

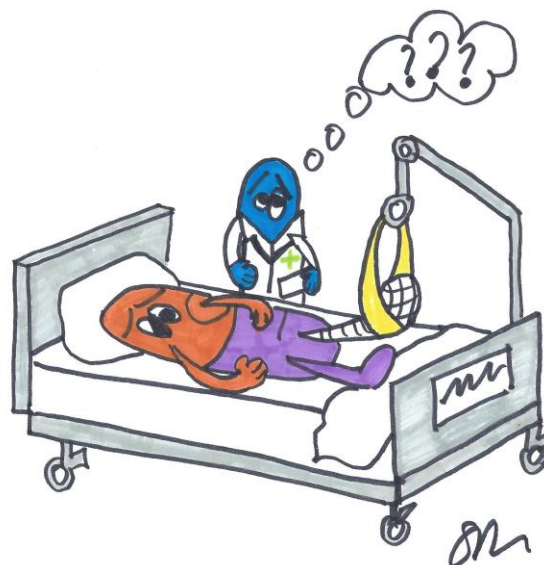
Decision-making

After completing this tutorial, you will be able to:

- Outline why some clinical problems about medicines may be harder to solve.
- Describe strategies for managing these clinical problems safely.
- Discuss the steps to take if you discover you have made an error.

An important part of being a professional is making decisions. You will often rely on facts to make decisions: information that you've learned, data from a patient's notes, evidence that you find in a book or online.

But the decisions you make professionally will not always rely solely on facts, or you may not always have all the facts that you need. And in these situations you may feel less certain about what to do. You might, for example, need to make a decision in circumstances where:



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- *The medicine or the clinical situation is unfamiliar to you.*
- *You don't have enough information or the information you have is conflicting.*
- *There is pressure on you to make a quick decision.*
- *You or a colleague has made a mistake.*
- *There is no ideal solution, but a decision still needs to be made.*
- *A colleague or patient is upset, angry, or threatening to complain.*

It is difficult to teach you how to handle these 'less straightforward' situations. Many of them might be said to require **professional judgement**. This is something that we tend to learn by experience. However, in this section of the Learning Portal we will provide some scenarios to help you think about these kinds of situation in advance, and also introduce some principles to guide you.

Multiple priorities

Pharmacists are often busy. How do you deal with a problem when you already have too much to do?



Imagine you are in the dispensary. You're the only pharmacist on duty and you can't leave. It's busy: there's a complex prescription for a clinical trial medicine that you must check and there's a research nurse waiting for it; a senior manager has walked in to talk to you about health and safety; there's lots of outpatient prescriptions to check; a ward has just requested a compliance aid. In the middle of everything else that's going on, a doctor phones and says she needs advice from a pharmacist immediately. What do you do?

Have a think about the kind of strategies you might adopt to deal with this. Think of at least three things you could do. When you've had enough thinking time, turn to the next page.



Some suggestions

When faced with a situation like this, you could do a number of things:

Gather information

Make an informed decision about the phone call, by asking some questions:

Ask the doctor what she wants to know.
Find out when she wants an answer.

The doctor wants to check the dose of a medicine that you've never heard of, and she says she needs it straight away.

How important is the doctor's question compared to everything else you must do?

Her question is **important** because the doctor must prescribe accurately, but how **urgent** is it clinically? For example, it's urgent if the patient is critically ill or the medicine is part of a vital intervention – in which case, the information must be provided quickly. But the doctor might be asking for a speedy answer simply because she doesn't want to be kept waiting.



This is about **prioritisation**. Assess what else you are responsible for at this moment. Then prioritise your work according to clinical urgency. This means asking yourself the question: *Which jobs are most likely to put patients at risk if I delay doing them?* If in doubt, always put patient safety first. Of all the jobs you have on your plate in this scenario, only the phone call might have safety implications for a patient. All the other tasks might keep people waiting if you delay, but they're less urgent. So you must find out what the doctor wants.

