The ethics of pharmacy practice: an empirical and philosophical study

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Abstract

This thesis explores some of the dilemmas pharmacists face in their work, and argues that a combined philosophical and empirical approach is essential for understanding pharmacy ethics.

The aims of the research were to discover (i) the types of ethical problems that occur in pharmacy practice; (ii) how often these problems occur; (iii) the decisions pharmacists make when faced with certain ethical problems; (iv) pharmacists' understanding of ethics; (v) what the respective roles of empirical and philosophical research in applied ethics ought to be; (vi) what the role of the individual professional in ethical decision-making ought to be.

The research took a multi-disciplinary approach. Empirical methods included focus groups with community pharmacists, pharmacists training to become supplementary prescribers, and pre-registration pharmacy students. The quantitative questionnaire was sent to community, hospital and primary care practice pharmacists. Philosophical analysis was used throughout, but most directly to address aims (v) and (vi).

It was found that pharmacists face a range of ethical problems in their work. The most common were: receiving an unsigned prescription; being asked for emergency hormonal contraception over the counter; receiving a prescription lacking full information; a patient returning unused, in-date, unopened medication; and a family member requesting confidential information about a patient.

Pharmacists were found to take a 'patchwork' approach to ethics, relying on a combination of common sense, official guidance, strict rules, professional obligations, and professional autonomy. Pharmacists understood ethics as being a mixture of personal opinion, peer consensus, culture and institutional rules.

It is argued that professionalism requires individual decision-making and the acceptance of responsibility for action within the boundaries of the core values of the profession. It is concluded that philosophy and empirical research are both essential in applied ethics, and that the future research agenda in pharmacy practice needs to take this into account.

Table of contents

Chapter Three: Analysis of Qualitative data

Chapter Four: Quantitative results

Chapter Five: The use of empirical data in applied ethics

Chapter Six: Professionalism

List of tables and figures

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Chapter One: Introduction

1.1 Overview

This research offers an innovative approach to pharmacy practice ethics as part of a recent swell in academic attention to the subject. Until recently, pharmacy has been largely neglected by applied ethicists. Although they are a little more common, investigations from social scientists have also been fairly small in number. This year, the pharmacy profession made substantial changes in its revision of its code of ethics. Following a report by Barber and Cribb in 2000,[1] which concluded that there was a need for greater value literacy in pharmacy practice, the Royal Pharmaceutical Society of Great Britain (RPSGB) initiated two doctoral projects into ethics in pharmacy practice.[2] These are two of a number of recent and ongoing research projects in the field, each of which uses a different approach.[3] My thesis takes as its approach a combination of empirical and philosophical investigation, initially answering questions about pharmacists' perceptions of ethics, and about how common certain ethical problems are for pharmacists and the decisions they make concerning these problems. The research then probes further to understand how significant these findings are for applied ethics, and to question the role of the individual pharmacist in ethical decision-making.

This introductory chapter will set the background to the project, outlining the need for research in the area, and will then state the aims of the project before going on to describe the course of the thesis and how the chapters are arranged.

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[1] Cribb and Barber (2000) *Developing Pharmacy Values: Stimulating the Debate - A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain)

[2] This thesis is one of the doctoral projects. For the other see Benson, A. (2006) PhD Thesis 'Pharmacy values and ethics -A qualitative mapping of the perceptions and experiences of UK pharmacy practitioners' King's College, London

[3] See Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham and Charr, B. (Untitled) PhD Thesis University of Sydney (Forthcoming)

1.2 Background and context

Pharmacy practice has received little attention from practical ethicists, despite extensive research into other areas of health care. Biomedical ethics is arguably the largest branch of contemporary ethics with, for example, major publications for medics such as Beauchamp and Childress' textbook *Principles of Biomedical Ethics,*[4] a collection of articles in *Ethical Issues in Modern Medicine* by Steinbock, Arras and London,[5] and the journal *Bioethics.*[6] Yet none of these addresses pharmacy ethics and, as Cribb and Barber note, there has been very little literature produced on the subject of ethical values in pharmacy at all.[7] Wingfield, Bissell and Anderson recently carried out an extensive literature search of pharmacy ethics and found "that there is little research literature specifically addressing ethics in pharmacy practice and almost none addressing fundamental philosophical issues or values for pharmacy ethics."[8] Wingfield, Bissell and Anderson found that what little research has been done has not specifically addressed pharmacy ethics as a philosophical problem. It seems that once the patient enters the pharmacy she is almost forgotten by philosophers. Research into the area tends to be psychological studies[9] or discussion of the legal aspects of pharmacy practice. Often, too, the geographical focus is the United States of America, not Great Britain. The research that does set out to address genuinely ethical issues in pharmacy is concerned with specific issues of confidentiality, consent and the beginning and end of life, but such studies tend to be descriptive, and non-philosophical. To give two examples, Bissell and Anderson's[10] study provides interesting insight into

