Objective: To provide a brief introduction to the ethical and, to some extent, the legal issues surrounding patient privacy and confidentiality.

Data synthesis: The privacy of patient medical records and patient confidentiality has moved to the forefront of ethical and legal issues in health care. Technological advances, the growth and expansion of managed care, the emergence of consumerism, and the dramatic increase in the number of individuals and organizations with access to or a need to access patient medical information have all contributed to patient concerns about who has access to their records and for what purposes.

Conclusion: Questions of patient privacy and confidentiality are likely to remain at the forefront of health care ethics and law in the coming years. Health professionals, including pharmacists, have a greater responsibility than ever before to ensure that safeguards exist to prevent inappropriate access to patient information.

Keywords: Ethics, confidentiality, privacy.

Robert L. McCarthy, PhD, is Dean and Professor, School of Pharmacy, University of Connecticut, Storrs.

Correspondence: Robert L. McCarthy, PhD, School of Pharmacy, University of Connecticut, 69 North Eagleville Rd., Unit 3092, Storrs, CT 06269-3092. Fax: 860-486-1553. E-mail: r.mccarthy@uconn.edu

Continuing education credits: See learning objectives below and assessment questions at the end of this article, which is ACPE universal program numbers 202-000-08-231-H04-P (for pharmacists) and 202-000-08-231-H04-T (for pharmacy technicians) in APhA’s educational programs. The CE examination form is located at the end of this article. To take the CE test for this article online, go to www.pharmacist.com/education and follow the links to the APhA CE center.

Disclosure: The author declares no conflicts of interest or financial interests in any product or service mentioned in this article, including grants, employment, gifts, stock holdings, or honoraria.

Published concurrently in Pharmacy Today and the Journal of the American Pharmacists Association (available online at www.japha.org).

Learning objectives
- Define privacy and confidentiality.
- Explain the moral rule of informed consent, including its five elements.
- Define the principle of autonomy.
- List two ways in which HIPAA impacts pharmacy practice.
- Provide two ways in which technology has impacted patient privacy.
- State two examples of third parties with access to or interest in accessing patient medical records who may threaten patient privacy.

Go to www.pharmacist.com and take your test online for instant credit.
"Since the time of Hippocrates, doctors have sworn to keep what they learn about a patient to themselves. But in the modern world, an oath alone is no longer sufficient to prevent that information from being distributed far and wide in electronic databases and perused by scores of people—hospital employees, insurance companies, pharmaceutical firms, medical researchers, employers, and even police."

Center for Public Integrity

The above statement describes the current legal and regulatory focus on patient privacy in the United States. It also makes note of the centuries-old ethical obligation of physicians to maintain patient confidentiality. Ensuring the privacy of medical records and the maintenance of patient confidentiality is both a legal and an ethical responsibility of pharmacists, physicians, and other health professionals. Contemporary America requires more than simple moral responsibility on the part of health professionals. Computerization, the growth and dominance of managed care, the expansion of clinical research, the emergence of consumerism, and the distrust within society have converged to require codification of a basic standard of practice.

Objective

This article explores, in a general sense, the ethical and, to some extent, the legal issues surrounding patient privacy. An introduction to the myriad of questions facing policy makers, legal scholars, ethicists, and health professionals is provided.

Privacy versus confidentiality

Imagine that two pharmacist colleagues meet at a local restaurant. While waiting to be seated, they begin conversing about a patient for whom they have been caring. Coincidentally, others in the vicinity, who know the patient in question, overhear the conversation. Contrast this scenario with that of a pharmacy technician who decides to access the medication profiles of several celebrities through her chain pharmacy’s computer system. In both instances, patient data are revealed; however, a violation of confidentiality has occurred in the former case and a violation of privacy has occurred in the latter case.

Although we tend to use them interchangeably, a difference exists between privacy and confidentiality. Beauchamp and Childress provide the following description: “When others gain access to such protected information without our consent, we sometimes describe their access as an infringement of confidentiality and at other times as an infringement of privacy. The difference is this: An infringement of X’s confidentiality occurs only if the person to whom X disclosed the information fails to protect that information or deliberately discloses it to someone without X’s consent. A person who sneaks into a hospital record room or breaks into a hospital data bank, despite appropriate protections, would be accused of a violation of privacy rather than a violation of confidentiality.”

“Privacy relates to patients’ rights to protect information about themselves.” As health professionals, we often violate—generally with permission—a patient’s privacy because we have access to his or her medical record. The patient has abdicated to us some of his or her privacy so that we can effectively care for them. As Justice notes, "A very serious problem arises when there is a breach of privacy. ... Remember that a breach of confidentiality involves information over which one has been granted authority. It is quite different if no such authority exists. To view information about a patient when you have no authority (situational or otherwise) to do so is a breach of privacy, and to disseminate that information is unforgivable.” We only violate patient confidentiality when we blatantly or carelessly reveal medical information to others without the consent of a patient.
Establishing the context
Patient privacy has become an important ethical/legal issue in contemporary medical practice. The National Committee for Quality Assurance (NCQA) and the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) note that "growing public mistrust about the privacy of personal information presents a serious threat to health care."1 In a joint report, Protecting Personal Health Information: A Framework for Meeting the Challenges in a Managed Care Environment, published nearly a decade ago, the two organizations warn that "patients who are worried about the privacy of sensitive personal and medical information may withhold information from health care professionals, increasing the risk of misdiagnosis and inadequate or inappropriate treatment."2 The issues and recommendations addressed in the report include the following:

- Dealing with consent in an evolving health care delivery and financing system. All disclosure of patient information must be done, unless required by law, with the informed consent of the patient, including with whom the information will be shared and for what purposes.
- Ensuring accountability. All managed care organizations (MCOs) should develop policies for the handling of patient information, including procedures to ensure compliance.
- Educating about policies, practices, rights, and responsibilities. MCOs should inform patients about the handling of confidential information, including storage and dissemination, and provide opportunities for patients to review and comment about their records.
- Using technology as a solution. MCOs should use information systems that maximize the protection of patient records.
- Providing legislative support. Clear regulatory guidelines which are consistent across jurisdictions should exist for gaining access to patient records.
- Guiding research. MCOs should ensure the confidentiality of patient records shared with investigators for research purposes.3

These recommendations predated the current HIPAA (Health Insurance Portability and Accountability Act of 1996) world in which we live that formally codified patient confidentiality; however, the issues are as pertinent today as when they were initially released. Current NCQA Standards and Guidelines for Managed Care Organizations focused on quality management and improvement, and members’ rights and responsibilities incorporated expectations with regard to privacy and confidentiality, including ensuring the confidentiality of patient records.4

Ethical principles and moral rules
Today, virtually every school of pharmacy, medicine, and nursing requires coursework in the basics of biomedical ethics. Given the myriad of ethical issues facing health professionals, a basic grounding in ethical principles and moral rules is essential. For practitioners who completed their studies before the widespread inclusion of ethics into the curricula, opportunities for continued professional development in this area are available.

