IPJ July 2008 WORKFILE 30/07/2008 16:31 Page 170

ETHICAL AND LEGAL ISSUES IN HEALTHCARE

The ethics of resource management in Pharmacy

***Cicely Roche** has worked in community pharmacy in Canada and Ireland since graduating from Trinity College Dublin in 1983. She holds an MSc in Community Pharmacy from Queen's University Belfast (2001) and an MSc in Healthcare Ethics and Law from RCSI (2007).*

Wastage of High Tech medicines is a long-standing source of unease in community pharmacy practice. Contractors complete an 'annual return' of High Tech medicines stocked in the pharmacy, in order to facilitate accounting practices in the HSE. Such lists almost inevitably include a number of medicines, within a year of their expiry date, which are no longer required by the relevant patient. It is a fait accompli that such items would be en route to incineration by the following 'annual return' date. Notwithstanding the procedural issues which facilitate this wastage, the basis of pharmacists' unease merits review.

The potential for commercial factors to influence pharmacists' decision-making when distributing medicines from which they make a profit is a source of continuing debate. However, High Tech medicines are distributed from community pharmacies under a 'patient care fee' meaning that the medicines themselves generate neither a debit nor a credit to the pharmacy. There is no gain or loss to a community pharmacist when procedural matters prevent the redistribution of High Tech medicines before wastage, through expiration of shelf life. Therefore the cause of unease at the impending 'wastage' is something other than commercial. While a philosophy of 'waste not, want not' is itself to be applauded, this desire to not waste healthcare resources is more likely grounded in ethical principles.

The four core principles of healthcare ethics are considered to be ***autonomy***, ***beneficence***, ***non-maleficence*** and ***justice***. Regular readers of this column will already be acquainted with the first three principles but it is within the principle of justice that pharmacists' duties in the area of resource management may be best considered.

Justice as a healthcare principle includes the elements of distributive justice, respect for the law, rights-based justice and retributive justice. Respect for the law is an ethical duty; retributive justice concerns the fitting of punishment to the crime, including leniency for those deemed to be mentally less competent; and a rights-based approach to healthcare suggests that if a person has a right it gives him/her a special advantage which is a safeguard, so that his/her right is respected even if the overall social good is thereby diminished. In this context, injustice is defined as an act or omission which denies people access to benefits to which they have a right. While these aspects of the justice principle are all relevant to the functioning of the healthcare system, they do not generally provide guidance to the individual practitioner seeking to deal with dilemmas related to the resource management aspect of their role.

Distributive justice is the fair, equitable and appropriate distribution of resources in society. Also referred to as 'resource allocation', distributive justice recognises that when resources are limited, rationing must take place. If it is accepted that resources are inevitably finite and that needs, wants and desires have no limits (Kuhse and Singer, 2006), then an ethically defensible way of allocating these finite resources must be agreed. Decisions must be made which require the setting of priorities and the provision of a means of deciding who accesses available resources.

Society generally subscribes to values that promote fairness, and policies which promote the allocation of resources in a manner which appears to be 'unfair' will meet with resistance. The general expectation is that policy development will ensure that patients in similar situations will normally have access to the same healthcare. Consider the public reaction to 'Rosie's'[1] radio interview, wherein she verbalised the unfairness of her extended wait for a biopsy to confirm her bowel cancer, while the patient who had private health insurance obtained an appointment in a matter of three days. Empathy with Rosie's plight was universal, regardless of whether or not individuals held private insurance.

The outstanding question is, therefore, to identify a basis for rationing available resources that will meet criteria to define them as 'fair'. Finding a just means of healthcare rationing generally requires consideration of need (the patient with the greatest need is accommodated first), maximising (that resources are distributed in such a manner as to achieve the greatest good for all of the population) and egalitarian (that resources are distributed in an equitable manner) principles. The difficulty is that all three principles are open to interpretation.