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[4] Beauchamp and Childress (2001) *Principles of Biomedical Ethics* (USA: Oxford University Press)
[5] Steinbock, B., Arras, J. D. & London, A. J. (2003) *Ethical Issues in Modern Medicine* (USA: McGraw Hill)
[6] *Bioethics* (Oxford, Blackwell)
[7] Cribb and Barber op.cit.
[8] Wingfield, Bissell and Anderson (2004) 'The scope of pharmacy ethics – an evaluation of the international research literature, 1990 – 2002' *Social Science and Medicine* 58: 2383 – 2396
[9] Latif and colleagues have carried out several studies of this kind.
[10] Bissell, P. & Anderson, C. (2003) 'Supplying emergency contraception via community pharmacies in the UK: Reflections on the experiences of users and providers' *Social Science and Medicine* 57: 2367-2378

pharmacists' and users' opinions of the availability of emergency hormonal contraception from pharmacists, and while the analysis is interesting, informative and valuable within the social science discipline, it does not seek to philosophically analyse the ethical concepts mentioned. Similarly, Auguste, Guerin and Hazebroucq's study[11] reports the opinion and attitudes of pharmacists with respect to confidentiality, but does not delve into philosophical analysis of confidentiality, going no further than assuming patient confidentiality is ethically important.

Even though descriptive research makes up the vast majority of work in the area of pharmacy ethics, Cooper, Bissell and Wingfield, in their critical literature review, claim there is still a shortage: "Empirical ethics research is increasingly valued in bioethics and healthcare more generally, but there remain as yet under-researched areas such as pharmacy, despite the increasingly visible attempts by the profession to embrace additional roles beyond the supply of medicines."[12]

This lack of academic interest is surprising and a matter for concern when one considers the enormous changes to pharmacy practice in Britain as new medicines are developed and made available in different capacities and circumstances, and as the responsibilities of the pharmacist increase. For example, over-the-counter sale of the emergency hormonal contraception (EHC or 'morning after pill') marks the rapidly changing responsibilities of pharmacists after a recent change in the law. At about the same time, the profession introduced a new role for pharmacists as supplementary prescribers, giving them more responsibility and involvement in individual patient care. While in the past the pharmacist was thought of as simply the maker and supplier of medicines, the NHS is now encouraging the public to visit the community pharmacist before the General

[11] Auguste, V. Guerin, C & Hazebroucq, G. (1997) 'Opinions and practices with regard to confidentiality in French hospital pharmacies' *The International Journal of Pharmacy Practice* 5: 122-7

[12] Cooper, R. J.; Bissell, P.; & Wingfield, J. (2007) 'A new prescription for empirical ethics research in pharmacy: a critical review of the literature' *Journal of Medical Ethics* 33: 82-86 p82

Practitioner (GP) for advice on the treatment of minor ailments and for general health-related life-style advice.

The relative lack of research into pharmacy ethics can perhaps be accounted for by the perception that pharmacy does not often come across dramatic and headline-hitting ethical problems. Brazier writes, "Philosophers, social scientists and academic lawyers continue to demonstrate a worrying tendency to concentrate almost exclusively on ethical dilemmas of high drama and low incidence or even likelihood.... The pharmacist's work reaches out to the entire community. The impact of his or her practice affects us all, but when pharmacists do their job, we barely even notice its importance."[13] Björnsdóttir and Hansen remark on a similar situation in the everyday work of GPs. "The big issues have been prioritization, end of life decisions and recent advances in biotechnology."[14]

In fact, it seems to me that pharmacy *does* encounter dramatic dilemmas. Pharmacists are involved in the dispensing of life-saving and life-ending medication and they often deal directly with patients whose healthcare and treatment are closely linked with their personal and social circumstances. Perhaps pharmacy's low profile in these matters is maintained because of the image of the profession, and because pharmacists are regarded as only one component of a larger healthcare team, or as being 'behind the scenes' so that doctors and policy makers are the ones in the limelight.

