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2006 Conley essay contest
Distributing drug samples in a free clinic: a personal or policy decision
Response by Amanda J. Redig

Scenario
The accepted guideline for distributing free drugs at a particular community clinic for the uninsured is to dispense them according to clinical need, on a first-come, first-served basis. When the clinic is out of a drug, the physician writes a prescription if the patient can afford the medication for a short period of time, during which the physician tries to enroll the patient in the manufacturer-sponsored indigent drug program (IDP). The clinic has a limited supply of Viagra and Cialis samples from the manufacturers of those drugs. One physician breaks the first-come, first-served rule in distributing these drugs. He has several patients with erectile dysfunction, but one of them smokes heavily. The physician reckons that the patient spends about $240 a month on cigarettes (if he is truthful about his smoking habits) and that if he did not buy cigarettes he could afford $260 per month for the drug. The patient does not qualify for the manufacturers' IDP. Having discussed smoking cessation programs and other interventions like the nicotine patch with the patient for more than a year, the physician now tells him that he is withholding free supplies of Viagra and Cialis from him, giving them instead to patients with similar clinical indications who do not smoke and have greater financial need.

Response
The life of a physician is a never-ending series of exams, from medical school admission to board certification. The jargon of the tests—Step 1, surgery shelf, Internal Medicine boards—eventually becomes as familiar as the language of ACE inhibitors or PIC lines. Yet challenging as the knowledge-based demands of medicine can be, the ethical dilemmas of the profession are no less complicated. And for these situations there is no review book or UptoDate.com entry to provide answers. Instead, each physician must balance the duty to provide medical care with the equally compelling obligation to uphold the ethical tenets that lie at the heart of the profession of medicine. The true challenge for the physician lies in deciding what to do when these responsibilities collide.

In this scenario, the physician in question, henceforth referred to as Dr. X, confronts two related dilemmas. First, given limited resources, how does a physician best serve the competing needs of all of his patients? In an individual patient-physician relationship, both clinical judgment and ethics agree: the patient's well-being is the goal of the physician. But what happens when the best outcome for one patient

comes at the expense of another's? Dr. X's community clinic lacks sufficient free samples of erectile dysfunction medication for all those who need them. When Dr. X dispenses Viagra or Cialis to one patient, he knows that another clinic patient will probably go without.

This primary dilemma, however, leads to a second, even more troubling question. If we accept the reality that finite resources prevent all patients from getting the medical care they need, then how are the resources that are available allocated when demand outstrips the supply? In this case, given that some clinic patients will get the medicines they need and some will not, who decides—and on what grounds—which patients to treat? When patients must be hierarchically classified, what factors shape that decision? This community clinic has attempted to address the situation with a first-come, first-served policy for pharmaceutical assistance. Dr. X, however, has chosen to break with this policy and provide ED medication selectively to non-smoking patients with the greatest financial need, as judged by the doctor himself. His decision is presumably predicated on a cost-benefit analysis of beneficence as well as on justice, but a critical question remains. Is an individual physician's assessment of what is "fair" the best way to resolve the problem of limited resources and unlimited needs?

Considering patient equality

This case shows a physician casting himself in the role of arbiter with regard to resource allocation. An analysis of the physician's decision consequently begins with a basic question: are all patients created equal? From a human rights perspective, the answer is clearly "yes." Article 25 of the United Nation's Universal Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including…medical care..." [1]. More specifically, the profession of medicine has long recognized patients' inherent humanity and physicians' responsibilities to all their patients. The oft-quoted Hippocratic oath of ancient times reminds us, "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice…" [2]. In a more modern adaptation, the American Medical Association's "Principles of Medical Ethics" begins with Article I— "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights"—and ends with Article IX— "A physician shall support access to medical care for all people" [3, 4]. Seen in this light, the actions of Dr. X seem to be in opposition to longstanding professional ideals.

While the fundamental ideals of a profession should challenge us to strive for equity and justice, the application of such principles is far more complicated. The reality of life is that inequality occurs despite our best attempts to minimize it. For physicians, ethical standards of professionalism provide guidelines for operating in an imperfect world; they do not obviate the difficult decisions for which there is no perfect outcome. In the real world of medical decision making, hierarchies of patient need are routinely created and maintained as we attempt to best manage infinite needs and finite resources.

Indeed, such decisions influence medical care in numerous and varied settings on a daily basis. Age or comorbidities may disqualify a patient from receiving a life-saving organ transplant [5, 6]. It is a testament to the power of an ethically grounded argument that, in some patients, HIV infection can no longer be an excuse for carte blanche disqualification, but with a widening pool of potential recipients and a relatively steady level of donors, some patients are still chosen over others for life-saving treatment [7]. And the case of organ transplantation is not an isolated one: eligibility for care ranging from influenza vaccination to Medicaid is preferentially stratified [8, 9]. Although the medical needs of one individual are intrinsically no less valid than those of another, the profession of medicine—and individual physicians—must sometimes choose between patients. Accordingly, Dr. X's actions are neither unique to him nor prima facie unethical but rather reflect the challenges of practicing medicine under less-than-ideal conditions. Instead, the more fundamental question this scenario challenges us to address is the grounds upon which such resource allocation decisions are based.

Ethics revisited

Although the idealism at the heart of ethical codes may not always be completely attainable, the value of such principles lies in their ability to provide a consistent framework for making difficult decisions. If the validity of selectively distributing free medication rests on the framework by which the choice is made, not on the decision itself, how does Dr. X's thought process measure up to the "best practice" guidelines of medical ethics?

