INTRODUCTION

Change is the theme in health care as individual hospitals or health plans are merging or being acquired as part of the larger goal of providing population health in a marketplace transformed by the Patient Protection and Affordable Care Act (PPACA). As a result, many traditional operating rules are being altered or overlooked in the chaos brought about by this change. However, some things have not changed—including professional and institutional liability, as well as the oversight role of organizations’ board members, executive committees, and medical executive operating committees, such as the P&T committee.

This column will discuss ethical and legal violations involving pharmacists and physicians whose employers include hospitals and retail pharmacy companies. The purpose of this brief review is to offer context to P&T committee members’ responsibilities for oversight in their organizations for unethical and/or legal issues that may arise on their watch. Case reports will be referenced and commentary presented to aid in re-establishing the important professional role of oversight in health care organizations regardless of their size, location, or purpose.

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PROFESSIONAL OVERSIGHT OF PHARMACY DEPARTMENTS AND OPERATIONS

The 2014 national survey of pharmacy practice in hospital settings by the American Society of Health-System Pharmacists (ASHP) reported increases in services that contribute to improved outcomes from health-delivery programs. Adoption rates for electronic health information, medication barcodes, and smart pumps continued to increase, and transition-of-care and discharge prescription services nearly doubled. Pharmacy operations have broadened in scope in ways that more directly affect patient care.

Early in a long editorial career, O’Donnell chose “Standards of Practice” as the theme for the inaugural issue of the Journal of Pharmacy Practice. That August 1988 issue included an invited review on “Pharmacy Ethics” by Knowlton et al., who wrote:

Principles, written or unwritten, that are accepted in any profession as the basis for proper behaviors are the ethics of the profession. Rule of law and rules of ethics are commonly held to differ because law is enforced by the state while ethical rules are only morally binding. But law and ethics are not opposites. The law itself has a basis in ethics; in general it reflects the moral standards of the community.

While violations of ethics may not be violations of law, they can serve as the source of personal or financial injury and can result in civil jury awards of monetary damages. O’Donnell’s own simple definition of ethics is doing the right thing.

AGE DISCRIMINATION

Troubling legal case reports renewed our interest in age discrimination, a subject related to O’Donnell’s expert-witness consulting work.

Nine veteran hospital pharmacists sued Mercy Medical Group in St. Louis, Missouri, alleging that they had been fired because of their age, according to the St. Louis Business Journal. The lawsuit alleges that between January 2012 and March 2013, Mercy manager Steve Frigo fired the pharmacists and replaced them with younger employees. Pharmacists Robert Overmann, Susan Gallagher, Susan Holly Baker, Ronald Johnson, Judy Lagemann, William Macke, John Mullins, Sandra Ahearn, and Richard Myers are each seeking more than $50,000 in punitive damages. Attorneys for Mercy, the sixth-largest Catholic health care system in the nation, filed a motion in St. Louis County Circuit Court to have the cases heard separately.

The pharmacists claim that a disproportionate number of the pharmacists Frigo dismissed were more than 40 years old. Was that a coincidence? Was it for cause, out of concern for competence and thus patient safety? If it was driven solely by age and financial savings, it would be, in the authors’ opinion, unethical: not the right thing. It would waste the valuable experience of nine pharmacists who had long served the hospital. Indeed, the courts could issue a finding of age discrimination, penalize the hospital, and award the pharmacists monetary damages for their financial losses.

QUOTAS: ARE YOU MEASURING UP?

 Debates about quotas or metrics for production in clinical services have emerged as well. Metrics have increasingly become part of the professional landscape as organizations seek the efficiency needed to deliver cost-efficient care—value-based purchasing, in the terminology of the Centers for Medicare and Medicaid Services.

Can metrics (calculating the time to
perform tasks or tracking other quantifiable measures) be a form of age discrimination? Perhaps younger pharmacists may be able to perform tasks faster than their senior brethren, particularly physical and repetitive activities, but it is troubling to hear complaints about counseling and termination of employment based solely on metrics. To be sure, the metric or quota is not unique to pharmacy practice. Physicians air similar complaints that they are judged solely on numbers and not on the quality of the care they provide. The problem is that metrics can play a part in age discrimination. The use of metrics can also penalize pharmacists and other health care workers for taking the extra time necessary to solve a patient’s problem.

