Pharmacy, its Ethics, and an Examination of Recent Ethical Dilemmas in Pharmacy

As an intern with the Institute of Ethics and Social Policy at Pacific University, I have researched the history of the pharmacy profession, its ethics and how ethical dilemmas in pharmacy can be analyzed and approached with a professional as well as caring attitude. This paper summarizes the knowledge I have gained from my research as well as presenting a case study I have created involving an ethical dilemma that I found compelling to investigate.

History of the Pharmacy Profession

Throughout history societies have used medicines to treat the sick. Early civilizations designated usually one person the power to heal the sick. This role often evolved from the religious leader’s responsibilities. Recorded history has shown that a form of pharmacy has been practiced since at least 2600 B.C. in Babylon according to prescriptions and directions for compounding found on clay tablets. Chinese medicinal practices have been attributed to the studies of Shen Nung around 2000 B.C. and Egyptian pharmaceutical practice is well documented in the “Papyrus Ebers” dating to about 1500 B.C. Greece brought the writings of Theophrastus around 300 B.C. which recorded quite accurate qualities of medicinal plants. Rome produced many great scholars of pharmacy including Mithridates VI, King of Pontus (100 B.C.), Pedanios Dioscorides (first century A.D.) and Galen (130-200 A.D.).

In these ancient cultures, pharmacy was usually practiced by the person who held the role of doctor. Greco-Roman medicinal practice dominated Europe until the pharmacist’s role began to separate from the physician’s during the Middle Ages. The Arabic nations began the practice
of privately owned drug stores in the 8th century A.D. creating the apothecary. The movement of Islamic nations across Europe introduced pharmacy as a specific occupation. The Persian scholar Ibn Sina’s pharmaceutical teachings were accepted as authority in the West until the 17th century. It was around 1240 A.D. in Italy, that pharmacy was separated from medicine. Frederick II of Hohenstaufen, who was Emperor of Germany and King of Sicily, presented pharmacists with the first European edict completely separating their responsibilities from those of medicine, and prescribing regulations for their professional practice.

In 17th century England physicians competed with apothecaries for business. Both charged a fee for dispensing medicine, but the apothecary only charged for the medicine. Free treatment gave them the advantage over the physician in terms of respect in the community (Anderson 60). The founding of the Society of Apothecaries in 1617 began regulation of the profession in England and the regulation of drugs by allowing quality inspections of apothecaries’ shops. The apothecary began to become a profession, but the variety of groups that dispensed medicine created a mix of physicians, apothecaries, chemists, druggists, surgeons and other healers that characterized a chaotic health care system in England, which was brought to North America by English settlers (Knowlton and Penna 20).

In colonial America the majority of people knew little about medicine and many were illiterate so a combination of medicine and pharmacy was practiced by political leaders, clergymen and midwives. Apothecary shops were only found in large cities where medicine was supplied for landowners and physicians (Knowlton and Penna 21). America's first hospital was established in Philadelphia in 1751 and the first hospital pharmacy in 1752. The establishment of the retail pharmacy business began in the early 19th century when doctors who owned
medicine shops would sell their business to their clerks so they could expand their own practice. Hospitals began employing apothecaries full-time and dispensaries used full-time apothecaries instead of medical apprentices. The trend of specialty shops opening in the early 1800’s allowed the apothecary shop to flourish as a stand-alone business. In 1820 a group of physicians founded the United States Pharmacopoeia which would create standards for medicine. In 1821 a group of apothecaries and druggists organized the Philadelphia College of Apothecaries which later became the first College of Pharmacy.

Imported drug quality began declining causing federal authorities to pass the 1848 Drug Importation Act. Drug inspection soon became a corrupted practice, so in response, the College of Pharmacy of the City of New York called a meeting to create standards for imported drugs in 1851. The second convention in 1852 saw the establishment of the American Pharmaceutical Association providing leadership for the emerging profession of pharmacy. Kremers and Urdang state that “a true pharmaceutical profession did not exist before the American Pharmaceutical Association created and developed it” (290). After the Civil War, focus was put on pharmacists’ competency and regulation was being pushed by physicians. In response, the APhA started a committee to draw up a state pharmacy act so as not to be controlled by physicians. The laws that were enacted created state boards of pharmacy, lead by pharmacists who began examining and licensing pharmacy apprentices.