Several ethical precepts provide a good starting point for examining the complicated issue of patient privacy. The moral rule of confidentiality and its relationship to privacy has been discussed. The principle of autonomy and rule of informed consent are also applicable and provide guidance. A brief primer for each is provided below.

Principle of autonomy
The principle of autonomy—a fundamental ethical right to self-determination—states that an individual should have liberty of thought, choice, and action. An individual’s autonomy cannot be justifiably overridden unless one of two conditions exists: weak paternalism or the harm principle. Weak paternalism involves overriding one’s autonomy when the individual is not autonomous or minimal intervention is necessary to determine if the individual is autonomous; the patient’s rationality is in question. The harm principle may be justifiably invoked to violate one’s autonomy if, in the exercise of that autonomy, harm may come to others.

Respect of patient confidentiality is an application of respect of patient autonomy. Patients have a right to expect that health professionals will keep medical information private, regardless of whether that request is made explicitly by the patient. In doing so, health professionals honor the autonomous wish of their patients to restrict access to patient medical portfolios. This obligation on the part of health professionals even extends to those instances in which they would deem it appropriate and/or necessary to divulge confidential information to others; if the patient objects to such disclosure, the health professional is ethically obligated to comply.

Rule of informed consent
Informed consent is a logical extension of the principle of autonomy in several respects. The rule of informed consent requires full disclosure to a patient and their voluntary consent before initiating any medical action (e.g., surgery, emergency treatment). By ensuring that informed consent is obtained, health professionals demonstrate their respect for patient autonomy. Failure to meet any of the elements of informed consent (disclosure, understanding, competence, voluntariness, and consent) violates patient autonomy.

One of the elements of informed consent (competence) requires patients to be rational in order to provide their consent. Consequently, individuals who lack the ability to make an autonomous decision (e.g., minor children, patients suffering from severe mental illness) are likewise unable to provide informed consent. Once an individual is determined to be capable of acting autonomously, another element of informed consent, volum-
The final set of HIPAA regulations, Standards for Privacy of Individually Identifiable Health Information, went into effect in April 2001. In announcing the regulations, the Bush Administration added that guidelines for implementation would be issued and modifications considered as needed to ensure quality of patient care.8,9

The HIPAA regulations affect pharmacy in two primary ways. First, pharmacists must ensure that patient consent is obtained and documented. Second, pharmacies must reaffirm their commitment to patient privacy in all business practices. More specifically, HIPAA requires that pharmacies formally identify who within the organization has access and under what circumstances; pharmacies must clearly articulate that they have made every effort to limit access to confidential information only to situations in which it is necessary.10 The stringent nature of the HIPAA regulations has caused some to speculate that they are better at ensuring confidentiality than ensuring that patients receive the best care possible. For example, discussion regarding a patient and their medications that should occur in the normal course of caring for a patient may not take place because of fear among caregivers of sharing confidential medical information with colleagues.10

Health information trustee
Some have suggested that protecting patient records from unauthorized access and use might best be accomplished through the use of a health information trustee. The trustee could be a health plan, data management company, actuarial, or general consulting firm. Health care providers would provide needed information to the trustee, who in turn would remove individually identifying information before disseminating to employers and others.11 Legislation has recently been introduced in Congress to establish a nationwide health information technology network. The legislation would place patients in charge of their own health information and allow them to restrict select information to various health care providers.12

Hospital ethics committees
Recent years have witnessed the growth of hospital or health care ethics committees (HECs). These committees, first mandated by the Joint Commission in 1992, provide institutions with

Legal principles
The laws and regulations governing patient privacy vary by state; a full discussion of these laws and regulations is beyond the scope of this report. As a result, a brief description of federal statutes and regulations, focusing primarily on HIPAA, appears below.

HIPAA was not the first federal legislation addressing patient privacy. The Privacy Act of 1974 protects health information collected by federal agencies. Federal regulations protect the privacy of alcohol and drug abuse patient records. The Department of Health and Human Services Policy for Protection of Human Subjects shields the records of individuals involved in research trials.7

HIPAA is the most recent federal legislation addressing patient privacy. The law and its regulations prevent release of patient information to anyone not authorized to have the information or to have a need to know the information. The regulations apply to anyone who handles patient information. Individuals are liable for unauthorized release of confidential information whether unintended or intentional. Authorized use of patient information includes patient care, payment, and operations of the health care providers’ organization.3 Health care providers, however, are required to obtain written permission even for authorized uses, including to whom the information is being disclosed and the manner in which it is being used.8 Any other use must be disclosed to patients and documented by the provider. Under HIPAA, patients also have the right to access their medical records and make corrections as necessary.3,8

Like informed consent, the rule of confidentiality can be viewed as an application of the principle of autonomy. As discussed above, by keeping medical information private, the health professional respects a patient’s autonomous right to confidentiality. Like autonomy, confidentiality may be violated if a patient is not autonomous (weak paternalism) or if a potential of harm to others exists (harm principle). Consider the following practical examples. A pharmacist who is caring for a patient with severe Alzheimer’s disease and is unsure that her medication counseling is understood by the patient may also choose to share the information with the patient’s caregiver; weak paternalism is applied in this scenario. The harm principle may be applicable if, for example, a pharmacist is aware of a patient with epilepsy who has chosen not to take his medication as prescribed. This would be especially pertinent in the case of an individual in whom a seizure may place others at direct risk (e.g., bus driver, airline pilot).

Confidentiality, from an ethical perspective, represents the cornerstone of a patient’s right to privacy of his/her medical information. From a practical perspective, adherence to patient confidentiality and respect for patient autonomy can result in difficult ethical scenarios. For example, beyond a hospitalized patient’s physician and the nurses caring for him/her, who should have access to the patient’s medical records? Should the ethical criteria be “sufficient need?” What about health professionals in training (e.g., medical residents, student pharmacists)? Patients generally choose their physician but not others caring for them (e.g., nurses, pharmacists); must patients approve access to their records by these individuals?

tariness, must be ensured. Rational, fully informed individuals must have the capacity to make decisions about their care and treatment unencumbered by overt or subtle acts of coercion by health professionals. If this is not the case, an individual’s autonomous right to self-determination would be violated.

Like informed consent, the rule of confidentiality can be viewed as an application of the principle of autonomy. As discussed above, by keeping medical information private, the health professional respects a patient’s autonomous right to confidentiality. Like autonomy, confidentiality may be violated if a patient is not autonomous (weak paternalism) or if a potential of harm to others exists (harm principle). Consider the following practical examples. A pharmacist who is caring for a patient with severe Alzheimer’s disease and is unsure that her medication counseling is understood by the patient may also choose to share the information with the patient’s caregiver; weak paternalism is applied in this scenario. The harm principle may be applicable if, for example, a pharmacist is aware of a patient with epilepsy who has chosen not to take his medication as prescribed. This would be especially pertinent in the case of an individual in whom a seizure may place others at direct risk (e.g., bus driver, airline pilot).

