

## ETHICAL AND LEGAL ISSUES IN HEALTHCARE

# Collegiality challenged?



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You are a part-time staff pharmacist working at one location of a five-pharmacy chain. You return from two weeks' holiday to a busy day in the dispensary, assisted by the two full-time technicians. When filling a prescription for 30 Tylex capsules you remove a strip of ten from the outer carton and notice six empty blisters...

The likelihood that the box of capsules was returned to the pharmacy for disposal, and accidentally returned to the shelf is low, as the date-stamp identifying when they were received from the wholesaler refers to only four days prior. The possibility that the capsules were removed before delivery to the pharmacy remains. As you contemplate this latter idea, one technician takes the part-filled strip, cuts away the empty blisters, and returns the remaining product to the dispensing tray, muttering that the replacement pharmacist needed regular doses of Tylex to cope with the hangovers...

What do you do?

At issue is the fact that a member of your professional support staff team has made allegations that a pharmacist has been consuming Tylex, while at work, in a manner that appears to be both illegal (without having had them dispensed on a prescription) and for a use other than analgesia. "Codeine can produce drug dependence of the Morphine type, and therefore has the potential for being abused. Prolonged regular use ... may lead to physical and psychological dependence (addiction)... Codeine may impair the mental/or physical abilities required for the performance of potentially hazardous tasks." (www.imb.ie – SPC: Tylex) The implication that this individual required the codeine to cope with regular high consumption of alcohol suggests additional risk in the context, in that 'Tylex may exhibit an additive depressant effect'. If true, it is in the person's 'best interests' that such potential addictions be addressed in a proactive manner, and there are patient-safety risks posed where a pharmacist practises while 'under the influence' of alcohol and/or codeine.

Professional practice standards and the Code of Conduct for pharmacists are also at issue, in that a pharmacist ought not to permit another person do anything which would impair or compromise his/her ability to practise professionally.<sup>1</sup> To be seen to condone or accept such behaviour would undermine the pharmacy practice itself; pharmacists and professional support staff. It is possible that the second technician is even more uncomfortable about the behaviour of the replacement pharmacist and is awaiting your reaction before voicing deeply held concerns.

The reality is that many of us would hesitate as to what to do next. Natural justice requires that an innocent pharmacist's reputation be protected. However, it may be that there are a number of other concerns influencing our decision-making, not least of which might include collegiality, personal risks associated with 'whistle-blowing' and a fear of 'doing the wrong thing'.

'Collegiality', a version of loyalty to a person or 'cause', is commonly used with reference to groups such as professions. The term has a 'caring' undertone, not inconsistent with the notion that in a scenario such as presented, the well being of the individual ought not to be unnecessarily sacrificed to the process used to deal with the situation responsibly. Efforts should be made to ensure that a colleague who demonstrates addictive tendencies or other mental health problems be encouraged to avail of treatment. Indeed, many larger organisations have Alcohol and Drug policies in place and the introduction of the Health, Safety and Welfare at Work Act (2005) has further stimulated development of such policies. Professional programmes are available to direct and counsel through a detoxification process. Where appropriate, organisations such as the Benevolent Fund seek to support individuals undergoing such processes. Where such supports are available the dilemma would be ameliorated.

However, 'loyalty' assumes that one's actions will be in the best interests of all concerned... the individual, the pharmacy, the professional staff therein, the profession and the patients being served. David Kline, in 'On Complicity Theory', challenges that if a pharmacist is 'aware of the wrongdoing and he does not try to stop it, he is implicated in the wrongdoing'. Irish society has seen serious examples of the cost of 'silence' in recent times – not least in the guise of the Neary Case<sup>2</sup>, Ryan Report<sup>3</sup> and the Anglo Irish<sup>4</sup> debacle. These clearly demonstrate how healthcare, institutional care and our banking and finance systems could and can benefit if more proactive approaches are taken by those on the periphery of events.