The 1890’s saw department stores adding pharmacies and chain drug stores begin to dominate the pharmacy market. The beginning of the 20th century saw an increase of scientific education, and educational requirements to help the professionalization of pharmacy. In the 1920’s the American Conference of Pharmaceutical Faculties, later to become the American
Association of Colleges of Pharmacy, began to establish more strict educational requirements. Colleges of pharmacy began requiring a bachelor’s degree. The 1930’s brought growth to the industry, but a change to the traditional role of the pharmacist. The majority of compounding and distributing usually done by pharmacists was being taken over by manufacturers. The drug store began carrying more general goods and preparation of drugs became the job of the mass merchandisers.

The 1950’s brought new and effective drugs which caused the number of prescriptions filled to rapidly increase, making pharmacists work harder and faster. This created a product-centered practice. An amendment to the Food, Drug, and Cosmetic Act in 1952 removed a lot of the pharmacist’s autonomy and limited their ability to interact with the patient (Knowlton and Penna 37). By the 1960’s profit gaining became the main focus of pharmacy practice. Pharmacists “retreated behind their prescription counters and concentrated on increasing productivity and profits” (Buerki and Vottero 6).

The 1970’s and 1980’s saw an increase in consumerism and higher standards of product safety. A more clinical approach to pharmacy began where the “customer” was being transformed into the “patient”. In 1989 the American Council on Pharmaceutical Education proposed Doctor of Pharmacy programs become the only accredited programs for pharmacists. This was supported by the APha, the American Society of Health-System Pharmacists and the National Community Pharmacists Association in 1992, changing the face of pharmacy. In the 1990’s and into the 21st century pharmacy has moved into a new era of “pharmaceutical care”, a philosophy proposed by Douglas Hepler and Linda M. Strand (Buerki and Vottero 21). Knowlton and Penna indicate that the pharmacy community is embracing this philosophy of
caring for the patient (41). The pharmacist is becoming a respected health care professional for their specialized medicinal knowledge, and hopefully in the future for their patient care ethic as well.

**History of the Ethics of Pharmacy**

Ethical practice is expected of professionals in our society. Ethics can be defined as “the rules of conduct recognized in respect to a particular class of human actions or a particular group, culture, etc” (Dictionary.com). And so, “What a norm is or what determines behavioral standards of conduct that one must meet in thought and action can be considered ethics” (White 26). Pharmacy ethics would then be defined as the rules of conduct in regards to pharmacy practice. Professionals are usually recognized by their skill and experience and their ability to pass on this knowledge to the layperson. Bruce A. Berger notes that the professional role of the pharmacist does not end with the provision of the information to the patient:

“There is an advocacy role (providing support) here, one of patient empowerment. Patient advocacy involves more than giving patients information in order to satisfy their right to informed consent or autonomy…Concerns that patients have about their illness or treatment must be addressed in a way that legitimizes, not minimizes, the concerns. That is pharmaceutical care requires caring….Ethics and morality depend on caring about the welfare of others, care and concern for the value of human life.”

The ethics of caring appears to have evolved with the pharmacy profession. Pharmacy, along with medicine, can claim its beginnings in the Hippocratic Oath (4th century BC) in that by following it one intends to keep the sick from harm. Although, traditionally, pharmacists have
been kept behind the counter where their activities focused on the drugs but not the therapy they provide (Buerki and Vottero 13). Technical competence was emphasized, not patient counseling.

The pharmacy profession has always been seen as a responsible one. The Philadelphia College of Pharmacy founders created an early code of ethics in 1848 that focused on respectability and accuracy, but barely a mention of the person receiving the medicine. Later versions of this code such as the 1852 Code of Ethics focused on pharmacist’s personal behavior and fair treatment of customers, and in the 1922 version the fair business practices seemed to dominate the message, although it does mention the safety of the patron is the pharmacist’s first consideration, perhaps beginning the shift to a more patient-centered approach, although this same document instructs the pharmacist to never discuss drug effects with a patron (Buerki and Vottero 37, 103).

