
A pharmacist respects the autonomy (independence) and dignity of each patient.

According to a 2006 article in the Washington Times, titled “States move to legalize pharmacists’ right to refuse,” pharmacists working in the following states are legalized to deny certain care or prescriptions based on individual morals and beliefs: Arkansas, Georgia, Mississippi and South Dakota. Pharmacists working in the following chains are also allowed to refuse filling contraceptive prescriptions: Target, Walgreens, and Winn-Dixie. However, pharmacists who choose to deny a patient care must refer the customer to an alternate drug store where they are able to get assistance.

In the following eight states: Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico and Washington, the American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and American College of Emergency Physicians have passed laws allowing women to purchase the morning after pill without a physician’s prescription (Ackerman, 156).

3. Do you think pharmacists should have the right to refuse to participate in these types of care? What defines “participation”?

According to Merriam-Webster’s online dictionary, the term ‘participation’ means “to take part, to have a part, or to share in something.”
Based on my research, there are many arguments that argue both in favor and against a pharmacist’s right to object and deny a patient of treatment or medications. Many of these arguments are found to be controversial in regards to the morning after pill being related to an abortion pill. Similar discussions involved sedatives prescribed for assisted suicide in relations to the Oregon Suicide Law. Other topics that collided were whether or not a pharmacist is acting in the best interest of their patient. The following list below consists of different arguments that are in favor and against a pharmacist’s right to object.

**Arguments in favor of a pharmacist’s right to consciously object**

- According to Grealis, pharmacists are not able to exercise independent discretion (Grealis, 1720). Instead, pharmacists are viewed simply as technicians who are responsible for filling customers’ orders and occasionally offer their customers advice. Retail and community pharmacists spend about 2/3 of their time processing orders and performing other duties that could be done by technicians or non-licensed staff (Grealis, 1720).

- A pharmacist can and should be able to exercise independent judgment
  - Society relies on pharmacists to instruct patients on the appropriate use of medications and to ensure the safety of drugs prescribed in combination (Cantor, et al. 1).

- Professionals should not forsake their morals as a condition of employment
  - Choice is the norm in the health care setting.
• Lawyers are able to express their morals by choosing clients and issues
  in which they feel comfortable in representing.
• Physicians are able to select their patients and diagnose them with the
  appropriate procedures.
• Ethics and law allow physicians, nurses and physician assistants to
  refuse to participate in abortions and other reproductive services
  (Cantor, et al. 2).

- Conscientious objection is integral to democracy
  • Pharmacists should be able to refuse to participate in acts that conflict with
    personal ethical, moral or religious manners. This is an essential element in a
    democratic society.
  • In Oregon, we acknowledged this freedom with the Death with Dignity Act
    (1997). This act allowed pharmacists and other health care providers to
    prescribe lethal medications to terminally-ill Oregonians to end their lives via
    voluntary self-administration (Cantor, et al. 2).
  • According to Cantor, he stated “A pharmacist should have the right not to be
    complicit in what they believe to be a morally ambiguous endeavor, whether
    others agree with that position or not (2).”

**Arguments against a pharmacist’s right to object**

• Pharmacists choose to enter a profession bound by fiduciary duties
  • Pharmacists chose their profession with the knowledge that they are
    expected to exercise special skills and care in the best interests of their
    clients above their own immediate interests (Cantor, et al., 2).
Pharmacists willingly enter the field of pharmacy and are expected to adopt its corresponding obligations.

According to Cantor’s article, experts on the profession of pharmacy explained, “A pharmacist promotes the good of every patient in a caring, compassionate and confidential manner. [They] respect the autonomy and dignity of each patient and serve an individual, the community and their society based on their needs (Cantor, et al.2).”

Emergency contraception is not an abortifacient

- Plan B tricks the ovaries into sensing that ovulation has already occurred, thus resulting in immature eggs. When consumed, Plan B also thickens the cervical mucus so that sperm’s travel is delayed (Ackerman, 154).
- Plan B creates an unfavorable environment for the implantation of a blastocyst to occur (Cantor, et al., 2).
- Plan B itself is unable to be categorized as abortion because one can never be too sure whether or not conceptions has occurred. Pregnancy may well begin with fertilization or implantation in the uterus; currently, there are no studies that can finalize the exact time an egg has been conceived.