Confidentiality, from an ethical perspective, represents the cornerstone of a patient’s right to privacy of his/her medical information. From a practical perspective, adherence to patient confidentiality and respect for patient autonomy can result in difficult ethical scenarios. For example, beyond a hospitalized patient’s physician and the nurses caring for him/her, who should have access to the patient’s medical records? Should the ethical criteria be “sufficient need?” What about health professionals in training (e.g., medical residents, student pharmacists)? Patients generally choose their physician but not others caring for them (e.g., nurses, pharmacists); must patients approve access to their records by these individuals?

Legal principles
The laws and regulations governing patient privacy vary by state; a full discussion of these laws and regulations is beyond the scope of this report. As a result, a brief description of federal statutes and regulations, focusing primarily on HIPAA, appears below.

HIPAA was not the first federal legislation addressing patient privacy. The Privacy Act of 1974 protects health information collected by federal agencies. Federal regulations protect the privacy of alcohol and drug abuse patient records. The Department of Health and Human Services Policy for Protection of Human Subjects shields the records of individuals involved in research trials.7

HIPAA is the most recent federal legislation addressing patient privacy. The law and its regulations prevent release of patient information to anyone not authorized to have the information or to have a need to know the information. The regulations apply to anyone who handles patient information. Individuals are liable for unauthorized release of confidential information whether unintended or intentional. Authorized use of patient information includes patient care, payment, and operations of the health care providers’ organization.3 Health care providers, however, are required to obtain written permission even for authorized uses, including to whom the information is being disclosed and the manner in which it is being used.8 Any other use must be disclosed to patients and documented by the provider. Under HIPAA, patients also have the right to access their medical records and make corrections as necessary.3,8

The final set of HIPAA regulations, Standards for Privacy of Individually Identifiable Health Information, went into effect in April 2001. In announcing the regulations, the Bush Administration added that guidelines for implementation would be issued and modifications considered as needed to ensure quality of patient care.8,9

The HIPAA regulations affect pharmacy in two primary ways. First, pharmacists must ensure that patient consent is obtained and documented. Second, pharmacies must reaffirm their commitment to patient privacy in all business practices.8 More specifically, HIPAA requires that pharmacies formally identify who within the organization has access and under what circumstances; pharmacies must clearly articulate that they have made every effort to limit access to confidential information only to situations in which it is necessary.10 The stringent nature of the HIPAA regulations has caused some to speculate that they are better at ensuring confidentiality than ensuring that patients receive the best care possible. For example, discussion regarding a patient and their medications that should occur in the normal course of caring for a patient may not take place because of fear among caregivers of sharing confidential medical information with colleagues.10

Health information trustee
Some have suggested that protecting patient records from unauthorized access and use might best be accomplished through the use of a health information trustee. The trustee could be a health plan, data management company, actuarial, or general consulting firm. Health care providers would provide needed information to the trustee, who in turn would remove individually identifying information before disseminating to employers and others.11 Legislation has recently been introduced in Congress to establish a nationwide health information technology network. The legislation would place patients in charge of their own health information and allow them to restrict select information to various health care providers.12

Hospital ethics committees
Recent years have witnessed the growth of hospital or health care ethics committees (HECs). These committees, first mandated by the Joint Commission in 1992, provide institutions with
a consultative body for addressing ethical issues confronting the organization. Committee membership is interprofessional and may include physicians, nurses, pharmacists, and social workers, as well as nonmedical staff such as attorneys, institutional trustees, clergy, and public members. HECs provide a range of functions from prospective services, such as identifying relevant ethical issues and facilitating the resolution of disagreements to retrospective activities, such as formulating policies and guidelines and determining the appropriateness of decisions. Consequently, HECs can provide useful assistance in developing institutional guidelines for handling and disseminating sensitive information.

**Law and ethics**

Profound conflicts between law and ethics exist throughout health care. Although most laws represent a codification of our moral beliefs as a society, they cannot address every specific situation, nuance, or eventuality. Laws attempt to cover the general circumstances. In pharmacy, for example, dispensing a legend drug without a prescription is illegal. Consider a situation in which a patient’s antihypertensive prescription has expired and the prescriber is unavailable to renew it. Most pharmacists would give the patient a few doses to hold them over until a new prescription is obtained; a strong ethical argument can be made in support of this action. Nevertheless, it is still an illegal action and, thus, a legal–ethical conflict results.

Conflicts between law and ethics also exist relative to the privacy of patient records. For example, a court might choose to subpoena medication records of a patient for use in a case, but the patient’s pharmacist might believe that they have an ethical obligation to keep the patient’s records private. What ought the pharmacist to do? The American Pharmacists Association (APhA) Code of Ethics provides guidance: “A pharmacist promotes the good of every patient in a caring compassionate, and confidential [italics added] manner.” However, although a guide to professional behavior, the code carries no federal or state statutory authority. Thus, pharmacists are left with a decision of whether to follow their conscience (exposing themselves to potential legal penalties) or the law.

Beyond patient records, the increased, and welcomed, responsibility placed on pharmacists to manage patient’s medication therapy, which is legislated through the Omnibus Budget Reconciliation Act of 1990 (OBRA ’90) and, more recently, Medicare Part D, has raised an important legal/ethical issue relative to pharmacist–patient privilege. Craft and McBride first explored this issue relative to OBRA ’90 by suggesting that, in many jurisdictions, pharmacists lack the status afforded other health professionals. They note that immunity laws protect professionals from revealing information that is gained during professional communications from court orders and subpoenas. They also ensure that patients can share confidential information with a health professional without concern that the information will be shared with others. Privilege is yet another example of a potential conflict between law and ethics. Although the pharmacist may feel ethically obligated to withhold information, even in the face of action by the court, they may lack the legal protection to do so.

**Medical consumerism**

Patients today have much different expectations about their care compared with patients even a generation ago. In the past, it was not unusual to see patients following “doctor’s orders” with little question; the doctor “knew best.” Such is not the case with most contemporary patients, who have become true consumers of medical care. Patients expect to be asked, not told; they expect to have choices presented to them; and they expect their wishes to be followed.

The growing trend of medical consumerism has important implications for patient privacy. When the HIPAA regulations are applied in an environment where medical consumerism dominates, physicians, pharmacists, and other health professionals must be more cognizant than ever of patient wishes relative to their medical records. Patients expect to be able to determine who has access to their records and deny access as they wish. The latitude health professionals may have taken in the past regarding access has been replaced by careful attention to record distribution, even among those with a legitimate right to know.

**Impact of technology**

The age of computerization has revolutionized American medical practice. The current generation of health professional students and practitioners may find it difficult to envision a time in which computers and personal digital assistants (PDAs) did not play a prominent role. Little is done today in medicine that does not involve computers and, increasingly, the use of artificial intelligence.

However, as Waldo suggests, though offering efficiency in health care, computerized medical records threaten patient privacy. “These [threats] include unauthorized access and tampering. Strategies to circumvent potential problems include physical safeguards, technology-based protection measures, and procedures and policies to control data integrity, access and ensure confidentiality.”