The practice of “non-counseling” continued into the 1950’s and pharmacy students were even taught inventive ways to answer patient questions by avoiding the subject and always referring them to a physician (Buerki and Vottero 104). The changing society of the 1960’s began a trend for the patient to want to know what they were taking, but information provided by pharmacists was limited to scientific drug knowledge, until the 1967 Conference on Ethics held by the APhA (Buerki and Vottero 105). The prohibition of discussing drug effects was dropped in 1968, and the pharmacist was instructed to use his professional judgement when necessary to discuss drug therapy with patients. 1973 brought power to the patient when the “Patient’s Bill of Rights” was enacted to provide complete information to the patient, intolerance of paternalistic
treatment was enforced, and the autonomy and rights of the patient was to be preserved (Buerki and Vottero 108).

The 1981 revision of the Code of Ethics of the APhA specifically addresses the patient and how the pharmacist “should strive to provide information to patients regarding professional services truthfully, accurately, and fully and should avoid misleading patients…” (Buerki and Vottero 204). The rest of the 1981 code focuses on business practices and professional conduct as in past versions. While professional integrity is very important, the patient is still not the central theme. A 1986 state Supreme Court ruling stated that pharmacists have a duty to inform patients about the risks of prescribed drugs therefore increasing patient expectation for counseling (Buerki and Vottero 112). This ruling and the 1992 National Association of Boards of Pharmacy encouragement for the Pharmacy Patient’s Bill of Rights acknowledged the fact that the public was becoming more aware of their rights and that there is a relationship between the pharmacist and the patient.

The 1994 APhA Code of Ethics revision truly addresses the patient, their rights, and the duty of the pharmacist to respect the patient. It emphasizes the moral duty the pharmacist has towards the patient: “Considering the patient-pharmacist relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust” (“Code of Ethics”). Section II describes the patient as being the “center of professional practice” and that preserving the patient’s dignity with caring, and serving them with compassion and confidentiality is central
to the pharmacist’s duty, and section III promotes communication and respect of cultural differences (“Code of Ethics”).

These massive changes to the language of the APhA’s Code of Ethics shows how different our society has become in regards to autonomy and respect for the self, and the expectation in professionals to treat their customers/patients with respect as well. These ethical standards for pharmacists give the patient the confidence to entrust their health with this person, but they also give the patient a sense of entitlement as well. The patient expects to get the treatment that they believe is the best, and the optimal treatment is of course going to include respect for their health and personal beliefs. As section III of the 1994 APhA Code of Ethics states, “A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients”.

These ethical standards provide a base for the pharmacist to act upon when faced with an ethical dilemma, a situation in which the proper action is not clear, but the code of ethics may be “vague and not easily applied to practice situations” (Buerki and Vottero 43) or the pharmacist’s personal ethics interfere with their decision to act. When a drug is available, and prescribed to a patient, but the personal ethics of the pharmacist interferes with their decision to actually dispense it, ethical reasoning can be applied to the situation to help make a professional decision. Buerki and Vottero propose a four step process for problem solving in an ethical dilemma: “identify the problem, consider alternative courses of action, select one alternative, and consider objections” (45). This guide can be helpful, but in real-life situations the proper action does not
always seem so clear. In the following three cases one can see how the law and personal values can confuse a situation. Hopefully, a basis of ethical guidelines can help a pharmacist make a professional and caring decision.

**Three Current Ethical Issues in Pharmacy**

The APha Code of Ethics states that “A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients” (“Code of Ethics”). To some, this statement indicates that no matter the patient’s beliefs, the pharmacist is there to serve their medical needs. Pharmacists are taught they have a right to refuse to fill a prescription, but most would agree that the professional should not leave the patient without resources, although some do. “If a pharmacy employs a pharmacist that has identified circumstances that would preclude the filling of prescriptions for particular products, the owner and supervising pharmacist should devise, within reason, accommodations that will respect the pharmacist’s choice while assuring delivery of services to patients in need. This may include special attention to scheduling of professionals to allow a pharmacist who has a religious, moral or ethical objection to practice simultaneously with another pharmacist who will fill the requested prescription, entering into collaborative arrangements with pharmacies in close proximity, or other accommodations designed to protect the public” (Mokhiber).