Can you ask for help?

Don't be afraid to ask for help. It's not a sign of weakness. It's a sign that you're mature enough to recognise that everyone has limitations. Perhaps you could bleep a clinical pharmacist working in the area concerned and ask them for the answer or even request that they take over the problem. If you have a Medicines Information centre, you could ask them. Or maybe there

is another pharmacist in the dispensary, or your line manager, who could look into the doctor's query for you?

Finally, whatever you decide to do, you must **communicate** with the doctor on the phone and explain what you are doing:

- *I do apologise but I'm the only pharmacist on duty this morning and I can't leave the dispensary right now. Since you're not due to see the patient until 4pm, I'll look this up when I go off duty at 12 o'clock and get back to you as soon as I can.*
- *I'm a new member of the team here and I've not come across this before. I know you need an answer quickly. So, would you mind bleeping our Medicines Information Pharmacist on 1234, and they will be able to help you.*

Summary

So there are four general strategies you can often use if confronted with a problem when you have multiple other priorities:

- Gather **Information**, define the issues so you can make an informed decision.
- **Prioritise** the demands on your time. What is *most clinically urgent*?
- Ask for **Help**. You're not alone, you're part of a team.
- And always **Communicate** what you're doing with the people you're dealing with.

Sometimes you will have to **say 'no'** to other people's priorities. You may find this difficult – especially at the beginning of your career. If you'd like to see our thoughts on how to do this, read on.



Saying 'no'

This isn't always easy. In the scenario about priorities, you might have to say 'no' to the doctor's request for immediate information if you don't think it's urgent enough. Here are bad ways to say 'no':

- *No, I can't do that I've got too much going on.*
- *I can't help you there. I've never heard of that. I've got to go.*



An important aspect of successfully saying 'no', is not to leap in with an immediate 'no' but to be respectful of the other person's agenda, and to be **polite**. A good technique is to give the **reason for declining**, *before* you decline:

- *I do apologise but I'm the only pharmacist on duty this morning and I can't leave the dispensary right now...*
- *I'm a new member of the team here and I've not come across this before. I know you need an answer quickly, so...*

The second example acknowledges the fact that the doctor wants a quick answer. So it shows that the pharmacist recognises the importance of the request: it's not being dismissed.

Once you've explained your decision, you should try to **signpost** the person to other sources of help if you can or offer assistance that you think is more appropriate.

- *Would you mind bleeping our Medicines Information Pharmacist on 1234, and they will be able to help you.*
- *I'll look this up when I go off duty at 12 o'clock and get back to you as soon as I can.*

So if you need to say 'no' to a request then be polite, explain your reasons, and signpost.



Lack of information

You may be asked to give advice when there is simply no, or very little information on which to base your answer. Consider the following situation;



You are on a ward round at a local mental health unit and the consultant asks you about prescribing trihexyphenidyl. The patient is suffering with extrapyramidal side effects because of the antipsychotic medicines that they take. However the patient has chronic renal failure and receives haemodialysis (HD) three times per week. Does the dose of trihexyphenidyl need to be adjusted?

Have a think about where you might look for the information before reading the next paragraph.



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So, you begin to look for information. You check the manufacturer's SmPC, the Renal Drug Database, Bazire's Psychotropic Drug Directory, and the Maudsley Prescribing Guidelines in the first instance. But you find no relevant information. You then undertake a Medline and Embase search for published experience of using trihexyphenidyl in patients on haemodialysis and don't identify any useful papers.

What should you do now? Take time to think about this before moving on to the next page.

Some suggestions

Theoretical predictions

If there is no published evidence to guide you, then you must use alternative strategies. You might, firstly, try to make a theoretical prediction about how trihexyphenidyl would be handled in a patient on HD. You can read a little about the factors that affect drug removal by Renal Replacement Therapy [here](#).