Another possible reason for the relative lack of academic interest in pharmacy ethics is that pharmacy has for some time not been fully recognised as a values-based profession, but instead is seen as purely technical and fact-based. As Cribb and Barber explain in their discussion paper on pharmacy values, it is "essential to recognise that pharmacy is a 'values-based' as well as a knowledge-based profession. Value judgements

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[13] Brazier, Margaret (2005) Foreword in Appelbe, G. E. & Wingfield, J. *Dale and Appelbe's Pharmacy Law and Ethics* 8th Edition (London: Pharmaceutical Press) pxxii

[14] Björnsdóttir, I & Hansen, E.H. (2002) 'Ethical dilemmas in antibiotic prescribing: analysis of everyday practice' *Journal of Clinical Pharmacy and Therapeutics* 27: 431-440 p431

are inherent in every facet of pharmacy - including accounts of the goals of pharmacy, philosophies of practice, and day-to-day decisions (whether or not these overtly take the form of ethical dilemmas). It is important for pharmacists to be literate about values and ethics, both in order to be able to reflect on, and account for, their own practice, and to be able to participate in broader debates about pharmacy practice, medicines policy, health care and society."[15]

Recognising pharmacy as a values-based profession is to understand the profession's new profile as one that is more patient-focused than it once was. Although pharmacists have not lost the technical expertise in matters unique to pharmacy, their day-to-day work is far less about compiling medicines than it once was, and is much more about making decisions about patient treatment.[16] As a values-based profession, pharmacy must address two matters. The first is the question of what the values of pharmacy currently are. Benson's research involved mapping these values and as a result we now have a greater understanding of the kinds of values pharmacists hold and act upon.[17] The values pharmacists brought up in Benson's interviews were broad ranging, and included more than just ethical values. The investigation in my thesis involves a sub-category of these values, or as Cribb and Barber describe it, those at the "sharp end" [18] of the values found in pharmacy, namely ethics. The empirical questions pursued in this project include those concerning pharmacists' understanding of ethics. There is also an attempt to quantify the types of ethical problems pharmacists encounter, and to quantify pharmacists' responses to these problems.

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[15] Cribb and Barber op. cit. p9

[16] Of course, pharmacists' roles differ, most notably between sectors. For a detailed account of pharmacists' day-to-day work see Stone, P. (2002) *Pharmacy Practice* 3rd edition (London, Pharmaceutical Press)

[17] Benson, A. (2006) PhD Thesis 'Pharmacy values and ethics -a qualitative mapping of the perceptions and experiences of UK pharmacy practitioners' King's College, London

[18] Cribb and Barber op. cit. p10

The second major question a values-based profession must address is what its values *ought* to be. To an extent, this is what has been happening recently with a carefully considered change to the code of ethics. The dialogue about pharmacy ethics is gaining momentum but, as I argue in this thesis, this cannot be done properly without philosophical engagement. Besides the empirical investigation, this thesis examines pharmacy ethics from the perspective of philosophy. It questions the very use of empirical investigation in applied ethics and concludes that empirical investigation is a valuable method. The thesis then seeks to demonstrate how empirical data can be used effectively in applied philosophy as the findings from the empirical work stimulate conceptual analysis, and philosophical arguments relevant to pharmacy practice ethics.

1.3 Aims of the research

The thesis brings an understanding about pharmacists' perception of ethics, revealing the kinds of problems pharmacists face, how often these problems occur and how pharmacists deal with them. It then enters discussion into the purpose of empirical data in applied ethics, and uses questions arising from the empirical data as springboards for philosophical investigation into relevant areas of pharmacy ethics.