Risks to whistleblowers include the underlying concern they may find themselves the subject of retaliatory complaints and disciplinary action or are "advised to keep quiet or their careers would suffer" (Varielius). A well-known example of whistle-blowing, and its risks to the whistleblower, is dramatised in the 1999 film 'The Insider'... Jeffrey Wigand (Russell Crowe) exposes executives of big tobacco

companies in the USA as being aware that cigarettes were addictive and that they added carcinogenic ingredients to cigarettes. He certainly put himself at risk. There is, of course, additional risk where the pharmacist him/herself has not actually witnessed the misuse of medicines by another colleague, and is depending on information from one or more members of the professional support staff. There may be instances where an approach to the 'accused' pharmacist him or herself may be appropriate or, failing that, to the supervising or superintendent pharmacist, or owner of the business. Difficulties may arise if the replacement pharmacist is the owner or/and superintendent, or has influence over the part-time pharmacist's employment or professional position, in which case the 'Protection of Disclosures of Information' (Health Act 2007, section 14) provides a further option. This legislation provides for statutory protection in respect of disclosures made, in good faith, by "a person to a regulatory body" where such person registered with such regulatory body has posed, is posing or is likely to pose a risk to the health or welfare of the public. In the case of the PSI, Dr Cora Nestor MPSI has been appointed as the officer to accept protected disclosures.

To quote Peter Gooderham, in his editorial in the *BMJ* (May 2009), "Professional people may feel damned if they do raise concerns, and damned if they don't... a start would be for those in official positions to recognise the risks of whistle-blowing." It seems that the 2007 Protection of Public Disclosures Act does address those concerns.

Notwithstanding the direct risks to whistleblowers, "False allegations can cause hurt, distress and embarrassment", a sometimes costly affair given current controversy surrounding the €1.872 million award against Independent Newspapers for making "false claims about PR Consultant Monica Leech" (*Irish Times*, Friday June 26th). The article highlights that, "had Leech lost both her arms she could have expected damages of between €141,000 and €197,000."<sup>4</sup> Such is the perceived value of one's reputation: "the purest treasure mortal times afford is spotless reputation" (Richard II). The proposed Defamation Bill (2006) clearly identifies that a defence of qualified privilege, or protection for a whistle-blower, shall fail if the whistleblower lied or acted out of spite, ill will or improper motive. Factually accurate information is essential.

Once the decision to act is made, the next question is how. It seems that the choice of action(s) must seek to minimise the risks to the reputation of the pharmacist, the profession and the business – be that in a community, hospital or other setting. Establish what 'facts' are available to you from the support team, clarifying that if an issue exists, action is required. The ideal is to use internal structures and reporting mechanisms to minimise any perceived or real risks to patient care and pharmacy practice, while seeking to care for any colleague prone to addiction. There may even be situations where the jobs/livelihoods of both the reporting pharmacist and the technicians involved are perceived to be at risk, in which cases routes to protected disclosure might be engaged.

However to 'turn a blind eye' could be to facilitate ongoing misuse of medicines, facilitate the likelihood that a registered pharmacist will work in a state of mind not conducive to safe practice, and represent a betrayal of one's professional responsibility to lead professional support staff in the practice of pharmacy. Like it or not, the colleague pharmacist in the opening scenario ought to properly be considered vulnerable on a human level, but a potential risk to patient safety on a professional level. Once a pharmacist is aware such risks exist he/she is in the difficult position of being required to take all reasonable steps to intervene in an appropriate manner.

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### References ~

- 1 Code of Conduct for Pharmacists, PSI, 2009
- 2 DoHC (2006) The Lourdes Hospital Inquiry
- 3 The commission to inquire into child abuse (2009)
- 4 *Irish Times* (2008) Statement issued on behalf of Sean Fitzpatrick. 18th December [online]

### Further Reading ~

- 1 Gooderham, Peter (2009). Editorials: Changing the face of whistleblowing. *British Medical Journal*. 338: b2090
- 2 Kline, David A. (2006). On Complicity Theory. *Science and Engineering Ethics*. 12: 257–264
- 3 Larmer, Robert A. (1992). Whistleblowing and employee loyalty. *Journal of Business Ethics*. 11:125–128
- 4 McDermott, James. (2009) Juries should not be left alone in calculation of damages. Analysis. *Irish Times Newspaper*. P.14
- 5 Varelum, Jukka. (2009). Is Whistle-blowing Compatible with Employee Loyalty? *Journal of Business Ethics*. 85: 263–275.