# History and Human Values in Ethics Instruction

Robert A. Buerki

## *THE VALUE OF HISTORY IN ETHICS INSTRUCTION*

"Pharmacy," intoned W. W. Charters in the introduction to his seminal *Basic Material for a Pharmacy Curriculum* (1927), "is an ancient and honorable profession." The purpose of this chapter is threefold: 1) to show instructors of professional ethics how the heritage of our "ancient and honorable" profession can be used as a tool in teaching ethics to pharmacy students; 2) to show how this body of historical information can make the teaching of ethics more meaningful to these students; and 3) to show how codes of ethics reflect changes in professional practice.

Why should pharmacy students be concerned about the historical evolution of professional ethics when they are just beginning to grapple with ethical issues related to the contemporary patient-oriented practices of pharmacy? First, ethical problems faced by pharmacists in the past can provide a common starting point for discussions of contemporary ethical issues. My experience suggests that pharmacy students deal easily with issues that are already well understood, quickly grasping ethical problems that have already been resolved within the profession; these discussions provide a common starting point or springboard for discussions of contemporary ethical issues. For example, the ethical issue of physicians

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restricting freedom of choice of pharmacy services by relying upon overly convenient technology can be illustrated by their use of speaking tubes in the 1890s or direct telephone lines in the 1950s as well as it can be illustrated by their use of facsimile machines in the 1990s.

Second, older versions of professional codes of ethics demonstrate how these documents mirror changes in professional practices over time, reflecting changes in educational standards, legal obligations, and professional functions. For example, the adoption of the new practice standard of patient counseling in the 1960s led to a revision of the Code of Ethics of the American Pharmaceutical Association (APhA) in 1969 permitting such counseling; similarly, the consumerism movement of the 1970s encouraging the advertising of prescription prices led to a change in this Code in 1975. The codes of ethics of other pharmacy associations can also be studied and compared with profitable results. Why does each specialty association in pharmacy feel obliged to have its own code of ethics? Do ethical standards vary with one's place of practice or with one's professional functions? Or is the fractionation of the ethical standards of organized pharmacy merely a reflection of the incomplete professionalization of our sector of the health-care system?

Finally, the historical approach provides a useful introduction to contemporary attempts by the APhA and other professional associations in pharmacy to revise their ethical practice standards. Unfortunately, the traditional codes of ethics developed by these professional associations contain either paternalistic language or self-serving statements that ignore the rights of the patient. Indeed, the very fact that codes of ethics mirror practice so closely reinforces the contention that these codes are not based upon universal principles of moral philosophy.

## *REFLECTIONS FROM PERSONAL TEACHING EXPERIENCES*

For many of you, the teaching of professional ethics in a school or college of pharmacy has been an acquired taste, based on your personal interest in teaching such a course or through a teaching assignment. My initial exposure to the area was obtained through a proseminar in professional ethics at the University of Wisconsin as part of its M.S. program in Social Studies in Pharmacy in the mid-1960s. This proseminar allowed students to compare and contrast several professions–pharmacy, medicine, nursing, engineering, law, and architecture–based upon their published codes of ethics. By looking at how well these codes were constructed and what mechanisms–if any–were used for their enforcement, the codes could

be used as one measure of the extent of the professionalization of these fields.

While I have not pursued this essentially sociological model in my teaching of professional ethics, I have retained the proseminar format with some success: Students read from carefully selected assigned readings prior to class and come to our two-hour lecture-discussions prepared to discuss these readings and the ethical issues that flow from the readings. This technique appears to assist students in identifying ethical problems, allowing them to discuss alternatives and come to closure on solving the problems they have identified. The technique also has the advantage of shifting the focus of instruction from the teacher to the students: The teacher becomes a discussion leader and facilitator rather than a content expert or the source of "correct" answers, helping the students consider alternative solutions to the ethical problems at hand. This is not to say that your personal opinions or judgments on particular ethical problems should be suppressed; rather, your opinions should be expressed—and identified as such. While I would not suggest that you encourage a system of ethical pluralism in your classroom, it seems useful for pharmacy students to be exposed to a wide range of value systems in their search for the unique and personal set of values that will form the basis for their own ethical problem-solving.

For purposes of discussion, the students in my proseminar are divided into three groups of about ten students each; in addition, each group is responsible for reading and summarizing approximately one-third of the readings in enough detail to enlighten the other two groups. This technique allows us to cover an extensive and rather wide-ranging amount of material without unduly burdening the students.