A closer reading of ethical principles does highlight the physician's autonomy in providing patient care. Outside of emergency situations and as long as continuity of care is maintained, Article VII of the AMA's "Principles of Medical Ethics" recognizes the physician's right to choose the patients he serves [10]. A shift away from a paternalistic view of the physician also emphasizes the rights and corresponding responsibilities of the patient. The autonomy of the individual patient must be respected, but on the flipside of the physician's obligations exist the patient's "…responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed upon treatment program" [11].

Together, physician autonomy and patient responsibility have direct applicability to the challenge of fairly allocating a limited supply of free medication. On the one hand, it seems reasonable to withhold a non-life-sustaining medication from a patient with financial resources who is not committed to his own well-being despite concerted attempts by his physician to address a colossal health risk. This does not sever the patient-physician relationship, but it does lead to considering the patient's financial needs when distributing manufacturer-donated prescription medication. In this case, Dr. X's calculations concerning the cost of ED medication versus the amount his patient spends on cigarettes seem appropriate and are further validated when the patient does not qualify for the manufacturer-sponsored indigent drug program. If a patient allocates substantial financial resources to cigarettes, it seems

legitimate for a physician to allocate free ED medication to those patients whose financial inability to pay results from spending on food or rent.

Yet even as this logic appeals to our desire to be fair—and, perhaps, to a negative perception of those who smoke—it is also internally inconsistent. First, such a decision implies a professional mandate no individual physician can truly claim. It is legitimate to transfer care of a patient to another physician on the grounds that the patient's continued smoking prevents the maintenance of an effective patient-physician relationship. However, the physician's autonomy in this regard does not justify the manipulation of a patient's behavior through a carrot-and-stick maneuver that is grossly inappropriate in a medical context. Dr. X's desire to see a patient quit smoking is commendable, but his decision to effectively punish the recalcitrant patient by withholding medication is not. (It is also worth noting, as a not-insignificant aside, that nicotine addiction is extremely powerful. This patient may have refused the physician's attempts to help him quit, but can Dr. X be sure that he fully understands this patient's circumstances and the factors that contribute to his continued habit?)

Moreover, when a physician independently singles out smoking, or any other personal choice, as grounds for excluding a patient from subsidized medication, that physician is presuming to act on the basis of an omniscience he cannot possibly possess. Smoking is a costly habit and one that is detrimental to the health of the smoker, but does that mean that nonsmokers deemed worthy of free medication may not themselves maintain unhealthy personal habits that also require a financial investment? Is it fair to the smoker if the obese patient who spends an equivalent amount per month on movie rentals or junk food is prescribed a free medication the smoker is denied? What about the patient with a drinking habit about which the physician may be ignorant? It would be unfortunate indeed if the patient who trusts his physician enough to be honest about negative lifestyle choices winds up being penalized for it. As this case illustrates, the physician who decides to circumvent the accepted standards of a multi-physician clinic may be setting a dangerous precedent. Dr. X is projecting a personal bias into the patient-physician relationship without attempting to be either internally consistent in the way he evaluates his patients' habits or to seek out a more objective consensus from colleagues, even as he violates the very practice guidelines they supposedly share.

This, in fact, is the most compelling reason for consistency in distributing a service some patients will get and others will not. As a profession, we have to live with the reality of stratifying medical needs; such decisions can only be tolerated when their application is not arbitrary. Maybe the first-come, first-served policy is not the best paradigm for determining who gets free medication and who doesn't. Perhaps other factors, particularly the financial status of the patient, may provide a more consistent and just model with which an individual clinic can manage its resources. Such a change in policy, however, is a decision to be made by the leadership of the clinic, not by an individual physician who decides to become, in effect, a vigilante prescriber. In his attempt to be fair, Dr. X has instead created a double standard that

is a disservice both to the clinic's patients and to his own colleagues. Were he in solo practice, Dr. X would be free to change his policies independently; as a physician at a community clinic that is the beneficiary of donated medication, he is obligated to work within the professional guidelines of the clinic and to respect the institutional process by which those guidelines are amended. In the long term, the physician who works to improve the system is far more effective than the one who chooses to simply disregard it.

This clinical case is a compelling one because Dr. X stands as an example of the best and worst of his profession. As presented here, his actions are intended to convince a patient to quit smoking and to provide more equitable care for an economically disadvantaged community. The decision to withhold medication from one patient is based on a desire to be just with regard to all of his patients; his intentions, at least, are ethically sound. The problems his decision creates arise from the application of these initially noteworthy intentions. In this sense, the fictional Dr. X stands as a warning for his real-life counterparts: even that which seems like a good idea must be consistent with accepted professional guidelines to avoid creating more problems of equity than it solves. Justice is key to the professional integrity of the physician, but it is also a balance between being fair and being consistent.

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The John Conley Foundation for Ethics and Philosophy in Medicine has sponsored an ethics essay contest for medical students since 1994. John J. Conley, MD (1912-1999), was a head and neck surgeon and clinical professor at Columbia's College of Physician and Surgeons in New York City. A specialist in reconstructive and maxillofacial surgery, Dr. Conley was an author on more than 300 scientific articles and 8 books and was honored by Columbia through the establishment of the John Conley Lectureship in 1997. The John J. Conley Department of Ethics was established in 1998 at Saint Vincent's Hospital in New York City where Dr. Conley served as chief of head and neck surgery.

Winners of the Conley Ethics Essay Contest for Medical Students appeared in *msJAMA* for ten years and have been published in *Virtual Mentor* since 2005.

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