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The Run on Tamiflu — Should Physicians Prescribe on Demand?

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“Doctor, I need a prescription for that bird flu drug.” If recent newspaper headlines are any indication,¹ this request has been repeated tens of thousands of times around the country this fall. So much oseltamivir (Tamiflu) has been prescribed — presumably for personal stockpiling in case of an avian influenza pandemic, given that the human influenza season has not yet begun — that at the end of October, the drug’s manufacturer stopped shipping it to the United States.

A busy outpatient office is no place to think through complicated ethical dilemmas. But a request for oseltamivir is just that, and it must be examined from both the perspective of individual patient–physician encounters and that of public health. From the first perspective, such requests raise a more general question: What is the physician’s obligation to grant patients’ requests for specific interventions? As an outgrowth of the patient-autonomy movement, patients’ preferences have come to play an important role in clinical decision making. It is widely accepted that, in nearly all clinical circumstances, patients may refuse unwanted interventions proposed by physicians. Less straightforward, however, are clinical encounters in which patients insist on inter-

ventions that are deemed inappropriate by physicians. These encounters have been discussed both in the context of common problems in primary care (e.g., when patients demand antibiotics for viral infections) and in the context of life-sustaining treatment near the end of life (in cases in which physicians have deemed further treatment to be futile). The literature on ethics in the clinical setting and professional guidelines generally support the conclusion that physicians are not obligated to honor requests for nonbeneficial tests and treatments — although what should count as nonbeneficial or inappropriate may remain problematic.

Physicians are trained and licensed to practice medicine according to scientific evidence and professional standards. When there is at least a modicum of benefit from the perspective of conventional medicine, physicians should generally defer to patients’ requests, and a patient’s weighing of benefits and harms should drive the decision. But if a patient requests an intervention that falls outside the boundaries established by scientific evidence, a physician is not obligated to provide it.

In the case of avian influenza, a human outbreak in any given geographic area is currently a purely hypothetical concern; physicians

are not required to dispense medications for hypothetical scenarios when it is not yet possible to determine who is at risk. If a human outbreak occurred, it is unclear whether the virus would be generally susceptible to oseltamivir and whether this drug would still be the treatment of choice. Moreover, in an epidemic, any indicated drug could be used in several different ways — for preexposure prophylaxis, postexposure prophylaxis, or treatment after symptoms have appeared. If oseltamivir were dispensed well in advance of an outbreak, patients would probably use their stockpiles in a chaotic fashion, rather than optimally for any of these indications. Indeed, some or most of it would no doubt be wasted on viral illnesses other than influenza.

From the perspective of the individual patient–physician encounter, these factors suggest that physicians have no obligation to prescribe oseltamivir to patients who request it for a hypothetical outbreak of avian influenza: the threshold for a modicum of benefit has not been reached. The relative lack of side effects does not constitute a sufficient reason for prescribing oseltamivir.

From a public health perspective, preventive or therapeutic interventions should be optimally

allocated across a population. Accordingly, a major focus of public health ethics is maximizing the health of the population while minimizing infringements on individual liberty.² Ethical dilemmas arising from the tension between the two are typically posed by cases in which a person refuses to comply with a public health imperative (such as mandatory vaccination or quarantine). Less common are cases in which a person demands an intervention that is perceived as conferring individual benefit but that might contribute to net harm to the public health. The personal stockpiling of oseltamivir for a potential avian influenza pandemic represents just such a case.

The current supply of oseltamivir is inadequate to meet the demand that would arise in the event of an avian influenza pandemic. Moreover, personal stockpiling of oseltamivir depletes the supply available for patients who could benefit from the drug during the usual human influenza season: a person who is assertive enough to ask for a prescription does not necessarily need the drug more than unassertive people do. The likely confusion about whether to use stockpiled oseltamivir for prophylaxis or treatment and the probability that much will be used for illnesses other than influenza are relevant from the public

health perspective as well. Finally, the inappropriate or chaotic use of oseltamivir will increase the risk that resistant strains of influenza virus will develop. These considerations strongly suggest that random stockpiling of oseltamivir would confer no benefit to the overall population and would probably confer harm.

Thus, an individual physician has no obligation to prescribe oseltamivir in response to a patient's request — a position that discourages prescribing of the drug but does not prohibit it. In contrast, the public health perspective clearly suggests that the physician has an obligation not to prescribe oseltamivir — a position that is tantamount to a prohibition against prescribing it. The public health perspective need not always trump the individual perspective, but since both point in the same direction in this instance, the prohibition should prevail.

As in 2001, when physicians were besieged with demands for ciprofloxacin after the anthrax attacks, this year's run on oseltamivir should stimulate public health experts to consider more generally the dilemma encountered by physicians who have simultaneous obligations to individual patients and to public health. Physicians who faced demands for oseltamivir in the early fall of 2005 would have welcomed explicit directives

from public health institutions such as the Centers for Disease Control and Prevention and state departments of health. Such directives were helpful in the fall of 2004 when physicians were forced to ration influenza vaccine.³ In the absence of formal guidelines from the government, some professional societies⁴ and private medical groups⁵ have stepped in to issue statements that are consistent with our conclusion: physicians should decline any request for a prescription for the purpose of stockpiling oseltamivir, optimally with an explanation that reflects the reasoning here.

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Safety of Long-Acting Beta-Agonists — An Urgent Need to Clear the Air

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Eleven years after the first long-acting beta-agonist, salmeterol, was approved for sale in the United States, the Food and Drug Administration (FDA) has issued a stern

public health advisory alerting “health care professionals and patients that these medicines may increase the chance of severe asthma episodes, and death when those

episodes occur” (www.fda.gov/cder/drug/advisory/LABA.htm). The announcement followed a July 2005 meeting of an FDA advisory committee on this topic. What are the