The historical aspects of the course constitute approximately three of the ten two-hour sessions, or about one-third of the lecture-discussions, laying the foundation for other sections of the course. During the first period, I provide an historical overview of the development of codes of ethics in medicine and pharmacy over the centuries to emphasize the long ethical tradition in the health sciences and provide some definitions, distinguishing between law, morals, ethics, etiquette, codes, and oaths. Next, I distribute the 1994 Code of Ethics for Pharmacists, impressively printed on imitation vellum paper, suitable for framing, and heavily laden with implicit moral authority. My students may not have thought much about the ethics of pharmacy practice up to this point, but if they did, they invariably think about ethical issues in terms of such a code of ethics. I then provide the students with a systematic comparison of four earlier versions of the APhA Code published in 1852, 1922, 1952, and 1969,

highlighting the changes in public policy, legislation, and practice standards that occurred during this span of time which are reflected in the codes of ethics. Finally, near the end of the course, assisted by a lawyer and a physician, I discuss the ethical standards in the professions of law and medicine, with particular emphasis upon complying with or enforcing a professional ethos.

## *EXPECTED STUDENT BEHAVIORS USING THE HISTORICAL APPROACH*

In summary, using the historical approach in teaching professional ethics to pharmacy students appears to help these students achieve five goals: 1) students develop an appreciation for the evolution in standards of professional practice, 2) students reflect upon how codes of ethics mirror changing standards of professional practice, 3) students reflect upon how codes of ethics mirror the human values associated with pharmacy practice, 4) students discover the shortcomings of codes of ethics as blueprints for professional practice, and 5) students discover the shortcomings of codes of ethics as enforceable standards of practice. You will note that these expected student behaviors are not stated in terms of behavioral objectives; nevertheless, these behaviors can be observed in class discussion and are reflected in the students' answers to their essay-style final examination for the course. My sense is that analyzing professional codes of ethics using the historical approach allows pharmacy students to see for themselves the lack of human values in many early codes. Moreover, the approach allows students to better appreciate the difficulties associated with establishing ethical standards for a profession.

## *RESOURCES AVAILABLE FOR TEACHING USING THE HISTORICAL APPROACH*

There is a wide variety of materials available if you decide to employ the historical approach in teaching your course in pharmacy ethics, a few of which are included in the Selected Readings at the end of this chapter. You may wish to expand this list, eliminate the ancient texts, include more information about medicine, compare the codes of ethics of various pharmacy associations, or the ethics of other professions.

### *Ancient Preludes*

The texts of ancient codes are valuable teaching aids because they demonstrate that the concern for the behavior of health-care practitioners

dates back thousands of years; many of these texts were gathered together by Charles H. LaWall in 1921. *The Code of Hammurabi* (3000 B.C.) was not a code of ethics, but rather a code of law. The Code did, however, refer to medical practices and set fees based on the patient's ability to pay, as well as discouraging malpractice by the simple expedient of cutting off the right hand of a physician who wrongfully blinded or killed one of his patients. The *Hippocratic Oath* (300 B.C.) was formulated several hundred years after Hippocrates's death as a protest document against the incompetent medical treatment which prevailed at the time. A modern form of the Oath is still administered in some schools and colleges of medicine, but some moral philosophers consider its underlying tenets paternalistic and self-serving. The *Oath and Prayer of Miamonides* (1100s) was the first expression of the specific ethical duties of the pharmacist, while the *Oath of the Florentine Guild of Apothecaries* (1300s), the *Oath of the Journeyman Apothecary* (1600s), and other guild documents illustrates how these bodies were able to control adulterated drugs, business dealings with physicians, and other professional problems with moral suasion, censure, fines, and–if necessary–expulsion. *Percival's Medical Ethics* (1803) is the first modern articulation of medical ethics, which served as the basis for the first Code of Ethics of the American Medical Association (1847). Percival's words carried such moral authority that many passages in that first Code were lifted intact from Percival's work, a practice apparently not considered unethical at the time.

### *American Codes of Ethics*

The *Philadelphia College of Pharmacy Code of Ethics* (1848) is the first American statement of ethical principles for pharmacists. These dour Quaker pharmacists framed their Code to reflect their "professional conduct and probity" and the "standards of scientific attainments" they felt their College had achieved. The various versions of the *Code of Ethics of the American Pharmaceutical Association* are available in the Appendix of *Ethical Responsibility in Pharmacy Practice*, a textbook I coauthored in 1994. The *1852 Code* emphasized fair business dealings, discountenancing "quackery and dishonorable competition," prohibiting "professional amalgamation" with physicians, counter-prescribing, and other related problems. Sworn to as an early requirement for Association membership, the Code set a pattern of lofty professional aspirations far beyond the realities of pharmacy practice in mid-nineteenth-century America. The *1922 Code* called upon pharmacists to encourage the use of "official" drugs and preparations and to uphold the laws regulating narcotic drugs and liquor, reflecting events which were transforming pharmacy from a