So, you could try to find out about the pharmacokinetics of the drug such as how it is normally eliminated from the body, whether it is metabolised, whether any metabolites are pharmacologically active, the degree of protein-binding and its volume of distribution (Vd). However, making a theoretical prediction is not without risk, especially in a complex situation such as this when multiple factors could influence how the drug is handled by the body.

Asking the experts

Think about who might have experience of managing such patients. You may have a team of practitioners at your hospital with renal expertise, or if not you will have a regional renal unit that may be able to help. Consider whether any expert bodies may have issued consensus guidelines in the area, or whether there may be relevant specialist discussion groups that you may be able to search. You might be able to contact a colleague in the [UK Renal Pharmacy Group](#) for assistance.

Explore the alternatives

If you really can't find any evidence upon which to base a decision, then is there an alternative drug that may be suitable? In this case you could check to see if there were data for e.g. procyclidine in patients receiving HD.



Making a decision

If there is no, or very limited information, remind yourself that the decision to use any medicine should be based upon a careful consideration of the perceived benefit to the patient versus the potential harm. This will differ between patients according to their individual preference, the severity of their disease, and their risk of developing side effects. It's also important to think about where the patient is based (e.g. in the community or an inpatient), as this will affect how closely they can be monitored for treatment benefits and for adverse events.

In this kind of situation, you should always check your proposed solution with a senior colleague first before getting back to the consultant. You also need to be upfront with the consultant that there are no published data on which to make a decision and, wherever possible, the lack of information should be discussed with the patient too.

The rule of thumb of 'starting low: going slow', which means starting at a low dose and building it up gradually, could be helpful in this situation. You may want to discuss this with the consultant to determine between you a sensible starting dose and speed of dose increase. This is the kind of ward-based intervention that you would want to document carefully for future reference.

Summary

From time to time you can face situations where you've been asked for advice, but have no published evidence to guide you. Assuming you've looked thoroughly for information and drawn a blank, the general approach below may help to structure your thinking:

- **Theoretical predictions.** Are there ways to predict the best medicine to use, or how a given medicine might behave?
- **Ask the experts.** You're not alone - who can help you in your hospital, locally, or even nationally?
- **Explore alternatives.** If you're faced with a complete lack of information, are there different medicines you could use where there are more data to guide you?

The decision to use any medicine is a balance of potential benefits versus potential risks. You need to remember this, and discuss any proposed solutions with a senior colleague in pharmacy, the consultant, and the patient. In this situation, a lack of information is an important risk and you must be open about it.



Out of my depth

You may sometimes be asked to make decisions and/or provide advice in unfamiliar situations. It's important to have rehearsed these types of scenarios, so that when they happen for real you have already thought about how to address the problem. Consider the following example;



You are a newly qualified hospital pharmacist and on-call for the first time. It's been a busy night and at 1am you still haven't slept. The pager rings again and it's a new Sister on the neonatal unit asking for urgent advice about the dose of THAM. You've never heard of the drug, and missed some of your on-call induction training because you were asked to cover the dispensary. The Sister wants to hang on the phone while you find the information



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Have a think about how you might handle this problem. When you've had enough thinking time, move to the next page.

Some suggestions

Admit you don't know

You will be asked questions about medicines that you don't know the answer to, and it is okay to admit it. The amount of information about medicines is vast and you are not expected to know everything, especially when newly qualified. You should advise the nurse that you haven't come across this situation and that you'll need to look into it for her.



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Buy yourself some time

Errors are more likely to occur if you are asked to provide advice or make decisions under pressure. Therefore, rather than the nurse staying on the phone while you try to find the answer, take a contact number, and explain that you will phone back. Even buying yourself a few minutes will reduce the risk of you making a mistake. Before you hang up, make sure you've asked sufficient questions about the patient and the medicine to find an answer yourself or to decide who else might help.

Unfortunately, when you look through the various resources available to you on-call, you're not sure that you understand how to calculate the dose of THAM.

