

Virtual Mentor

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From the Editor

Rx for physician prescribing practices

One of the unique privileges and responsibilities accorded to medical practitioners, the act of prescribing drugs lies at the heart of the physician-patient relationship. Pulling the prescription pad out of the pockets of our white coats, pen in hand, signals to patients that we have help to offer, that we can give them something to alleviate or even eliminate the source of their complaints, and that their trust in the medical profession's collective knowledge, judgment and desire to serve is merited. Prescribing carries with it the promise of comfort and hope. Even since ancient times, it has been seen as an act of goodness. The well-known symbol Rx may even be derived from Egyptian hieroglyphics. According to the legend, Horus, the god of sky and of light and the keeper of secret wisdom, sustained a terrible eye injury while seeking to avenge the murder of his father. Later, the eye was magically healed. The eye of Horus thus became a symbol of health, now recognized as Rx, and its placement by physicians on written prescriptions represents an appeal for the success of the recommended remedy.

Recently, a multitude of front-page, ethically charged issues relating to prescription medications have been publicized and discussed in both the lay and professional press, sometimes calling into question the good intent behind prescribing and the ability of physicians to make sound prescribing decisions. Increased knowledge of the marketing tactics employed by pharmaceutical companies, in particular those directed at physicians, has prompted much-needed reflection within the profession about the influence such tactics may have on prescribing habits. Other headlines have raised concerns about drug safety, including the FDA approval and monitoring process for new drugs. Adverse events due to inappropriate or erroneous prescribing have also made the news, prompting numerous calls for computerized prescribing programs to assist physicians.

In this installment of *Virtual Mentor* we consider some of the challenges relating to the ethics of sound prescribing. Given the vast range of the topic, we have tried to highlight a spectrum of issues, from public policy trends in the area of post-market drug safety to appropriate medication choice in a pediatrics clinic. However, we have placed particular emphasis on some of the many dilemmas associated with the pharmaceutical industry. Growing public awareness of the potential conflicts of

interest between pharmaceutical companies and physicians will require us to navigate this relationship carefully in the future.

In the first case commentary, Jonathan Finkelstein, MD, suggests how a physician can respond to patient requests for treatments that are not likely to be of benefit. He also reflects on the dilemma faced by physicians who witness inappropriate prescribing by their colleagues. The second clinical case commentary, by Richard Adair, MD, delves into the hidden effects of free drug samples from pharmaceutical companies and offers some practical, clinic-based solutions designed to help patients acquire the drugs they need but may not be able to afford. Commenting on the third case, Frederick Sierles, MD, considers how medical students may be unconsciously influenced by free gifts, including the ever-popular gift of free food. In our final case, Perry Fine, MD, examines the prescribing of placebos and re-emphasizes the importance of the informed consent process and shared decision making in prescribing. In the clinical pearl, I take a brief look at vitamin B-12, once commonly, if inappropriately, prescribed as an injection for relief of fatigue and other non-specific symptoms.

A number of articles in this issue concern current trends in the law and government policy and how they may impact the ability of a physician to prescribe safe, appropriate and necessary medications. In this month's journal discussion, Philip Perry considers a recent proposal made in the *Journal of the American Medical Association* by Aaron Kesselheim, MD, JD, and Jerry Avorn, MD, to extend the legal principle of eminent domain to biomedical patents, permitting the government to use its authority during times of crisis to seize control of the production of biomedical products, thereby potentially increasing access to life-saving medications and vaccines. The policy forum section by Daniel Carpenter, PhD, reviews historical and current efforts by the federal government to reform the post-market regulation of drug safety. Dr. Carpenter points out that "reputational incentives" and a reluctance to reconsider standing FDA decisions may create a conflict of interest within the FDA between its Office of New Drugs, charged with pre-market approval, and the Office of Drug Safety, charged with post-market evaluation. Christian Krautkramer analyzes one of the more controversial prescription drug-related legal cases in the health law section, with a careful look at the off-label marketing tactics associated with the anti-seizure drug Neurontin.

Our medicine and society section explores patient autonomy in the face of an explosion of direct-to-consumer televised and print drug advertisements. In this section, Richard Kravitz, MD, MSPH, and Jodi Halpern, MD, PhD, also comment on the duties that patients have, as health care consumers, in the prescribing relationship. Jorge Ruiz, MD, and Brian Hagenlocker, MD, discuss the advantages and obstacles of e-prescribing/CPOE (computerized physician order entry) in the medical education section and consider the potential for e-prescribing to reduce medical errors. Finally, in the op-ed section, Adriane Fugh-Berman, MD, and her colleague Sharon Batt question the role of the pharmaceutical industry in continuing medical education, finding an inherent and possibly insurmountable conflict of

interest between educating and drug marketing. In a complementary op-ed article, Murray Kopelow, MD, chief executive of the Accreditation Council for Continuing Medical Education (ACCME), answers that the ACCME Standards for Commercial Support effectively maintain independent continuing medical education by separating education from drug promotion.

Of course, all physicians can remember the secret thrill of consulting the Tarascon Pocket Pharmacopoeia and carefully writing out our first prescriptions in medical school. Early in our careers, our greatest fear, perhaps second only to coming up with the wrong diagnosis, is of prescribing the wrong drug. In our concern to do no harm, I suspect that we younger physicians fail to reflect on what pressures, both internal and external, may be affecting our prescribing behavior. Prescribing drugs is something that experienced, practicing physicians do dozens of times daily, with great confidence but perhaps only rarely with consideration of the broader significance of the activity. Whatever your place on the medical education and training continuum, it is our hope that this month's issue will help you contemplate some of the social, political and, most importantly, ethical challenges related to sound prescribing, especially those pertaining to the influence of the pharmaceutical industry. In conclusion, I wish to express my gratitude to all of the authors for sharing their wisdom and expertise with our readers.

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