specialized occupation to a burgeoning profession–the emergence of advanced educational standards, professional associations, and practice-related legislation on both state and national levels. The Code cautioned the pharmacist to "never discuss the therapeutic effect of a Physician's prescription with a patron" nor add any "extra directions or caution or poison labels" without "due regard for the wishes of the prescriber," reflecting the pharmacist's subservient status as the "handmaiden of the physician." The *1952 Code* asked the ethical pharmacist to "recognize the significance and legal aspects of brand names and trade-marked products" and to follow the prescriber's directions when refilling prescriptions, reflecting the development of prescription specialties and the provisions of the Durham-Humphrey amendments. Still subservient in the matter of patient counseling, the pharmacist of the 1950s "suggests that the qualified practitioner is the proper person with whom such matters should be discussed." The *1969 Code*, while silent on the issue of patient counseling, calls upon the pharmacist to "render to each patient the full measure of his ability as an essential health practitioner," reflecting the emergence of a clinical, patient-based practice of pharmacy. The Code was to be enforced by a Judicial Board, which had broad authority to apply sanctions against Association members engaged in unprofessional conduct, including violations of the Code of Ethics. A complaint to the Board regarding a violation of the prohibition against advertising of professional services resulted in a lawsuit and a FTC-mandated amendment to the Code of Ethics removing this prohibition (1975), reflecting the consumerism movement of the 1970s. As a result, however, the Board was subsequently disbanded, irrevocably injuring a process by which organized pharmacy sought to enforce its ethical standards. The 1981 revision of the Code removed all masculine pronouns, reflecting an increased sensitivity to the changing nature of the professional work force.

The *1994 Code of Ethics for Pharmacists* is strikingly different from all previous codes adopted by the APhA, reflecting the significant advances in medical ethics and pharmacy practice over the past two decades, particularly the emphasis upon patient-based clinical practice in both institutional and community pharmacy settings and the emerging practice philosophy of pharmaceutical care. The Code establishes the pharmacist-patient relationship as a "covenant," places concern for the patient well-being at the center of professional practice, promotes patient autonomy and dignity, and emphasizes such basic virtues as honesty, integrity, and justice. Its appeal to "moral obligations and virtues" as the foundation for guiding the professional actions of pharmacies makes the Code both unique and a model for other health professions to consider.

In my course, I generally assign four groups to compare and contrast in point form two versions of these five association-generated Codes: 1852 vs. 1922, 1922 vs. 1952, 1952 vs. 1969, and 1969 vs. 1994. The resulting discussions, linked with the major developments in education, legislation, and practice standards in American pharmacy during the past 150 years, reinforce my contention that codes of ethics closely mirror changes in professional practice.

## *THE SHIFT FROM A TRADITIONAL CODE-BASED ETHOS*

Although the American Pharmaceutical Association and other professional pharmacy associations continue to wrestle with their codes of ethics, this activity does not appear to reflect the parallel developments in the fields of ethics and bioethics over the past forty years. You may find it useful to introduce this concept to the students in your course in pharmacy ethics as a springboard to a discussion of human values. Nazi medical experimentation during World War II and the subsequent Nuremberg Trials in 1945 led to the first articulation of the concept of informed consent. Since that time, America's health-care professions have had to deal not only with the ethical implications of emerging medical and pharmaceutical technology, but the impact of shifting public attitudes as well.

### *The Impact of Medical and Pharmaceutical Technology*

During the past several decades, we have witnessed the dramatic development of sophisticated life-support systems, organ transplants, and other developments which have profound ethical implications. Although this new technology has been announced with excitement and launched with great fanfare, its innovators are generally oblivious or insensitive to the ethical questions they engender. While discussions about patient access to new technology, allocation of scarce resources, physician-assisted suicides, abortion, euthanasia, randomized clinical trials, and genetic engineering are not directly related to pharmacy practice, these discussions can sensitize the pharmacy student to the ethical problems faced by a society driven by technology.

These discussions lead logically to a consideration of the development of life-extending therapies. It is useful to point out the dramatic shift in the nature of mortality and morbidity since the turn of the century: The same people who would have died from acute infectious diseases in the 1890s are now kept alive longer through modern antibiotics and vaccines, only to

succumb to the chronic debilitating diseases of the 1990s–heart disease, cancer, and stroke. Americans are also living longer, more productive lives as the result of better diets and modern pharmaceuticals. The dark side of this picture–soaring drug prices, crowded nursing homes, and the challenge of counseling elderly patients taking over a dozen different prescriptions–can evoke stimulating discussions of not only contemporary ethical issues, but also the challenges of providing pharmaceutical care in the 1990s and beyond.