To clarify, the project's aims were to:

- Understand pharmacists' perception of ethics
- Identify the dilemmas pharmacists face in their work
- Describe the frequency of the occurrence of these dilemmas

- Describe the decisions pharmacists make when faced with these dilemmas
- Question the purpose of empirical data in applied ethics
- Offer a philosophical analysis of a selection of matters arising from the empirical data

Pharmacists involved in the empirical part of the study comprised community pharmacists, hospital pharmacists, primary care practice pharmacists, locum pharmacists and pre-registration pharmacists. Inclusion of these groups provided a suitable cross-sectional range of background, experience and exposure to ethical dilemmas.

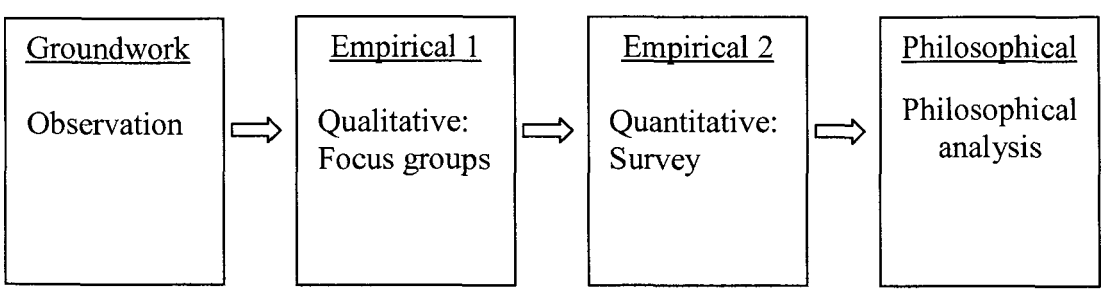
1.4 Structure of the thesis

This thesis simultaneously argues the case for greater use of philosophy in pharmacy ethics and demonstrates the merits of a combined use of empirical and philosophical investigation in applied ethics. This is done by carrying out empirical work, arguing its worth in conjunction with philosophical engagement, and then using the empirical data to engage with two specific philosophical problems in pharmacy ethics. It is argued that the relationship between empirical and philosophical investigation in applied ethics operates in two directions: while philosophy has something to offer pharmacy practice, pharmacy practice may also have something to offer philosophy. The philosophical part of the thesis demonstrates both directions of the relationship, first by using a scenario arising in pharmacy practice to question the boundaries of the concept of confidentiality and, second, by using philosophy to question the individual pharmacist's role in ethical decision-making.

Figure 1.1 shows the methods used over the course of this research. In practice, there was a great deal of over-lap, but in all important respects the order of the methods was followed. For example, it was important that the focus group data were analysed sufficiently to inform the content of the quantitative questionnaire, and so the data were examined superficially before the questionnaire was compiled. However, analysis of the qualitative data from the focus groups continued until after the qualitative questionnaire had been sent out.

The first substantive chapter, Chapter Two: Methods, describes in detail the methods used in the thesis. I began with some background work to orientate myself with the subject of pharmacy practice by simply observing work in pharmacies. The formal research began with focus groups, which were designed to answer questions about pharmacists' perceptions of ethics and to identify the problems pharmacists faced. The focus groups also served to inform the postal survey. The questionnaire sought to answer questions about the frequency of the occurrence of dilemmas pharmacists encountered, and which decisions pharmacists made when faced with these dilemmas. The chapter gives details of the procedure of the focus groups and the questionnaire, and describes the statistical analysis carried out on the results from the questionnaire. The chapter also gives a brief explanation of philosophy as a research method.

Figure 1.1 Flowchart showing the stages of methods used in the research



The findings from the empirical part of the investigation are presented in two chapters. Chapter Three presents qualitative data and analysis from the focus groups and Chapter Four reports the quantitative data from the questionnaire and gives analysis of these data. The focus groups brought up some interesting data regarding pharmacists' understanding of what ethics was, and also offered insight into how pharmacists understood certain ethical concepts. Pharmacists' understanding of their role as ethical decision-makers was complex, and contained themes involving legal and professional rules, the non-objective status of morality, and 'moral neutrality'. The chapter in which the focus group data are presented and discussed stays true to the social science discipline, and the data are analysed on their own merit. It is not until the final substantive chapter that the notion of the individual pharmacist as an ethical decision-maker is examined more philosophically in detail.