Ask for help

This is probably the most important step to take in any unfamiliar situation such as this. If you've checked your reference sources and you're still unsure what to advise, it is not unreasonable to contact one of your specialist pharmacists. Most colleagues would prefer to be

contacted (even in the middle of the night), rather than risk you making a decision beyond your competence.

Consider signposting

In this scenario about THAM, you may not be able to get hold of a paediatric pharmacist locally to help you in the middle of the night. And you're still unsure how to calculate the dose yourself.

However, some decisions aren't yours to make, and recognising what falls within your remit will come from your training and with experience. When you can't help someone always try to point them in the direction of a person who may be better placed to assist. The decision about the dose of THAM is really the responsibility of the paediatric consultant so if you don't know how to advise the ward sister, you should ask her to speak to the prescriber or another consultant with experience of using the drug.

Following up

The next day, follow up the patient for your own development and share with your newly-qualified colleagues so that they can learn from your experience. Also ensure that your on-call training programme is completed so that you are as well prepared as possible for the problems you will encounter.

Summary

If you are out of your depth, the most significant step you can take is to recognise that fact. It's a sign of professional maturity when you can do it. When you realise you're beyond your own competence, these thoughts may help you:

- **Admit you don't know.** Don't bluff, just be honest.
- **Buy yourself time if you can.** It's important not to be rushed into a hasty decision in an unfamiliar situation. Give yourself time to think.
- **Ask for help.** It's a recurring theme of these tutorials that you're not alone, and you must recognise when you need help, and not be afraid to ask for it.
- **Signposting.** If you can't solve someone's problem, then try to point them in the direction of others who may be able to.

Try and learn from experiences like these. Reflect on them - they can make good CPD exercises.



Making a mistake

Healthcare professionals can make mistakes because they are human and no-one is perfect. One of the main concerns of the NHS is to make professional people and the environment they work in as safe as possible so that the risks of errors are reduced. But as a pharmacist you have a personal responsibility to reduce your chances of making a mistake as well. For example, you have a duty to be careful, to stay up-to-date, to not work when you are ill, to follow procedures, and to ask for help when you are not sure. These and other practices help reduce risk, but mistakes still occur and professionals must know how to handle them.

Consider the following example.



It's your first day on a surgical ward and you are on your own juggling new patients with patients going home and multiple other clinically urgent problems. A busy doctor approaches you and asks for advice about prescribing codeine postoperatively in a mother who is breastfeeding her 4-month-old child. You can't get access to the BNF online so, under pressure, you search for a paper copy of the BNF. You find an old one in the treatment room which advises that codeine may be used, and you inform the doctor accordingly. He asks you to speak to the patient to reassure her.

About an hour later you pass the Medicines Information office and drop in to double-check the advice you gave. The MI pharmacist checks the specialist lactation resources and establishes that codeine is no longer recommended in breastfeeding mothers due to the risks posed to the infant.



Have a think about how you might handle this problem. When you've had enough thinking time, turn to the next page.

Some thoughts

Ask for help and act quickly



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You've made a mistake and you need to act **quickly** to minimise the potential harm to the infant. You might want to consider talking to a more senior pharmacy colleague first to ask for **help** when informing the doctor of your error and dealing with the consequences of your mistake.

In this scenario you will need to assess whether the mother has taken a dose of codeine, and whether she has subsequently breastfed her child. If the child has been exposed to codeine then you will need to ensure that they are monitored closely until the drug and its metabolites have been cleared from their body. If the mother has taken a dose of codeine but has not breastfed her infant then you should advise that she avoid breastfeeding until she has cleared the codeine and its metabolites.

You'll have to document the incident in the patient's medical notes carefully including any remedial action recommended, and ensure that the prescription for codeine is changed to a suitable alternative. Consider whether you should inform the consultant caring for the patient if, so far, you have only been dealing with junior members of his or her team.

Saying sorry

Once you've taken steps to try to resolve the situation, then you need to consider whether you need to let the patient know and offer your apologies. Check with the doctor before you do this.

