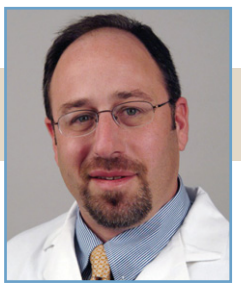
Medical Ethics



By Jonathan Evans, MD, CMD

Ethics and the Latest LTC Pharmacy Issues

Case One

A 76-year-old nursing facility resident with metastatic cancer of the kidney and bone had been taking extended-release morphine 60 mg twice a day for months. A 2-month supply was prescribed by the patient's attending physician. However, unbeknownst to her, only 1 month's worth was filled by the pharmacy because of an insurance issue.

About 30 days later, on a Sunday, staff paged the physician on call to say that the patient was out of morphine and ask him to fax a prescription immediately to the pharmacy. He stated, "I don't have a fax machine at home. Call the patient's regular doctor tomorrow."

Case Two

A 73-year-old woman was transported by ambulance from a hospital to a skilled nursing facility for admission on a Friday at 5:30 p.m. She had been expected many hours earlier. At the time of her arrival, she was in severe pain. Three days earlier, she had undergone decompressive spinal surgery for cervical myelopathy.

For months prior to the surgery, she had been taking oxycodone 20 mg 3 times a day and, since the day of surgery, she had been taking oxycodone 20 mg every 4 hours. The hospital has a goal of discharge by 10 a.m. for every patient and monitors hospital-based physicians for compliance with this policy.

This patient was technically discharged from the hospital at 7 a.m. but remained at the hospital on a gurney in a holding area until 4:45 p.m. when an ambulance arrived to take her to the skilled nursing facility. She received no medications all day while in the holding area at the hospital. Family had brought her food from a vending machine. A discharge summary with orders for care arrived with her from the hospital, but without a written prescription for any narcotic analgesic.

Case Three

An 89-year-old female nursing facility resident with chronic pain, a history of multiple pelvic fractures, severe kyphoscoliosis, osteoarthritis, and emphysema had been receiving fentanyl 75 mcg/hour for the past 6 months, via a transdermal patch that was changed every 3 days. As her monthly supply of medication was running out, a new prescription was written and faxed to the pharmacy.

The next day, her fentanyl patch was due to be changed. The evening nurse noticed that the pharmacy, located 2 hours away, had not sent the medication in its delivery that day. She notified the pharmacy and was told no prescription fax had been received from the facility. However, the original prescription and a fax confirmation, both dated the previous day, were stapled to the patient's chart.

The evening nurse made note in the patient's medication record that the drug as not being given because it was not available. The following day, the medication arrived from the pharmacy. However, it was not administered until 2 days later—the day that the patch was next due to be changed had the patient not missed her dose.

That evening, the patient was found to be extremely anxious and short of breath. She was perspiring and complained of feeling unwell but had no focal sign or symptom. Her physician was contacted, and he drove to the facility and evaluated her. He suspected infection—until it was discovered that she had not received her fentanyl for the past 3 days.

Discussion

Recent changes in the enforcement of rules governing the prescription and dispensing of controlled substances, particularly narcotics, have drawn increased attention to the challenges involved in getting nursing facility residents the medications they need when they need them. This has led some professionals to look again at the systems by which medications are prescribed, dispensed, delivered, and administered to residents of nursing facilities. The challenges posed are further magnified as a result of fragmented care across multiple sites and among multiple practitioners.

The ethical issues involved in these cases are the ethical underpinnings of medical treatment and of professionalism. The guiding principles are to do good (beneficence) and protect from harm (nonmaleficence). Each of these patients suffered harm. They experienced unnecessary pain, among other hardships. Regulations and restrictions on controlled substances represent the tension between the obligation to do good for a patient and the desire to prevent harm to others (resulting from drug diversion).

Problems related to planning, communication, interruption, and delays in care delivery during transitions all too often may reduce quality and increase suffering. The very idea of sending a patient out of the hospital sick and in need represents a significant ethical shift from a relatively few years ago.

What once was offensive to doctors and nurses is now acceptable, although it is economics—not improvements in care—that have made it acceptable. It often is assumed that patients will automatically get what they need when they arrive at the next place of care or see the next health professional. Care fragmentation is not, in and of itself, the problem. Rather, it is the lack of care coordination and lack of responsibility for ensuring that patients get what they need.

Communication problems and underlying attitudes contributed to the problems described in these cases. With regard to Case 1, the problem probably could have been avoided altogether had the pharmacy informed the prescriber that only a "partial fill" was being supplied at the time of the original prescription. That way, she could have made sure a new prescription was written before the drug ran out. Of course, her colleague on call had a duty to care for the patient and should have called an emergency prescription in to the pharmacy.

In Case 2, involving the new admission from the hospital, it first should be pointed out that tremendous pressure is regularly applied to facilities to accept patients quickly yet with little information or assistance from the referring hospital.

Facilities are obligated to meet the needs of residents they care for and are prohibited from accepting patients whose care needs they cannot meet. Hospital-based physicians are often unfamiliar with the nursing facility environment and don't understand what resources are and are not available there. Likewise, the interests of the hospital took precedence over the patient's interest in this case.

The physician discharging the patient from the hospital wasn't even aware that she had remained in the hospital all day before being transported. Nevertheless, given the many challenges in getting narcotic medications for newly admitted nursing facility residents, written prescriptions from the hospital must be provided in every case to ensure timely access to needed medications.

When a pharmacist cannot fill a prescription or comply with an order for any reason, it is important that he or she inform the prescriber directly, rather than nursing facility staff. This is especially critical since facility staff members are not considered "agents" of the prescriber. For facilities, it must be understood that patients who suffer pain because they do not receive their medication as ordered can be considered to have suffered "actual harm," and any patient who has been deprived of necessary care and treatment needed to ensure well-being can be considered to have suffered neglect.

Pain management is a constant undertaking. Pharmacy and physician services are not uniformly available 24 hours a day and 7 days a week, however. As the care of sick hospital patients continues to shift to skilled nursing facilities, the expectations placed on the facility, the attending physicians, and the pharmacies and pharmacists involved continue to rise. Physicians, pharmacists, and medications are going to have to be more readily available. Consequently, the current model of remote, centralized pharmacies serving long-term care facilities is beginning to seem less viable.

Skilled facilities themselves often have as many or more medically complex patients as do community hospitals that have their own fully stocked and staffed pharmacies. Having on-site pharmacies and pharmacists in larger nursing facilities probably would be the ideal model. Increasing the inventory of emergency kits or stat boxes or the use of automated pharmacy dispensing machines on site, while appealing in some ways, has its own drawbacks. Having a pharmacist directly involved in the dispensing of medications is an important patient safeguard that should not be eliminated.

Another option is a greater reliance by nursing facilities on retail pharmacies (and their pharmacists), many of which are open 24 hours a day. The role of retail pharmacies is changing, and with that change may come opportunity. Many insurance plans require or encourage beneficiaries to use mail-order pharmacy for lowest pricing. This has cut into retail pharmacies market share of medications for chronic conditions. Therefore, although drug prescriptions continue to rise in this country overall, the retail pharmacies' share of them is falling. Nursing facilities might therefore represent an important new market for retail pharmacies, particularly large national chains.

How well we treat pain is probably the most powerful indicator of how well we care for others. We have an obligation—and as health care delivery changes, perhaps an even greater opportunity—to do better.

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