Computerization has played an especially important role in the practice of pharmacy. McCarthy and Perrollo discussed the ethical impact of computerization in the early 1990s; in the time since, computers have come to play an even more prominent role and the ethical issues they describe have become more pervasive.

In community pharmacy, computers have become the center of the dispensing process. In addition to producing labels and maintaining records, they allow online third-party adjudication, formulary access, and determination of patient copay-
ments. Today’s community pharmacy would be hard-pressed to operate without its computer system. Despite the benefits of computerization, as noted by McCarthy and Perrolle,18 ethical concerns exist. For example, computerization has allowed easy access to patient information among pharmacies. A community chain pharmacy in Maine has easy access to the medication profile of a patient being cared for by another pharmacy in the same chain in California. Moreover, the opportunity for online identity theft made possible by the availability of computerized patient records, especially given the growth of online pharmacies, is an important concern. Therefore, in addition to being worried about the source and quality of medications purchased from potentially disreputable sources, patients must also be concerned about the security of confidential information. Unfortunately, computerized patient records are not the only source of potential breaches. A pharmacy in Texas was cited recently for not shredding confidential patient information, including credit card and Social Security numbers, before placing them in the trash.19

Similar privacy issues exist in institutional pharmacy. The combined effect of computerization and the growth of multihospital systems have greatly expanded access to patient records. Access to particular databases may be restricted to particular users or departments, but, not uncommonly, unauthorized individuals gain access.

As in other fields, PDAs have come to play a prominent role in the daily work of pharmacists. From the time they complete advanced pharmacy practice rotations as students, pharmacists come to rely on this technological marvel to provide quick access to a range of drug information. However, the widespread use of these devices comes at a potential price relative to the privacy and confidentiality of patient information. Unfortunately, computerized patient records are not the only source of potential breaches. A pharmacy in Texas was cited recently for not shredding confidential patient information, including credit card and Social Security numbers, before placing them in the trash.19

Managed care (PBMs and MCOs)
The evolution of managed health care, unlike any other trend in American health care delivery, has had a profound impact on patient privacy. Traditionally, access to patient records was controlled within a small sphere: the patient’s physician, pharmacy, and, perhaps, insurance company. Contemporary health care financing has profoundly expanded those who, it can be argued, require access.

Of particular note is the growth and influence of pharmacy benefits managers (PBMs). In the early 1990s, PBMs were just beginning the process of transforming themselves from fiscal intermediaries to true overseers of the drug benefit. Today, PBMs not only process claims but also manage formularies, perform drug use reviews, and design benefit packages. PBMs and insurers have access to extensive information about patients and their medical history. In many instances, non–health professionals view confidential information. Both professional and nonprofessional staff have access to confidential information, not all of which is pertinent to their work as drug benefit managers. Further, because these records are accessed online, the opportunity for inappropriate access and/or misadventures is increased.

Pharmaceutical companies
One might logically question how and why pharmaceutical manufacturers might gain and require access to patient records; their involvement is a relatively new phenomenon. First, a trend emerged in the 1990s for drug companies to vertically integrate by purchasing PBMs. The thought was that by vertically integra-
ing through owning a PBM, a manufacturer might be able to use such acquisitions to increase drug sales.\textsuperscript{22} As the federal watchdog overseeing such mergers, the Federal Trade Commission carefully monitored the number of a manufacturer’s products that appeared on its PBM’s formulary. Nevertheless, concerns still existed. One executive of a multistate league of health care buyer groups expressed his fear about the drug maker’s influence on the composition of a PBM’s formulary when the PBM is owned by a pharmaceutical manufacturer.\textsuperscript{23}

Although privacy concerns regarding the direct ownership of PBMs by pharmaceutical manufacturers largely ended with Merck’s spinoff of Medco in 2002 (following divestitures from their PBMs by Lilly and SmithKline Beecham),\textsuperscript{24} worries about the access of patient medication records by manufacturers still exist. For example, marketing companies have established partnerships between community chain pharmacies and pharmaceutical manufacturers to target patients for treatments of specific conditions. The pharmaceutical manufacturer determines the patient group they wish to target (e.g., patients with diabetes). Then, the marketing firm, using computerized data from the pharmacy chains, sends disease-specific promotional materials to patients. Marketing companies have argued that patient confidentiality is maintained because neither they nor the pharmacy chains provide the pharmaceutical manufacturers with access to prescription files.\textsuperscript{25}

Legal action has been taken against both pharmaceutical manufacturers and chain pharmacies for alleged collaborations in which manufacturers provided pharmacies with screening information that would allow them to directly market drug products to patients. Ironically, legal protections against such activities are based on state laws, not HIPAA, which allows pharmacies and PBMs to provide drug information to patients (commonly refill reminders) that can be funded by manufacturers.\textsuperscript{26} Maine and Vermont have passed laws protecting the confidentiality of the prescription-writing habits of physicians; several companies that collect and sell such data have recently challenged the constitutionality of such laws.\textsuperscript{27}

Beyond the legal questions, ethical concerns abound. Should pharmacies provide information to pharmaceutical manufacturers on patient medical conditions and medications without patient consent? Does it matter whether the information provided is deidentified and in aggregate form? Does HIPAA truly protect the patient information that it was designed to protect? According to the principles of autonomy and confidentiality, patients should consent to the release of such information and be told specifically to whom and for what purpose the information is being released. Just as individuals have the right to tell telemarketers to put them on the “do not call” list, ethically, patients ought to have the same choice.

Another opportunity for drug company access to patient records exists in situations in which the manufacturer requires patients to participate in a company-sponsored monitoring program. In such instances, manufacturers may have access to patient records that, again, may be beyond what is necessary for safe and appropriate monitoring.

**Potential employers**

When one examines the recent history of employer-based health insurance in the United States, a clear trend emerges: businesses have become focused on the ever-growing costs of providing health care for their employees and the effect that these costs have on their ability to compete in the world market. Of particular concern is the financial effect that a seriously or chronically ill employee can have on a company’s finances, especially for a small company. Small businesses with several employees who have accumulated considerable health care expenditures can experience an increase in insurance premiums that are often unsustainable. As a result, either the employee is terminated or the company must cancel its insurance policy. Consequently, employers have a vested interest in the health of potential employees. Any access to the medical information of potential employees by employers is invaluable. Ethically, do they have a right to such information if not volunteered by the patient? This question has received much public discourse recently in relation to access to genetic information. Should an employer (or insurer) have access to genetic screening tests conducted on a potential employee? Might such access be discriminatory in addition to violating patient confidentiality? Brice and Sanderson\textsuperscript{28} note concerns that insurers and employers will gain access to the results of genetic testing. They express trepidation that despite a moratorium on the use of these data by the insurance industry, the public may still be uneasy about its security.