In this scenario if the mother has taken a dose of codeine, regardless of whether she has breastfed her infant subsequently, she will need to know what has happened and the potential consequences. You'll need to answer any questions that she may have as sensitively as possible and in terms she can understand. You'll also need to explain what happens next in terms of whether she needs to withhold breastfeeding or the additional monitoring that her child will need to undergo. In addition, you should describe the steps you will take to minimise the risk of this error happening again.

Think about these points when making an apology:

- Prepare an opening sentence in your head or on paper. This initial dialogue can affect the whole conversation, so it's important to start in the right way.
- Describe what went wrong. Get your facts ready for any possible questions – when the dose was given, how long the effects will last etc. Try to predict the questions you might have. This will help to show confidence and professionalism.
- What happens next to manage any harm (or potential harm) to the patient or her baby.
- What action will be taken to prevent it happening again.
- Make sure you are familiar with your Trust's complaint procedure in case the patient asks to make a formal complaint.



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When saying sorry, patients and those close to them, are likely to find it more meaningful if you take personal responsibility for something going wrong, rather than offering a general expression of regret. So you should say: *"I am sorry that I made a mistake with your painkillers"*, rather than: *"Regrettably it has become apparent that a mistake has been made with your painkillers"*.

If, in this scenario, the mother hasn't taken a dose of codeine then you need to use your professional judgement to decide whether you should let her know. Some patients will want to be informed about 'near misses', but others won't as it may cause them unnecessary distress and confusion. If you are not sure about whether to talk to a patient about a near miss, seek advice from a senior nursing or medical colleague on the ward.

Finally, saying sorry to a patient and admitting you've made a mistake is difficult. If you don't feel that you have the experience to manage the situation alone then take a senior colleague with you for support.

Learning from the mistake

Once you've dealt with the immediate clinical consequences of your mistake and apologised to the patient then an important next step is to reflect on what happened. There are two aspects to this: self-reflection and organisational learning.



For **self-reflection**, you must think through the incident and ask yourself why it happened.

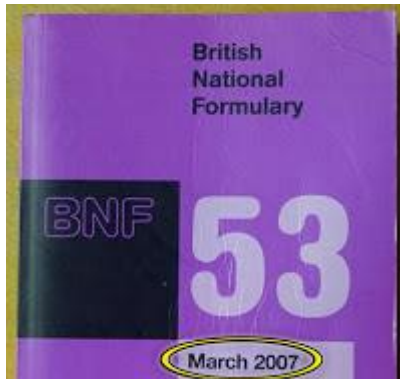
Consider the factors that may have contributed:

- *Yourself* – were you tired/was your mind on other things?
- *The task* – was it complicated, or difficult to understand? Why did you feel you had to use an old paper resource rather than the BNF online?
- *The environment* – were you being constantly interrupted? Did other people affect your behaviour?

By considering these three elements you can begin to learn how you work under different circumstances and can take remedial action early to avoid similar situations.

You might reflect that two things influenced how this incident played out. Firstly, you felt under pressure for a quick answer, and people under pressure are more likely to make mistakes. But the answer could have waited a bit. You could have said to the doctor: *“I’ll just look into that, and bleep you back in half an hour”*. Secondly, why was it that you decided to double-check the information that you’d given after you left the ward? Was there something nagging away that

told you it wasn't quite right or that you'd been rushed? Next time you get that feeling, you will want to double-check first *before* giving advice.



Organisational learning demands a more formal approach. Depending upon the nature of your error you will sometimes need to submit the details through your employer's incident reporting system so that it can be formally recognised and assessed. This enables a proper investigation ('a root cause analysis'), if required, to be undertaken to understand why the error occurred. Any faults in the system or barriers to safe practice can be addressed to help prevent colleagues making the same mistake.