Pharmacists’ objections significantly affect patient’s health

- Many pharmacists choose not to prescribe the morning after pill to their patients because they believe that the drug ends a life. This refusal to fill could often times place a burden on those with limited options. For example, a poor teenager living in a rural area with a single pharmacy will have a disadvantage in obtaining her desired prescription to be filled.
In comparison with Oregon’s assisted suicide law, it could be performed anytime at the interest of the ill patient; however, Plan B is only effective when it is used within 12 hours to 24 hours of unprotected intercourse. This means that an unconditional right to refuse is “less compelling with the patient requests an intervention that is urgent (Cantor, et al., 3).

Basically, I believe that pharmacists should be able to have the right to refuse to participate based on their moral and religious beliefs. These topics are currently and possibly will always be controversial. Also, by forcing pharmacists to abandon their morals imposes a heavy toll on the pharmacists themselves.

4. Are you aware of the Oregon Board of pharmacy’s Position Statement, “Considering Moral and Ethical Objections” and its accompanying clarification? Do you agree or disagree with their position?

Oregon’s Law on OCP’s updated September 2009

- Authorizes the Sexual Assault victims Emergency Medical Response Fund within the Department of Justice to pay for emergency contraception as part of a “complete medical assessment”.
- Require hospitals to provide unbiased, medically and factually accurate written and oral information about emergency contraception to female victims of sexual assault. The Oregon Health Authority will develop and approve informational materials, and may impose civil penalties against any hospital that does not comply with the rules detailed in these laws.
I agree with this statement because I feel that raped victims should not be penalized for something that is not their wrong doing. They should be able to seek help when needed. By providing emergency contraception as part of a ‘complete medical assessment’ is respectful and beneficial for rape survivors.

5. **You are the only pharmacist in 100 miles, how would you handle this situation, since you cannot refer the prescription to someone else?**

If the patient is a rape survivor, I feel that I will fill the medication. Even though I may be uncomfortable, I would not want the patient to bear a child that is unwanted and ends up experiencing long term abuse and neglect from the mother.

If the patient was not raped, but I was the only pharmacist within 100 miles, my best solution is to dispense the medication and provide care to the patient, even though I may be uncomfortable doing so; however, for future cases, I would make sure that there is at least one other pharmacist working with me who is comfortable with completing such a task. If not, I would make it a task to find a job at a different pharmacy that has legally accepted pharmacists to deny dispensing Plan B based on moral values and beliefs.

6. **What should Mary do in this situation?**

Based on my research, I believe that it is important for a preceptor and a pharmacy student on clinical rotations to be on good terms; however, in this
situation, I believe that Mary should not be forced to dispense a medication if she is uncomfortable in doing so. Mary should be able to freely express her opinions with her preceptor and be confident enough to discuss how uneasy it makes her feel to complete such a task. As mentioned in some of the articles above, if a pharmacist is uncomfortable with dispensing a medication, they are able to pass the job onto another pharmacist who is. Therefore, Mary’s preceptor has no right to force her into dispensing Plan B. More so, Mary is not even a pharmacist, she is simply a student on rotations, a student interested in gaining pharmaceutical experience.

To wrap things up, I would like to discuss briefly on a pharmacy student’s knowledge, attitudes and behaviors regarding emergency contraception. This research surveyed pharmacy students at the University of Arkansas for Medical Sciences. Among the 301 pharmacy students that were surveyed, 87% realized that Plan B has been approved by the Food and Drug Administration (FDA) for nonprescription use; however, 33% believed that it was worked by disrupting a newly implanted ovum (Ragland, et. al., 1). As a result, this studied concluded that misinformation regarding the morning after pill method of contraception was common and that attitudes varied widely towards the use of Plan B. These results also concluded that pharmacy students in Arkansas could benefit from additional training on emergency contraception. According to Ertelt, the American public in general is “very misinformed about what emergency contraception is, how to use it, and how to access it (1).”
Lastly, I found it interesting that in Oregon, assisted suicide is and will always be covered by insurance; however, the Oregon Health Plan will not cover treatment plans including medications such as emergency contraception for rape victims or treatment drugs for cancer patients to slow the rate of cancer growth and increase life expectancy (Ertelt, 1). This is another issue that I would love to further look into if I had more time permitting.

Overall, I enjoyed this year long internship a lot. I found this internship to be really beneficial because I was able to gain a great deal of knowledge behind the real world of pharmacy through investigating the common ethical dilemmas that are encountered on a daily basis. I feel that the information I gained through this internship is valuable because I would not have knew the history of pharmacy or its’ revised ethic codes simply through job shadowing a pharmacist or volunteering in a pharmacy. This pharmacy internship has allowed me to understand the dilemmas that current pharmacists are facing and allows me to brace myself for my future encounter with the world of pharmacy.
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