Some states feel the need to enforce laws for the good of the patient. As of May 2009, 11 states have enacted pharmacist conscience laws (“Pharmacist Conscience Clauses”). Four of these (Arkansas, Georgia, Mississippi, and South Dakota) passed laws allowing a pharmacist to
refuse to dispense emergency contraception. Illinois passed an emergency rule that requires a pharmacist to dispense FDA approved contraception. Four others (Colorado, Florida, Maine, and Tennessee) have broad refusal clauses for health care professionals that do not specifically mention pharmacists or specific drugs. California pharmacists have a duty to dispense prescriptions and can refuse to dispense a prescription when their employer approves the refusal and the patient can still access the medication elsewhere in a timely manner. New Jersey prohibits pharmacists for refusing to fill prescriptions solely on moral, religious or ethical grounds as of 2007. There are currently 48 such bills in 21 states being considered in the state legislative bodies, 37 of which expressly give pharmacists and other health care providers the right to refuse to participate in activities that they find morally or ethically objectionable. Many of these exempt the health care provider from legal consequences or disciplinary action from his or her employer or state board of pharmacy. Of the 37 proposed bills supporting the right to refuse, 8 specifically mention emergency contraception, 2 deal with family-planning issues, and 7 deal with procedures or products resulting in abortion or termination of pregnancy. Of the 11 proposed bills that expressly prohibit the pharmacist’s right to refuse, or impose fines on those who do, none mention specific drugs or procedures.

Gene Therapy

“Because gene therapy involves making changes to the body’s set of basic instructions, it raises many unique ethical concerns…there will remain controversy over just which changes are ethically acceptable. This will require judgments about what conditions in our species are unacceptable. Everyone might agree that a terrible disease like Lesch-Nyhan syndrome-condemning an infant to a dreadfully painful life lasting no longer than a few months—is a condition worth changing if we can; however the same technologies are likely to permit us to
intervene to modify conditions less obviously unacceptable. Example color blindness to sex of an embryo; unexpected paternity, notifying other family members of the diagnosis of a genetic anomaly, conflicts among parties over custody of a child (Veatch and Haddad 183-184).

The Genetics Home Reference Handbook lists common questions regarding the ethics of gene therapy:

“How can “good” and “bad” uses of gene therapy be distinguished? Who decides which traits are normal and which constitute a disability or disorder? Will the high costs of gene therapy make it available only to the wealthy? Could the widespread use of gene therapy make society less accepting of people who are different? Should people be allowed to use gene therapy to enhance basic human traits such as height, intelligence, or athletic ability?” (Lister Hill 129).

The pharmacists role in genetic therapy would involve dispensing medications that could be discriminatory in nature. “In the past, concern has surrounded the exclusion of groups such as women, elderly people, children, and the poor and marginalized ethnic populations from clinical trials. While most currently available drugs are designed and approved for universal use, bias in recruitment into clinical trials may mean that they have only been tested in the sub-set of the whole population. This raises issues about equality and social justice. The excluded or under-represented groups may fail to benefit from direct participation in the research (improved care, access to experimental therapy, etc.). Exclusion may also result in the development of new drugs that are poorly suited to them (Smart, Martin and Parker 329).
Another concern is that “patients that have been genetically defined as ‘non-responders’ or ‘at risk’ may also become excluded ‘orphan populations’, particularly if certain drug metabolism genotypes confer this status across a range of different medicine. Even if genotype status may only affect dosage, or there may be other medicines available, these groups may end up with secondrate therapy because new drugs are not being developed for them. Conversely, for those groups that are labelled as ‘good responders’ treatment may become more expensive” (Smart, Martin and Parker 329).

There is also “fear the misuse of pharmacogenetic profiling could lead to social injustice – such as discrimination by employers and insurance companies against individuals with certain genetic characteristics. Effectively, these groups fear the negative consequences of stratification– the classifying of patients into groups based on genetic information revealed by diagnostic pharmacogenetics” (Adis 4).