**Government**

In an attempt to control inappropriate prescribing by clinicians and prescription drug abuse, a number of states have initiated prescription monitoring programs. Despite the good intentions of such programs, fears exist about the loss of patient confidentiality, especially for individuals using prescription medications legitimately and appropriately. The Drug Enforcement Administration’s Office of Diversion Control has attempted to quell such fears by suggesting that prescription monitoring programs have adequate safeguards in place to protect patient confidentiality.\textsuperscript{29} Nevertheless, governmental agencies do have access to these private records without the consent of patients.

**Researchers**

An important ethical concern relative to privacy is the type of access, if any, that researchers should have to patient records. Researchers often have to review patient records in the course of their work. When this is done prospectively, patient informed consent is more easily obtained. When the investigator is con-
ducting a retrospective study, obtaining consent is much more difficult. Even in instances in which individually identifiable information has been shielded, ethical questions arise concerning the appropriateness of access.

Recently, the National Institutes of Health (NIH) released its policy governing its establishment of a central database of human genetic data, to which scientists will contribute and have access. NIH has promised that patient confidentiality will be protected by requiring researchers to remove personally identifying information before adding their genetic code to the database. Further, NIH will require researchers who wish to use the database to agree not to distribute it publicly. The concern is that insurers might gain access to this genetic information and, as noted above, deny coverage to these at-risk patients.26

Some investigators have protested that the removal of individually identifiable information will adversely affect potential benefits to patients from health care research.2 Privacy concerns might prevent researchers from contacting a patient. They argue that, should the research yield results that might be beneficial to the patient, they have no way to identify them. As Mckenzie notes, “Researchers could use an accessible database to identify patients who are statistically at risk of contracting particular diseases. They could then contact the patient’s doctor so that preventive measures could be taken.”31

Balancing privacy and quality of care

The impact that these restrictions might have on the quality of care is a primary concern cited by those who oppose increasing restrictions to access of patient records. Although removing individually identifying information from medical records is an important step in ensuring patient privacy, in some circumstances, this gap in data, while protecting privacy may in fact impact the quality of care adversely. For example, consider the case of a physician treating an unconscious patient rushed to the emergency department or a patient receiving polypharmacy therapy. In both instances, the health professional’s ability to easily access patient records could lead to a more positive outcome.31 Further, despite the unprecedented time and effort that health care practitioners and organizations spent to ensure HIPAA compliance, violations of the law have led to very few successful prosecutions of alleged perpetrators.32

Health professional organization statements and policies

Both organized medicine and pharmacy have come to realize that patient privacy issues are of considerable ethical and legal concern in contemporary health care practice. Consequently, each has issued strong policy statements in recent years. A report by the Ethical Force Program of the American Medical Association’s Institute for Ethics states, “Patients should have the right to access and add material to their own medical records and give consent for such information to be shared.” The report also recommends “that a local review committee oversee any instance where an individual is unable to obtain consent for the use of information.”33

In 1998, the APhA House of Delegates adopted the following policies:
1. APhA recognizes pharmacists’ need for patient health care data and information and supports their access and contribution to patient health records.
2. APhA supports public policies that protect the patient’s privacy, yet preserve access to personal health data for research where the patient has consented to such research or where the patient’s identity is protected.
3. APhA encourages interdisciplinary discussion regarding accountability and oversight for appropriate use of health information.34

These pronouncements provide strong reminders to physicians and pharmacists about the need to be vigilant in this area.

Conclusion

Questions of patient privacy and confidentiality are likely to remain at the forefront of health care ethics and law in the coming years. Health professionals, including pharmacists, must ensure that safeguards exist to prevent unauthorized access of patient records (privacy violations) and intentional or inadvertent disclosure (confidentiality violations). Beyond their legal obligations, health professionals have a basic moral obligation to patients to ensure that such breaches do not occur. Patients must feel confident that their records are safe from inappropriate and unapproved disclosure. Only then will patients be able to effectively focus their attention in the appropriate area—working with their health professional to improve the quality of their life.

References


Assessment Questions

Instructions: You may take the assessment test for this program on paper or online. For each question, circle the letter on the answer sheet corresponding to the answer you select as being the correct one. There is only one correct answer to each question. Please review all your answers to be sure that you have circled the proper letters. To take the CE test for this article online, go to www.pharmacist.com and click Education. Once you are on the Education welcome page, search for this article with the search function, using “CE” and a keyword. Follow the online instructions to take and submit the assessment test. This CE will be available online at www.pharmacist.com after November 30, 2008. You can also find it on www.pharmacytoday.org.

1. A breach of confidentiality can be defined as
   a. Unauthorized access to patient information.
   b. Inadvertent disclosure of patient information by a health professional.
   c. The right of an individual to liberty of thought, choice, and action.
   d. Requiring full disclosure to a patient and their voluntary consent before initiating any action.
   e. Alternatives a and b are correct.

2. A breach of privacy can be defined as
   a. Unauthorized access to patient information.
   b. Inadvertent disclosure of patient information by a health professional.
   c. The right of an individual to liberty of thought, choice, and action.
   d. Requiring full disclosure to a patient and their voluntary consent before initiating any action.
   e. Alternatives a and b are correct.

3. All of the following are elements of informed consent except
   a. Disclosure.
   b. Voluntariness.
   c. Privacy.
   d. Competence.
   e. Consent.

4. Hospital ethics committees
   a. Oversee all clinical research within the institution.
   b. Assist in formulating institutional guidelines for handling and disseminating sensitive information.
   c. Review and approve all institutional informed consent forms.
   d. Are also known as institutional review boards (IRBs).
   e. Alternatives c and d are correct.

5. Medical consumerism refers to
   a. Patients assuming a dominant role in determining the course of their medical care.
   b. Physicians assuming a dominant role in the care of patients.
   c. Physicians sharing the role of decision making in the care of patients with other health professionals.
   d. Physicians sharing the role of decision making in the care of patients with the patient’s family and caregivers.
   e. Alternatives c and d are correct.

6. The advent of technology in pharmacy has threatened patient privacy by
   a. Easing the sharing of patient records among health professionals.
   b. Increasing the likelihood of unauthorized access.
   c. Allowing pharmacy technicians access to patient records.
   d. Increasing e-prescribing.
   e. Alternatives b and d are correct.

7. A violation of patient confidentiality could occur when medication records are shared by a health professional with the patient’s
   a. Spouse.
   b. Child.
   c. Parents.
   d. Any of the above alternatives are correct.
   e. Alternatives a and c are correct.

8. Marketing companies have partnered with chain pharmacies to provide which of the following with computerized data to allow disease-specific promotional material to be sent to patients?
   a. Hospitals
   b. Long-term care facilities
   c. Pharmaceutical manufacturers
   d. Physicians
   e. Alternatives c and d are correct.

9. Employer access to confidential medical information may result in
   a. Cancellation of the insurance policy.
   b. Increased premiums.
   c. Termination of the employee.
   d. All of the above alternatives are correct.
   e. Alternatives a and b are correct.