For example, if staff cannot access the BNF online and old paper copies of the BNF are available on wards and in clinics then you probably won't be the first person to have made the mistake of using out-of-date information. You should take responsibility for using an out-of-date resource, but at the same time there should be a proper system for ensuring access to essential online resources and for recalling old paper information from clinical areas. Why couldn't you access the BNF online? Was there a WiFi failure, inadequate PCs on the ward, or was the internet connection too slow? Identifying the problem will help your organisation learn from it.

Rebuilding your confidence

Finally, when you make a mistake it will knock your confidence and, depending on the severity of the mistake and your personality, you may suffer a range of emotions including worry, guilt, shame, stress and disbelief. It's essential to get the right support whether that be from talking to your pharmacy colleagues, or from outside the department such as through the Occupational Health department or the hospital chaplaincy. Sometimes you might be able to ask for a mentor to help you. Completing a CPD record may also help you formalise your learning from an incident.

The General Medical Council and Nursing and Midwifery Councils have [joint guidance](#) on being open and honest with patients when things go wrong ('duty of candour'). It includes advice on making an apology and on learning from errors that have been reported. Although it's quite a lengthy document, it's recommended that you look through it. The GPhC has said it endorses the [summary statement](#) contained on the first page of the GMC/NMC document.

Summary

If you make a mistake, you must own up to it as soon as you realise what you've done and then deal with it immediately:

- **Put the patient first** and act *quickly* to correct a mistake or deal with the consequences of it: ask for help from colleagues if necessary and discuss the situation with the patient's doctor.
- **Apologise to the patient** in a sincere and personal way. Tell him or her what went wrong, describe the implications for them and how they will be managed, and explain how similar mistakes will be prevented in the future. Be able to give details of your employer's complaints procedure.
- **Learn from a mistake** by reflecting on what happened: what was it about you, the task, or the environment that led to the error? If appropriate, fill in an incident form so that your Trust can analyse it and reduce the risk of similar errors.

As an example of learning from other people's mistakes, you might like to read on to see what the NHS network of Medicines Information centres, UKMi, does. It has a formal process for reporting errors and near misses. You'll see that the recurring reasons for information errors that this system highlights is a helpful way to reflect on the risks that you might be exposed to professionally, whether you work in an MI centre or not.



Incident Reporting in Medicines Information Scheme

The Incident Reporting in Medicines Information Scheme (IRMIS) is a secure, password-protected database. Its purpose is to raise awareness amongst hospital pharmacy staff of the common reasons for errors and near misses related to providing advice and information about medicines, and to look at ways to avoid future incidents. Managers of Medicines Information centres can report errors and near misses identified within their service.

The IRMIS scheme is intended to complement, but not replace, existing incident recording systems within each Trust.

Here are some examples of recurring factors identified via IRMIS that seem to increase the risk of making mistakes when problem solving:

Risk factors	Ways of reducing risk
You are busy, rushed, feel pressurised for a quick answer, or are subject to lots of interruptions.	<i>Recognise that when you are in situations like this you are more likely to make a mistake. Try to step back and give yourself enough time to consider the question and research an answer properly. Prioritise the demands made upon you, and ask for help if you are swamped.</i>
Calculation errors	<i>Double-check all calculations yourself, no matter how simple they seem. If necessary, get the calculation checked by an independent person (without telling them what your initial answer was!).</i>
Similar-sounding drug names	<i>If in doubt, ask for all drug names to be spelt out by the person you're dealing with, especially OTC and alternative therapies. Or look at the original packaging yourself if you can.</i>
Answering the wrong question	<i>After the person you're dealing with has told you their problem, summarise it for them to make sure you've got it right. And when answering it later, your conversation or e-mail should start with confirmation of what the question was.</i>
Your personal knowledge is not up-to-date	<i>Regularly review your knowledge by undertaking training, using a current awareness service such as that run by NICE, reading journals, and networking with colleagues.</i>
You don't use a resource properly and miss information or misinterpret it	<i>Spend time learning to use information resources properly or get training, don't just plunge in.</i>



Conflicting information

You will come across sources of information and advice about medicines that give you different answers to the same question. This is a common problem and it is important to understand why this happens so that you can make the right decision for your patient. Consider the following scenario;



You are asked by one of your hepatology consultants about the choice of antidepressant for a patient with hepatitis C who has resulting liver impairment. The patient uses interferon and the consultant knows that this can cause depression. The doctor has some experience of using sertraline and wonders whether this would be okay.