### *The Impact of Shifting Public Attitudes*

Pharmacy students should also be exposed to the shifts in public attitudes toward health-care providers which have accompanied these advances in technology, particularly the consumerism movement and the changes resulting from the growth of corporate medical and pharmacy practices.

The consumerism movement of the 1970s not only made the public more price-conscious, but more curious about the nature and quality of their health care and the qualifications of their health-care providers. Price consciousness was reflected in consumer demand for specific, precise information about the cost of drugs, prescription prices, and how these prices were determined. Drug manufacturers reacted by developing generic drugs; the profession reacted by supporting the repeal of so-called "antisubstitution" legislation, prescription price-posting and price advertising, and professional fees. Consumer demands for more information about the medicines they consumed led not only to increased patient consultation on prescription drugs and over-the-counter medications by the pharmacist, but placed the *Physician's Desk Reference* on the annual best-seller lists as well. Finally, the increased public interest in professional accountability has led to mandatory continuing professional education, public members on licensure boards, and calls for periodic relicensure examinations for all health professionals.

By the same token, the growth of corporate medical practice since the 1970s has had a profound effect on the perceived quality of medical care. Individuals are no longer served by kindly, avuncular family physicians who make house calls and may take care of several generations of a family living in a home. To an increasing extent, individuals are served by the often faceless, interchangeable physicians of the HMOs or other managed health-care systems or show up at the emergency room of their local hospital. This perceived lack of continuity in health care has undermined the traditional relationship of trust between physician and patient and has contributed to the unnerving increase in professional malpractice suits and

the accompanying skyrocketing of malpractice insurance premiums. Given this background, pharmacy students can make comparisons between medicine and pharmacy and draw parallel conclusions concerning the professional and human values associated with emerging patterns of pharmaceutical care.

### *The Development of Bioethics*

The field of bioethics was nurtured and developed during this same postwar period. Scholars at university departments of philosophy began shifting their attention from the classical writings of the ancient Greeks to a consideration of some of the ethical problems facing modern man. A new brand of scholars began to consider the ethical implications of emerging medical and pharmaceutical technology, creating a new field they dubbed "bioethics." Applied ethics gained credibility and assumed greater importance in the halls of academe, and situational ethics were no longer considered unworthy of scholarly attention. The emergence of new scholarly journals examining these and other subfields in ethics, the development of the Kennedy Institute of Ethics and other "think tanks," and other new scholarly activity underlined this fundamental shift in the field of philosophy from classical to applied ethics. Pharmacy students generally appreciate this background because it allows them to make linkages to other aspects of a course in pharmacy ethics.

## *SUMMARY AND CONCLUSIONS*

As we have noted, most codes of ethics are promulgated by professional associations without much–if any–input from the patients we serve. If we are serious about emphasizing human values and caring relationships in our professional practices, our new codes of ethics must solicit input from both practitioner and patient. The ethical issues and problems challenging today's pharmacists are not taking place in isolation, but reflect concomitant changes in law, medicine, and other professions. Pharmacists and other health professionals today apparently place less reliance on formalized statements set down in rigid, self-righteous codes of ethics and greater reliance upon universally accepted moral principles and human values. The question becomes not "Did you break the code of ethics?" but, rather, "Did you act ethically?"

As I have suggested, the historical approach in ethics instruction has several benefits associated with it: First, the historical approach not only

allows pharmacy students to place contemporaneous materials in their historic context, but the considerable body of knowledge they gain from understanding how earlier generations of pharmacists solved their professional problems can assist them in identifying ethical problems, considering alternative solutions, and engaging in the problem-solving process, all of which hopefully results in defensible practice decisions. Second, by demonstrating to students that the profession of pharmacy has not simply passed a simple set of ethical standards from one generation to the next since antiquity, the historical approach introduces the dynamic nature of professional decision-making and how it has changed and developed over the centuries. Third, using the historic approach can help instructors dramatize shifts in human values, the changing standards of professional practice, and, perhaps, help students account for why pharmacy is practiced the way it is today. Finally, the historic approach can be used to provide students with very real alternatives to using association-generated codes as their sole tools for ethical decision-making by demonstrating that there is more to being an ethical practitioner than mere conformance to a code of ethics. In this, the instructor of pharmacy ethics can find no greater or more satisfying educational challenge.

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