10. Governmental prescription monitoring programs may violate confidentiality by
   a. Reviewing prescription records without patient consent.
   b. Sharing prescription records with hospitals.
   c. Sharing prescription records with pharmacy benefits managers (PBMs).
   d. Alternatives b and c are correct.
   e. All of the above alternatives are correct.
11. An argument raised by some researchers in opposition to removing individually identifiable information from patient records includes
   a. The quality of the research will be negatively affected.
   b. The ability to share potentially helpful information with patients will be eliminated.
   c. The National Institutes of Health is less likely to support such research.
   d. IRBs are not likely to approve such research.
   e. All of the above alternatives are correct.

12. One argument in opposition of the confidentiality provisions of HIPAA is that
   a. Access to health records by health professionals is easier.
   b. Few successful prosecutions of alleged perpetrators have occurred.
   c. In some instances, patient care could be adversely affected.
   d. Alternatives b and c are correct.
   e. All of the above alternatives are correct.

13. Autonomy and confidentiality may be justifiably overridden based on
   a. Strong paternalism.
   b. The harm principle.
   c. Weak paternalism.
   d. Alternatives a and b are correct.
   e. Alternatives b and c are correct.

14. Individuals who lack the competence to make an autonomous decision may include
   a. Children.
   b. Patients with chronic medical conditions.
   c. The elderly.
   d. Young adults.
   e. Alternatives a and c above are correct.

15. HIPAA regulations affect pharmacy by requiring that
   a. Patient consent is obtained and documented.
   b. Patients are explained the law each time a prescription is filled.
   c. They share patient information only with the patient’s physician.
   d. Alternatives a and b are correct.
   e. Alternatives a and c are correct.

16. Which of the following examples is a violation of privacy:
   a. A pharmacist discussing a case with the patient’s physician.
   b. An overheard conversation between two health professionals about a patient.
   c. Hacking into a patient’s medical record.
   d. Reviewing a patient’s medication regimen with their PBM.
   e. Alternatives b and c are correct.

17. Which of the following examples is a violation of confidentiality?
   a. A pharmacist discussing a case with the patient’s physician.
   b. An overheard conversation between two health professionals about a patient.
   c. Hacking into a patient’s medical record.
   d. Reviewing a patient’s medication regimen with their PBM.
   e. Alternatives a and d are correct.

18. Which of the following is an example of a situation in which weak paternalism is used as an ethically justifiable exception to confidentiality?
   a. Discussing a patient’s medication therapy with their physician.
   b. Informing an employer or physician about a patient who is not taking their medication and may be placing others at risk.
   c. Providing medication counseling to the caregiver of a patient with Alzheimer’s disease.
   d. Reviewing a patient’s medication regimen with a colleague.
   e. All of the above alternatives are correct.

19. Which of the following is an example of a situation in which the harm principle is used as an ethically justifiable exception to confidentiality?
   a. Discussing a patient’s medication therapy with their physician.
   b. Informing an employer or physician about a patient who is not taking their medication and may be placing others at risk.
   c. Providing medication counseling to the caregiver of a patient with Alzheimer’s disease.
   d. Reviewing a patient’s medication regimen with a colleague.
   e. Alternatives b and c are correct.

20. The lack of privilege protection for pharmacists is in direct conflict with the requirements of
    a. HIPAA.
    b. The National Committee for Quality Assurance.
    c. The Omnibus Budget Reconciliation Act of 1990.
    d. The Joint Commission.
    e. Alternatives a and c are correct.
CE EXAMINATION FORM

Ethics and patient privacy

This CE will be available online at www.pharmacist.com after November 30, 2008. To receive 2.0 contact hours of continuing education credit (0.2 CEU), please provide the following information:

1. Type or print your name and address in the spaces provided.
2. Mail this completed form for scoring to:
   American Pharmacists Association—CE Exam
   P.O. Box 791082
   Baltimore, MD 21279-1082
3. CE processing is free for APhA members. If you are not an APhA member, please enclose a $15 handling fee for grading the assessment instrument and issuing the Statement of Credit.

A Statement of Credit will be awarded for a passing grade of 70% or better. If you fail the exam, you may retake it once. If you do not pass the second time, you may no longer participate in this continuing pharmacy education program. Please allow 6 weeks for processing. Pharmacists or technicians who complete this exercise successfully before November 1, 2011, may receive credit.

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. The ACPE Universal Program Numbers assigned to the program by the accredited provider are 202-000-08-231-H04-P and 202-000-08-231-H04-T.

PARTICIPANT INFORMATION

<table>
<thead>
<tr>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
</tr>
<tr>
<td>CITY</td>
</tr>
<tr>
<td>E-MAIL</td>
</tr>
<tr>
<td>WORK PHONE</td>
</tr>
<tr>
<td>HOME PHONE</td>
</tr>
</tbody>
</table>

CE ASSESSMENT QUESTIONS—ANSWERS

| 1. a b c d e | 2. a b c d e | 3. a b c d e | 4. a b c d e | 5. a b c d e | 6. a b c d e | 7. a b c d e | 8. a b c d e | 9. a b c d e | 10. a b c d e | 11. a b c d e | 12. a b c d e | 13. a b c d e | 14. a b c d e | 15. a b c d e | 16. a b c d e |

Please circle your answers (one answer per question).

PROGRAM EVALUATION

EXCELLENT | POOR

<table>
<thead>
<tr>
<th>PLEASE RATE THE FOLLOWING ITEMS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall quality of the program</td>
</tr>
<tr>
<td>2. Relevance to pharmacy practice</td>
</tr>
<tr>
<td>3. Value of the content</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLEASE ANSWER EACH QUESTION, MARKING WHETHER YOU AGREE OR DISAGREE.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. The program met the stated learning objectives:</td>
</tr>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>After reading this CE article, the pharmacist or technician should be able to</td>
</tr>
<tr>
<td>• Define privacy and confidentiality.</td>
</tr>
<tr>
<td>• Explain the moral rule of informed consent, including its five elements.</td>
</tr>
<tr>
<td>• Define the principle of autonomy.</td>
</tr>
<tr>
<td>• List two ways in which HIPAA impacts pharmacy practice.</td>
</tr>
<tr>
<td>• Provide two ways in which technology has impacted patient privacy.</td>
</tr>
<tr>
<td>• State two examples of third parties with access to or interest in accessing patient medical records who may threaten patient privacy.</td>
</tr>
<tr>
<td>5. The program increased my knowledge in the subject area.</td>
</tr>
<tr>
<td>6. The program did not promote a particular product or company.</td>
</tr>
</tbody>
</table>

IMPACT OF THE ACTIVITY

The information presented (check all that apply):

| 7. Reinforced my current practice/treatment habits | ☐ | ☐ |
| Provided new ideas or information I expect to use | ☐ | ☐ |
| ☐ | ☐ |
| 8. Will the information presented cause you to make any changes in your practice? | ☐ Yes ☐ No |
| 9. How committed are you to making these changes? (Very committed) | 5 | 4 | 3 | 2 | 1 (Not at all committed) |
| 10. Do you feel future activities on this subject matter are necessary and/or important to your practice? | ☐ Yes ☐ No |

FOLLOW-UP

As part of our ongoing quality-improvement effort, we would like to be able to contact you in the event we conduct a follow-up survey to assess the impact of our educational interventions on professional practice. Are you willing to participate in such a survey?