Before you read the next paragraph, have a think about where you might look for the information initially. When you've thought about it, read on....



You try looking in psychiatry sources such as Bazire's Psychotropic Drug Directory and the Maudsley Prescribing Guidelines, your local psychiatry guidelines, the SmPC for sertraline, and Stockley's for the interactions aspect of this question. However, you quickly find that the precise recommendations vary according to which resource you use.

What would you do next? Take time to think about this before moving on.

Some thoughts

Know the limitations of your resources

It is important to understand the limitations of different resources so that when faced with conflicting information you can decide which course of action to follow. For example there may be important differences in information about doses and indications between UK and US sources because of variations in the marketing authorisations and variations in accepted practice.



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Information about using medicines in patients with co-morbidities in SmPCs may be quite cautious when compared to sources based partly on expert opinion such as the Maudsley Guidelines and the Psychotropic Drug Directory. The SmPC has to reflect the experience that the manufacturer has been able to gain with the medicine in clinical trials. For example, an SmPC will almost always advise against the use of a medicine in pregnancy, but [specialist resources](#) may be better able to guide your decision-making by drawing on other sources of information.

Sometimes official guidance such as that from the UK Health Security Agency or the Department of Health may differ (and sometimes override) information in SmPCs, and the BNF.

Breaking news

Faced with conflicting information, think about whether new evidence or guidance may have been published which may explain the differences you find. Most books are probably a couple of years out-of-date when they are published – could this account for some different advice you may have found online? Even online resources can be updated fairly haphazardly – for example SmPCs don't always incorporate new MHRA safety warnings immediately, and sometimes there can be a significant delay – could this explain your findings?

Getting to the bottom of things

If they are available, consult the reference lists of the publications you have used – do the resources vary in the evidence upon which they have based their conclusions? Could this account for the conflicting advice? Even using the same evidence, different experts may come to different conclusions. If necessary track down the original papers and make your own decision with your patient in mind.

Reaching the consensus

Is one of your resources at odds with everything else you are finding? Remember that the answer you provide should usually represent the consensus of opinion, and you will need to keep checking different resources until you get a feel for what the majority recommend.

Making the decision

Having worked through all of the steps above you hopefully will have worked out why your resources are giving you different messages and you've been able to make a decision about your individual patient. In discussing your findings with the consultant, and ideally the patient as well, you may need to highlight the differences you've encountered and justify your recommendations. As always, don't be afraid to ask for help if you need it, and you should consider documenting your decision and the reason(s) for it.



Summary

It is surprising that sometimes you'll find that different sources of information seem to provide different answers. Here is a summary of one way to tackle this situation:

- **Know the limitations of resources.** How up-to-date are they all? Do they contain opinions, or evidence from published research?
- **New evidence.** Has one or more apparently trustworthy source been superseded by new data?
- **References.** Are your sources quoting different references to support their data? What's the quality of these references?
- **Consensus.** Is one source at odds with all the others? Your answer may need to represent a majority view.

You should make the doctor and the patient aware of any differences in information or opinion that you uncover. Allow them to work with you in an informed way when you are advising them so that you can reach a decision together.



Ethical dilemmas



Pharmacists are the commonest source of clinical advice about medicines in hospitals. But this advisory role can lead to ethical dilemmas if there is a conflict between giving information and a duty to someone else. They are situations that can make you feel uncertain or uncomfortable.