An online article from The Atlantic tells the story of “Tony,” an emergency room physician who recently left his job partly because he was frustrated by his hospital’s use of patient satisfaction scores to evaluate doctors’ performances. Tony and his colleagues felt they were under a great deal of pressure to improve these scores. According to the article, “physicians can be hired, fired, promoted, and compensated based in part on their patient satisfaction scores.” However, those scores could be lowered by input from, for instance, an angry drug-seeker denied a narcotic prescription that would not have been medically justified. A doctor using his judgment to deny an unwarranted Vicodin prescription could damage his career. Thus, a poorly chosen metric could contribute to the flood of narcotics that are derailing U.S. population health initiatives. Good medicine cannot always be quantified, and therefore in some quarters it has no value.

Some drugstore chain executives and independent owners have established daily prescription quotas that their pharmacists are expected to fill. Proponents point to quotas as a management tool ensuring productivity, fair workload distribution, and efficient staffing levels. Critics counter that quotas add up to trouble—more medication errors, more stress among registered pharmacists, and less patient counseling.

When the magazine Drug Topics conducted a nationwide survey of community and hospital pharmacists in 1992,14% of the 1,259 respondents were working under quotas. Nine out of 10 of those registered pharmacists reported that the quota was merely a guideline. Quotas were most prevalent in chain drugstores. Among all the pharmacists surveyed, 69% believed quotas contributed to errors; 57% saw stress levels rising as a result of quotas; 56% thought there was less time to counsel patients when quotas were in effect; 66% believed quotas should be eliminated; and 84% said they would not apply for a job that included a quota.

However, pharmacists who actually worked under quotas were less critical. Two-thirds said they would sign on for a similar position. Among registered pharmacists who worked under quotas, 33% said quotas greatly contributed to stress, while 12% saw no increase in stress; 23% reported quotas greatly increased medication errors, while 29% said they had no effect on error rates; and 24% said they greatly curtailed patient counseling, while 22% said they did not restrict patient counseling.

When the Institute for Safe Medication Practices (ISMP) and the American Pharmacists Association (APhA) conducted a similar survey in 2012,7 policies related to the time it takes to fill prescriptions had become much more common, covering 62% of the 673 pharmacists who responded. Pharmacists had also grown more concerned about the potential for errors. The ISMP/APhA survey revealed that 83% of the pharmacists believed that distractions due to performance metrics or measured wait times contributed to dispensing errors and that 49% felt specific time measurements were a significant contributing factor.

ISMP President Michael R. Cohen, RPh, MS, FASHP, weighed in on quotas for pharmacists in his book Medication Errors.7 Explicit or tacit quotas for dispensing put pharmacists under stress and increase the risk of error, the book notes. Demands to dispense a certain number of prescriptions per shift are put in place by misguided supervisors or companies that value productivity over accuracy.

The problem of metrics and quotas was considered by the National Association of Boards of Pharmacy (NABP) in June 2013. The NABP passed a resolution citing the ISMP/APhA survey and concludes:9

BE IT FURTHER RESOLVED that NABP review and propose amendments to the Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy to address the regulation, restriction, or prohibition of the application of performance metrics and quotas that are proven to cause distractions and unsafe environments for pharmacists and technicians.

Clearly, pushing people past their limits for safe professional practice can lead to errors.

RISK MANAGEMENT

Preventing unethical and/or illegal practices protects the institution or system from liability. In an article on ethical decisions for Drug Topics, Kenneth R. Baker writes:9

“I told them if they didn’t get me more help, we would kill someone.” This sentence was part of a three-page handwritten letter sent to a board of pharmacy investigating a prescription error that led to the death of an elderly woman patient of a chain pharmacy. The pharmacist who wrote the letter had filled the woman’s prescription for a diuretic with digoxin instead. While there was a medical question of whether that mistake had caused the death, it probably was a factor. A reading of the pharmacist’s entire letter left little doubt as to its meaning: “It wasn’t my fault, it was the boss’s fault.” The patient’s family later introduced this letter into the civil trial against the pharmacy chain.

P&T committees should inquire about such potential ethical issues as discrimination, quotas, and even serious understaffing. Their patients’ wellbeing and the institution’s reputation and financial health may suffer if they do not.

CONCLUSION

This column discussed ethical and legal violations involving pharmacists and physicians employed by hospitals and retail pharmacy companies. Realizing that rapid change continues to occur in the PPACA-era marketplace, this brief review also sought to provide context for P&T committee members’ responsibilities for oversight within their organizations regarding ethical and/or legal violations. This is more important than ever when services are expanding to improve clinical and economic outcomes.

Leaders who are not clinicians may assume day-to-day management (including finances and employment) over all operating areas of your health care organ
nization. However, it remains important for P&T committees to establish clear policies and procedures for all medication-related issues within their organizations. It is likely that this responsibility will continue to grow in importance as a challenging marketplace prompts searches for value—sometimes regardless of professional standards of practice owed to the patient.

REFERENCES