☐ Yes ☐ No
redefining health care...

everyday

CVS Caremark redefines pharmacy by integrating the personalized reach of the nation’s largest retail pharmacy with the innovative delivery technology of the nation’s premier pharmacy benefits management provider. The result is health care that has the ability to enhance the lives of millions of patients in the United States.

We leverage the tremendous resources of CVS Caremark to provide our pharmacists limitless possibilities to grow personally and professionally.

We seek only the best pharmacists to join our team and advance the quest to deliver outstanding health care every day.

www.cvscaremark.com/careers
Stop Feeling Trapped

Let Rx relief* help your profession work for you.

Our pharmacists tell us their Rx relief* career works for them because it offers the benefits of a corporate employer, the flexibility of a small pharmacy owner, and the control they’ve wanted to create an independent lifestyle.

So, while employers are advertising everywhere with special offers and incentives, only Rx relief* lets you optimize your return as a pharmacist in a respectful environment while you exercise more control over your work and your working conditions.

Control Your Schedule
Change Your Scenery
Avoid Workplace Games
Control Your Income

For pharmacists who want to excel in their profession and in their lives.

1-800-RX RELIEF
www.rxrelief.com
DIRECTOR OF INPATIENT/OUTPATIENT PHARMACY

With responsibility for the operation of the pharmacy department, you will promote business and act as pharmacy liaison, ensure efficient and effective operation, address service issues and oversee the storage and distribution of all pharmaceutical items. In this leadership role, you will also assess the pharmacy’s revenue generation; maintain business documentation; direct supervisors regarding their sections; and assist with clinical studies. Other duties will include contracting with vendors; coordinating pharmacy educational programs including in-service training; and performing general pharmacist duties as necessary. Rate for this position is $52.00 – $78.60 per hour.

Requires a bachelor's degree in pharmacy and near-completion of advanced degree (MS, MBA, PharmD), completion of 1-year internship, registration with the Michigan Board of Pharmacy and 3-5 years of progressively more responsible pharmacist experience, preferably in an institutional environment. You will also need thorough understanding of pharmacological principles, knowledge of legal and regulatory requirements applicable to the pharmacy, strong interpersonal and leadership skills, PC proficiency and managerial and administrative ability to plan and direct the activities of a pharmacy and to coordinate the activities of professional pharmacists. Experience in a retail pharmacy desired.

Please send your resume to: ereply4@davidgroup.com and reference Job ID 112327 in the subject line. Applications cannot be processed without a Job ID. EOE

SIGN-ON BONUS Up to $10,000!

PHARMACISTS

Peninsula Regional Medical Center leads the healthcare industry with the latest technologies such as Computerized Physician Order Entry, Electronic Medical Records, Point of Service Bar Coding and a Robotic Medication Delivery System. As a 366 bed primary tertiary care facility, we have received national recognition from HealthGrades, Inc. Become a part of our exciting team! This Pharmacist position directs the preparation, filling and distribution of medications throughout the hospital complex and will be responsible for assessing and planning care for a broad spectrum of patients as it relates to their age (developmental) service needs. A Pharm D degree and active Maryland license (or eligible for licensure) are required.

We offer a competitive compensation package including Sign On Bonus up to $10,000 and Relocation Assistance plus 24/7 childcare! Please submit your credentials and work experience to Michelle Saburn, Medical Recruiter at michelle.saburn@peninsula.org Or apply online at www.peninsula.org EOE

EXPLORE YOUR OPTIONS

Join VA and advance your career better than anywhere else. As a VA clinical pharmacist, you can be at the bedside as part of a patient care team, obtain prescriptive authority, run a medication management clinic, conduct research, train pharmacy residents, and more. You’ll also earn a competitive salary and a robust benefits package:

- 13 to 26 days annual paid vacation
- 13 sick days and 10 holidays
- Flexible scheduling
- Exceptional education support and student debt reduction programs
- Stable health and retirement benefits
- One license covering all 50 states

VA is committed to hiring veterans

$12,000 RELO/Bonus

For Pharmacists

New Graduates and Experienced may apply

- Relocate to beautiful Shreveport, LA Permanent, full time positions in a non-for-profit health system
- Both Day and night shifts
- Receive $10,000 of bonus in first 4 months!
- Pay start as high as $55.63/hour
- Instant medical plan coverage on the first day of month following date of hire
- FREE RETIREMENT- no employee contributions are required! Plus full benefits, pd vacation, sick days, holidays

Professional growth in a clinical setting

- Picturesque family community on the Red River!
- Reasonable cost of living, outdoor sports & more
- Northern Louisiana- 200 miles north of the Coast!

Dane Rasmussen, Senior Consultant
800-304-3095 ext 32
E-mail: draasmussen@beck-field.com

Call toll-free
1-800-949-0002 or visit
www.VACareers.va.gov
At the recent Federal Pharmacy Advisory Committee meeting, the Air Force Pharmacy Consultant changed hands. Col Mark E. Butler, USAF, BSC, on the right, becomes the 12th Consultant to the Air Force Surgeon General, relieving Col Everett B. McAlister USAF, BSC.
Today’s News, Today

Go to www.pharmacist.com each day for new front-page news articles. Through the site, the editors and writers of Pharmacy Today provide continual coverage of the profession.

Some things can’t be measured by degrees

As the profession of pharmacy becomes more specialized and more demanding, the Board of Pharmaceutical Specialties offers a unique opportunity to demonstrate advanced clinical proficiency in five major practice areas: Nuclear Pharmacy, Nutrition Support Pharmacy, Pharmacotherapy, Oncology Pharmacy, and Psychiatric Pharmacy. Visit the BPS web site for details.

Did You Know...

- Pharmacy Today’s medication therapy management (MTM) tips offer practical information you can use now?
- Pharmacy Today’s continuing education opportunities allow you to earn a minimum of two credits each month?
- Pharmacy Today’s Product Showcase highlights new product approvals of selected Rx, generic, and OTC items?
- Pharmacy Today’s ISMP Error Alert information can help you recognize potential drug problems?
- Pharmacy Today’s practical OTC information can be used when you’re in the aisles with your patients?
- Pharmacy Today’s Counseling Corner gives tips for educating your patients about their acute or chronic conditions and treatment options?

And did you know, as a practicing pharmacist, you are eligible to receive a full-year subscription to Pharmacy Today, absolutely FREE?

Be in the know by joining thousands of informed pharmacists who subscribe to Pharmacy Today and receive the regularly featured MTM Tip, continuing education, Product Showcase, ISMP Error Alert, OTCs Today, Counseling Corner tip, and much more!