*The Emergency Contraception / “Plan B”*

Emergency contraception has faced intense opposition. Some pharmacists defend their right to refuse to dispense because it is against their religious beliefs. If an individual receives a prescription for emergency contraception, they may believe that they now have a right to have the prescription filled. White asks, “If one person has a ‘right’, then does another entity or person have a corresponding ‘duty’ or obligation to sustain or perform such that the first individual’s right is to be honored?” (91). There have been cases where pharmacists not only refuse to dispense, but refuse to make referrals to providers not even informing patients other options exist (Ackerman 156).
Accurate facts and scientific knowledge are just as essential in ethical decisions as in any other professional decision, but their importance is sometimes overlooked. Whether the emergency contraception can interfere with an actual pregnancy or simply prevent it means the difference between contraception and abortion. “It should not be permissible for a pharmacist to withhold a needed medication based on incomplete evidence or scientific misunderstanding” (Hepler). Pharmacists who claim it is against their moral or religious beliefs to kill a human being, and who believe life begins at contraception argue that they should not be forced to dispense emergency contraception since it can cause an abortion. Ackerman’s review of the situation between science and religion offers evidence, but does not clear up the debate on this issue. What is proven fact is that the “Morning After Pill” or “Plan B” is an increased dose of daily birth control, not an abortion pill.

“But in 2004, a review of the scientific literature by experts at the Karolinska Institute in Stockholm concluded that the contraceptive effects of a one-time dose of levonorgestrel, the active ingredient in Plan B, “involve either blockade or delay of ovulation . . . rather than inhibition of implantation.” Later in the year, the Chilean Institute for Reproductive Medicine reported that the drug interfered with ovulation 82% of the time in women who took it. Blood tests on those women showed that the drug suppressed the monthly surge of luteinizing hormone, which triggers ovulation. Still, because no test can determine exactly when fertilization has taken place inside the body, scientists concede there is no way to rule out the possibility the morning after pill may sometimes work after fertilization. One scientist notes there is also no way to prove coffee does not disrupt implantation” (Ackerman 154).
Emergency contraception is FDA approved and should therefore be dispensed to anyone with a valid prescription. If a pharmacists beliefs prevent them from dispensing contraceptives then they should be allowed to decline to dispense, as long as there a pharmacy that can dispense and be reached by the patient within the required time frame for taking the prescription.

Medication that can be used for euthanasia

A specific situation that is an ethical issue for some pharmacists is euthanasia or assisted suicide. Most literature focuses on the physician’s position in the ethical dilemma of physician assisted, but the pharmacist is the person that will be dispensing the drugs that will be used for the patient’s death. Oregon was the first to enact a law to legalize physician assisted suicide, and both Washington and Montana passed laws in 2008 to legalize euthanasia. Although only three states support the use of medication to end one’s life, under strict regulations of course, any physician, and any pharmacist are then subject to an ethical dilemma of they do not agree with assisted suicide.

Veatch states that “if the state wants to affirm that it is important for the patient to be able to choose physician assistance, physicians would have to be given not merely the right to prescribe but the duty to do so. Likewise, pharmacists would presumably have a duty to dispense, not merely the right to.” He also says that if physicians have a right to conscientiously object to prescribing lethal agents, pharmacists must have a right to object to dispensing them (Veatch).

The American Society of Health-System Pharmacists remains neutral on the issue of the right for a pharmacist to participate or not in morally, religiously, or ethically troubling therapies (“ASHP Statement”). The ASHP describes how a pharmacist should respect the patient’s
autonomy by making all legally available treatment options known to them. They emphasize patient confidentiality and supporting their ethical and legal right to choose or decline treatment depending on information provided by pharmacists and health care providers. They support the right of the pharmacist to participate or not in morally, religiously, or ethically troubling therapies but state that procedures should be in place to ensure that employers are able to provide care and adequate services to the patient and caregiver. “The employer has specific responsibilities, and the employee cannot be a barrier to the employer’s ability to fulfill those obligations” (“ASHP statement”).

Mandating pharmacists to dispense drugs that are used for euthanasia, or refusing a terminally ill patient their legal right is not acceptable on either side. “If pharmacists are entitled to the right of conscientious objection and a state insists on legalizing pharmacologic agents for suicide, then it could be argued that it is the responsibility of the state to make certain there are adequate pharmaceutical services available for these patients. State authorities could take on the responsibility for ensuring that pharmacists are available at adequately convenient locations” (Veatch). Another view is that the pharmacist can participate in euthanasia without it being “murder” or maleficence. Naaf states, “pharmaceutical care recognizes some of the most important needs of the terminally ill. If based on a patient-centered approach, euthanasia might be a logical last step in the efforts to alleviate the patient's sufferings” (130).