Decisions based on patient need, i.e. a patient's capacity to benefit from a healthcare intervention, are generally subjective interpretations made by individual clinicians. The risk of influence by the patient, healthcare system or political system is evident. Specific requests by well-informed patients, such as for tests or treatment options, will likely pressurise clinicians to utilise more resources on an individual patient than they might otherwise have done. The threat of litigation in an increasingly complex healthcare system risks over-dependence on resource-intensive technology. Politics, whether played out in the Houses of the Oireachtas or on 'Liveline', further pressurise a resource allocation system that focuses on the 'need' principle. Patients use pharmacists as a forum for venting frustrations experienced when trying to access therapy known to be available to some, but not necessarily being approved to all. The instinct for a pharmacist is to 'lobby' for the individual patient under their care, thereby influencing interpretation of the patient's 'need' as being greater. Indeed such lobbying may be interpreted as a means of honouring the duty of care by focussing on that patient's 'best interests'.

The maximising principle promotes the concept of evidence-based practice as a tool in decision-making. However, in order to provide a pharmacoeconomic evaluation, measures such as Quality Adjusted Life Years must be calculated. Many practitioners find the subjective nature of putting a value on another person's quality of life to be morally troublesome. Furthermore, there is always the risk that therapeutic options which have not attracted sufficient evaluative research funding may thereby fail to achieve legitimate approval. Further dilemmas arise for pharmacists when patients seek guidance on whether or not it is in their 'best interests' to partake in a 'double blind placebo controlled' clinical trial as requested by the general practitioner. In addition, there is 'the injunction to rescue identifiable individuals in immediate peril (the Rule of Rescue)', which national policy seeks to facilitate, but a question for Irish pharmacy is whether systems in place, such as those governing the use of Unlicenced Medicines (ULMs), could seek to piggy-back on the 'Rule of Rescue' in an unjustifiable manner.

The egalitarian principle is not without its critics either, in that 'equity of access' is subject to many interpretations. It could be argued that the most equitable system would be to allocate an equivalent share of resources to each person on a lifetime basis. This could be seen as a means of penalising those who live unhealthy lifestyles. After all, insurance premiums are higher for those who smoke. However, insurance premiums are also higher for those whose family history suggests that they may have an unfavourable genetic profile, e.g. for cardiovascular disease, information acquired by asking for the age and cause of one's parents' deaths. An egalitarian approach therefore has the potential to discriminate against those unfortunate enough to meet ill health, the mentally incompetent or the aged. Indeed, writers in the field of bioethics propose principles such as 'fair innings' (John Harris), wherein those of a certain age should accept that they will get nothing more than basic healthcare interventions or 'duty to die' (John Hardwig).

IPJ July 2008 WORKFILE 30/07/2008 16:31 Page 171

In reality, any system of resource allocation will use a blend of these principles, usually in association with some element of lottery. Those with sufficient funds will always be in a position to purchase additional healthcare. Notwithstanding the associated background debates, the question remains whether practising pharmacists have an ethical duty to curtail healthcare expenditure, and, if so, how? There are many ways in which pharmacists can reduce wastage. Simple measures, such as promoting the least expensive of comparable options and the minimisation of wastage through services such as MURs (medication usage reviews) and DUMP campaigns (disposal of unwanted medicines properly), would appear to be well within the remit of a pharmacist's potential. The redistribution of High Tech medicines would require team-working with others in the system, but should be possible. Such reductions in wastage increase the pool of resources available to other patients. The more difficult question arises when resource management at a macro level appears to conflict with the duty of care to individual patients. A forum for review of this question would appear to be warranted.

cicelyroche@eircom.net

Footnote ~

1 'Rosie', alias Susie Long, was interviewed on *Liveline* in January 2007. Susie Long died on October 12th 2007.

References ~

Cookson et al. (2008) Public healthcare resource allocation and the Rule of Rescue. *Journal of Medical Ethics*; 34: 540–544.

Cookson, R. and Dolan, P. (2000). Principles of justice in health care rationing. *Journal of Medical Ethics*; 26: 323–329.

Kuhse, H. and Singer, P. (2006) Resource Allocation: Introduction. In: Kuhse, H. and Singer, P. *Bioethics, an Anthology*. Blackhall Publishers Ltd. United Kingdom: 401-404.

Van Velden et al. (2005). Economic Evaluations of Healthcare Programmes and Decision-Making: The Influence of Economic Evaluations on Different Healthcare decision-Making levels. *Pharmacoeconomics*; 25(11): 1075–1082.