Ethical dilemmas are a grey area between questions that you would normally expect to answer (e.g. 'What is the dose of this drug?') and enquiries that you would definitely not answer (e.g. 'What dose of this drug can I use to kill someone?').

Junior staff need to be able to recognise ethical dilemmas, but should always refer them to a more experienced pharmacist.

In practice many ethical dilemmas involve questions from patients or members of the public. Remember that what may be an ethical dilemma from your point of view, is often simply a request for help or information from the enquirer's perspective so be helpful, polite, and sensitive. However, there are some recurring scenarios:

1. Third party enquiries.

These are enquiries from a member of the public about someone else. Examples could include:

- *I'd like you to identify these tablets I found in my 18-year-old son's jacket.*
- *My neighbour is taking tamoxifen. What's that for?*

You must never breach patient confidentiality, but you also have a duty to protect the patient's privacy (even if the information is in the public domain). So generally, the rule should be not to answer an enquiry about a third party. However, there may be exceptions where you feel it is vital that the enquirer is given the information. An example would be where a mother asks you to identify tablets found in her six-year-old daughter's room. Here the duty of the parent to safeguard the wellbeing of her child (a minor) is a very important consideration. If the daughter were 26 it might be inappropriate to answer.

Think about whether it is *fair* that the enquirer should know the information. Do not be afraid to refuse to answer if you think that the enquirer does not have a legitimate need to know.

2. Patient pursuing a complaint.

If a patient contacts you and makes it clear that they are pursuing a complaint against your employer, or may do so in the future, you must check your Trust's complaints policy. You may have a dedicated team that will manage patient concerns and complaints.



3. Enquiries involving illicit drugs.

It is desirable to answer enquiries about street drugs if the enquirer is clearly seeking help to avoid self-harm (e.g. interactions between street drugs and medication). But you should not answer enquiries which might help clients extend their range of abuse behaviour or assist them to break the law or deceive a healthcare professional. Pharmacists should know how to refer to local and national substance misuse services when appropriate.

4. Criticism of other healthcare professionals.

You should protect a patient's relationship with other healthcare professionals. However, the duty of honesty is more important. You should never assist anyone to deceive or lie to a patient – do not assist in 'covering up' a medication error for example. A patient may ask you to check on information provided by another professional which you know to be incorrect. You should answer this sensitively but truthfully.

Apart from enquiries from the public, other ethical dilemmas can involve enquiries from the police. Here you should only supply information that it is legitimate for the police to ask for in the course of solving a crime and it is reasonable to ask for this to be confirmed in writing. Enquiries from legal representatives or the media can also sometimes be problematic: follow your employer's policy in dealing with these.

Reducing risk



It is not possible to plan for every conceivable ethical dilemma that you might encounter. Each problem encountered will be different and will require an element of professional judgement, discretion and experience. Having said this, some general points should always be borne in mind when dealing with ethical problems:

- Always give yourself thinking time before replying.
- Consult with appropriate colleagues and/or managers before answering.
- There is no single 'right' answer to most ethical dilemmas, but you should be able to justify what you do.
- Do not answer queries that are beyond your sphere of expertise or available resources.
- Research your answers thoroughly, and document carefully everything that you do.
- You do not *have* to answer *every* question that you are asked: you can say 'no'.
- Be honest.

In **difficult cases** it is good practice to note your reasons for deciding to act as you did, so you can show that you weighed up the pros and cons. This may be the case when, on balance, you refuse to disclose information as much as when you decide to provide it.

Next steps in learning ...

Hopefully in this tutorial we have given you some helpful real-life scenarios which may anticipate some of the situations that could confront you as a pharmacist. Having thought about them in advance may make you better prepared.



The CPPE offers a [series of guides](#) to help pharmacists develop their personal and professional skills, and you may find some of these helpful in the context of decision-making. For example there are modules on risk management, stress, being influential, and improving assertiveness. Look through the list and decide which of these would help you. The [Problem solving](#) guide may be of relevance in the context of this tutorial.