Case Study

Following is the case study I have created examining the pharmacist’s role in physician assisted suicide. In the three states that legally support the use of medication to end one’s life, any physician, and any pharmacist working in these states are then subject to an ethical dilemma
if they do not agree with assisted suicide. While researching the topic of physician assisted suicide, I found that depression is an important issue to consider for patients that request a prescription to end their life. One concern is that a depressed person may not be able to make a clear decision. Golden & Zoanni (2010) argue that depression causes impaired judgment and the Oregon system of screening for psychiatric illness is inefficient. The Death with Dignity act states that if there is a concern that the patient has a psychiatric disorder including depression that may impair judgment the provider is required to refer the patient to a psychologist or psychiatrist (ASHP, 2008). According to Oregon’s department of Human Services, none of the patients that requested physician assisted suicide in 2009 were referred for formal psychiatric evaluation (Oregon.gov, 2009). This could mean none of the patients presented with depressive symptoms, although studies such as Ganzini and colleagues found that 3 of 18 terminally ill subjects were depressed, but all patients were prescribed a lethal drug and all three died by ingestion of the drug within 2 months of the interview (2008). The case study’s facts are as follows:

- Patient – 47 year old woman, Oregon resident
- Diagnosed with advanced ALS (amyotrophic lateral sclerosis)
- Request has been made for medication for assisted suicide
- Doctor knows the patient and approves of the request
- You are the dispensing pharmacist

**QUESTION 1**: As the pharmacist, you have access to the patient’s prescription records, and see a history of manic depression throughout lifetime. You question whether the request for assisted
suicide is due to the ALS or the depression. Is depression a good enough reason to approve of dispensing medication for pharmaceutically assisted death?

**QUESTION 2:** You know that a patient is required to undergo psychiatric evaluation if there is a concern that the patient has a disorder including depression that may impair their judgment. You ask the doctor if this patient was referred for psychiatric evaluation. He says no, he does not think the patient requires one. What do you do?

Comments for question 2: Obligation to team members. “…As active members of an interdisciplinary team caring for patients, pharmacists must be central participants in all decisions relating to medication management of the patient. Pharmacists should respect the opinions and specific areas of expertise of the other members of the health care team” (“ASHP Statement”).

**QUESTION 3:** The family tells you the last pharmacy they tried to fill the prescription at refused to dispense. Her husband and children are waiting to pick up the medication. They have accepted her choice. Do you fill the prescription?

Comments for question 3: Obligation to the patient. “Pharmacists should support appropriate drug therapy to ensure that palliative care and aggressive pain management are available for all patients in need. Pharmacists, as part of their professional responsibility, must offer to provide counseling services to the patient and caregivers and be prepared to provide pharmaceutical care to the patient until the end of life” (“ASHP Statement”).

**QUESTION 4:** What if there is no other pharmacist licensed to dispense drugs used for assisted suicide within 100 miles?

Comments for question 4: Professional Obligations. Conscientious objection.

“Pharmacists must retain their right to participate or not in morally, religiously, or
ethically troubling therapies. Procedures should be in place to ensure that employers are able to provide care to the patient and provide adequate services to the patient and caregiver. The employer has specific responsibilities, and the employee cannot be a barrier to the employer’s ability to fulfill those obligations. Employers must reasonably accommodate the employee pharmacist’s right to not participate in morally, religiously, or ethically troubling therapies” (“ASHP Statement”).

“Pharmacists are often inadequately trained in the care of dying patients. Therefore, pharmacists’ education at all levels (undergraduate, graduate, continuing education) should be sensitive to these issues and offer the development of skills and knowledge concerning care of the dying. Pharmacists should make a personal, professional commitment to learn more about end-of-life care” (“ASHP Statement”).

**Summary of my Internship Experience**

My research this year has shown me that ethical dilemmas in pharmacy are just as difficult as any other profession’s. There are guidelines established for the pharmacist to attempt to help them through the process of difficult decision making and the pharmacy profession continues to advance in the field of ethics. Researching this case study provided valuable experience giving me an opportunity to see inside the pharmacy profession providing me with experience most pre-pharmacy students do not have.
Literature Cited


Hepler, Charles D. “Balancing Pharmacists' Conscientious Objections with Their Duty to Serve.”