To receive a FREE full-year subscription to Pharmacy Today, click onto www.pharmacist.com/subscription.php and complete the online subscription form. Offer Code: PTHA-0708

As the profession of pharmacy becomes more specialized and more demanding, the Board of Pharmaceutical Specialties offers a unique opportunity to demonstrate advanced clinical proficiency in five major practice areas: Nuclear Pharmacy, Nutrition Support Pharmacy, Pharmacotherapy, Oncology Pharmacy, and Psychiatric Pharmacy. Visit the BPS web site for details.

www.bpsweb.org  1100 15th Street, NW, Suite 400  |  Washington, DC 20005-1707

www.pharmacist.com
More reasons to keep oral syringes in stock

In our January 2005 column, we shared a report of a 5-month-old boy who nearly died after a cap on a parenteral syringe became lodged in his throat. In that case, a pharmacist had given the boy’s mother a parenteral syringe (without the needle) to accurately measure and administer an oral antibiotic suspension to the child.

However, the pharmacist was unaware that the manufacturer had used a small translucent cap on the syringe tip as a protective cover. With the cap intact, the father inserted the syringe into the medical suspension, pulled back the plunger, and the medication flowed into the syringe. To him, the cap appeared to be part of the syringe. When the father placed the syringe containing the medication into the baby’s mouth, the cap flew off and became lodged in the baby’s airway. The infant was taken to the hospital, and became lodged in the baby’s airway.

The Institute for Safe Medication Practices has received similar reports since this occurrence. To prevent these tragedies, we recommend that parenteral syringes never be used for oral liquids and that practice sites stock several sizes of oral syringes for distribution or purchase.

Two recent reports, listed below, further support our recommendations.

In one case, a radiologist prescribed oral acetylcysteine (Mucomyst—Bristol-Myers Squibb) for a 69 year old patient to prevent worsening of renal impairment caused by radiographic contrast media. The oral acetylcysteine was to be administered during a diagnostic procedure. A pharmacist prepared each of the four prescribed doses in separate parenteral syringes. Each was correctly labeled with the dose, route, and frequency of administration; however, the syringes were dispensed with needles attached. Neither the physician nor pharmacist explained how the medication was to be taken (orally after dilution). As a result, the patient self-administered one of the doses subcutaneously. The patient was unharmed and the additional doses were administered correctly because his daughter noticed a sticker on the syringes warning that they were not to be used for injection.

Measure for measure

In another report, a mother shared an experience she had after picking up a liquid antibiotic at her pharmacy for her 2-year-old child. After speaking with the pharmacist about the medication, the mother looked around the pharmacy for a device to accurately measure the 5-mL dose. Unable to find a measuring device, she asked a pharmacy technician if they had one. A pharmacist located a 1-mL and a 20-mL syringe and gave her the 20-mL syringe marked in 1-mL increments.

When the mother later tried to administer the medication, she discovered that the barrel of the syringe was too large to fit into the antibiotic bottle. She considered several options, including using a dose cup provided with another product, delaying starting the antibiotic until the next day when she could get a new device, or using a kitchen teaspoon. Fortunately, the mother was a pharmacist, so she was able to figure out a way to accurately measure each dose, but not all caregivers would be able to do so.

Dosing with proper devices

In each of these cases, practitioners intended to assist their patients by premeasuring the dose or by providing a measuring device. However, they assumed, incorrectly, that patients or caregivers would know how to use the devices properly.

In addition to providing patients with appropriate devices for measuring doses, practitioners must ensure that patients or caregivers understand how to use the devices properly. This is best accomplished through patient education. Pharmacists should demonstrate proper device use and ask the patient to demonstrate proper use in return.

—Institute for Safe Medication Practices

The reports described in this column were received through the USP–ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the Institute for Safe Medication Practices (www.ismp.org) or U.S. Pharmacopeia (www.usp.org) Web sites or communicated directly to ISMP by calling 800-FAIL-SAF (800-324-5723) or e-mailing ISMP info@ismp.org. The topics in this column are covered in greater detail in Medication Errors, 2nd edition, written by ISMP President Michael R. Cohen, BPharm, MS, ScD. The book may be purchased from www.pharmacist.com or by calling 800–878–0729.

Recent attendees to the Quarterly APhA Federal Pharmacy Advisory Committee include (front row) CAPT Mary Fong, Coast Guard, John Gans, PharmD, APhA Executive Vice President, Lori Golterman, PharmD, representing the Department of Veterans Affairs; (back row) CAPT Stephanie Simon, Navy, Lindsay Garris, PharmD, VA Baltimore PG-2 Pharmacy Resident, Col Everett McAllister, Air Force, Col Mark Butler, Air Force, COL Isaiah Harper, Army, RADM Robert Pittman, Public Health Service, and Butler student pharmacist Joshua Lorenz.
The Pharmacist's Guide to Compensation for MTM Services
Michael D. Hogue and Benjamin Bluml

This guide provides important information about compensation for provision of MTM services in major practice settings. Practical information on documentation and billing is included. Also included is a section of resource materials providing background information, guidelines, and sample forms.

ISBN: 978-1-58212-096-6 • 2008 • 250 pp • Softbound
APhA Member: $44.00
Nonmember: $49.00

100 MTM Tips for the Pharmacist
Marsha K. Millonig

This book provides helpful hints for pharmacists struggling with the concept of integrating patient care/medication therapy management services into their practices. The book will be a practical, easy-to-use source of new ideas for pharmacy practices of any size or setting.

ISBN: 978-1-58212-107-9 • 2008 • 150 pp • Softbound
APhA Member: $23.00
Nonmember: $24.95

Public Relations for Pharmacists
Tina L. Pugliese

This is the only book on public relations designed for pharmacy, the third largest health profession in the United States. The book provides pharmacists and student pharmacists with all the tools available to advance their practice and the profession through public relations, including media relations, community involvement, and special events.

3 Star Doody Review from the first edition of Public Relations for Pharmacists: “This is an excellent resource for practical information on public relations. This is the first book on public relations for pharmacists and is definitely needed.

2nd Edition
ISBN: 978-1-58212-121-5 • 175 pp • Softbound
APhA Member: $27.00
Nonmember: $29.95

To order your copy visit www.pharmacist.com/shop_apha or call 800-878-0729.
NEW! Pen Needle UltiGuard™

Available in 6mm - 31g x 1/4", 8mm - 31g x 5/16", 12mm - 29g x 1/2"

UltiCare Pen Needles provide universal fit with all diabetes pens and dosers in the U.S.
They fit the following insulin pen delivery devices:

<table>
<thead>
<tr>
<th>Autopen®</th>
<th>BD® Pen</th>
<th>Humalog® Pen</th>
<th>Humulin® Pen</th>
<th>InDuo®</th>
</tr>
</thead>
<tbody>
<tr>
<td>InnoLet®</td>
<td>Innovo®</td>
<td>NovoPen® Junior</td>
<td>NovoPen® 3ml</td>
<td>FlexPen®</td>
</tr>
<tr>
<td>Lantus®</td>
<td>Byetta®</td>
<td>Forteo® Pen</td>
<td>SymlinPen®</td>
<td>HumaPen®</td>
</tr>
</tbody>
</table>