The quantitative results from the questionnaire follow in Chapter Four, which show what some of the most commonly occurring ethical problems are for community, hospital and primary care practice pharmacists. The chapter is organised in such a way to present the data from the respective sectors next to each other, and statistical analysis goes some way to answer questions about whether pharmacists from different sectors respond differently to ethical problems and suggests some possible reasons for differences between sectors. The chapter also answers questions about the kinds of things pharmacists consider to be priorities when making ethical decisions, and here the data from the questionnaire are fairly consistent with relevant data from the focus groups, both sets of which suggested that pharmacists have a notably high regard for the interests of the patient.

These empirical findings are valuable in and of themselves in uncovering truths about existing pharmacy practice. The qualitative data shed light on pharmacists' understanding of ethics, and the findings are useful for gauging the climate among

practising pharmacists. The results from the quantitative survey also point towards further avenues of research within the social sciences.

The empirical part of the research has another important part to play in applied ethics, and in Chapter Five this role is discussed in some detail. The chapter examines three possible ways in which empirical investigation could play a role in ethics. The first is linked to the metaethical theory of relativism. The fundamental principle of relativism is that the truth-value of moral claims is relative to the culture or society those claims originate from. The second approach described is that which uses empirical data and speculation, rather than rigorous philosophical argument, to arrive at normative conclusions. It is shown that this way of using empirical findings in applied ethics is often flawed, and that assessments about pharmacy ethics without philosophical input cannot be as readily relied upon as a more disciplined approach of both empirical and philosophical research.

The third approach described is essentially philosophical, but is heavily informed by empirical data. Here, the relationship two-way, so that philosophical analysis informs practice, and practical matters inform policy and challenge accepted philosophical concepts. This third understanding of the role of empirical investigation is the one adopted in this thesis.

Having concluded that both empirical investigation and philosophical engagement are necessary in applied ethics, the chapter finishes by giving an example of how practice can inform philosophy by challenging established concepts. The example used is the principle of confidentiality (i.e. that pharmacists are morally obliged to keep secret certain information about patients). This was something that generated a lot of discussion in the focus groups and raised some interesting questions about existing understandings of the concept. It is shown that particular examples arising from pharmacy practice (though not

unique to pharmacy practice) raise questions about exactly what types of information ought to be treated confidentially.

The last substantive chapter addresses some of the philosophical questions that have arisen from the focus group data, namely those concerning the role of the individual professional in ethical decision-making. The chapter begins with the debate about whether pharmacy is a profession, and then asks questions about the role of professional autonomy, thereby addressing some of the *ought* questions empirical data alone cannot satisfy. Using the supply of EHC as an extended example, the discussion involves questions about the role of the conscience and individual judgement in professional decision-making.

In this way the thesis answers empirical questions about the ethical problems pharmacists face in their work, describes pharmacists' understanding of ethics, and demonstrates the role philosophy can play in bringing greater understanding to some of the ethical questions in pharmacy practice.

Chapter Two: Methods

2.1 Overview

The methods for this PhD research fall into two main categories: empirical investigation and philosophical investigation. The first is characteristic of the social sciences, and the methods employed are qualitative and quantitative. It seeks to answer questions about how often pharmacists face certain ethical problems, which decisions pharmacists make about these problems, and what their understanding of ethics is. The second category of research is philosophical, and later chapters go into greater detail about some of the tensions in pharmacy ethics, including a discussion of professional autonomy in making ethical decisions, and the role of empirical data in applied ethics, which is crucial in understanding the significance of the empirical data and what might be done with such data when drawing up policy.

These empirical and philosophical methods of research combined lead to the delineation and better understanding of the ethical issues involved in pharmacy practice and offer sound reflection on these data using philosophical analysis. Understanding pharmacy practice in this way means treating it not just as something that presents social phenomena relating to ethics, but also as something that contains philosophical problems. Reflecting on pharmacy practice philosophically brings a greater understanding of pharmacy ethics and helps highlight any shortfalls of the profession's handling of ethics.

The previous chapter set the background for this research project, established the aims, and made clear the motivations for carrying out research into pharmacy ethics using a combined approach of social science and philosophical analysis. This present chapter describes in detail the research methods, which were focus groups, a quantitative survey

and philosophical analysis. The chapter finishes with consideration of the issues associated with research ethics of this type of study.

2.2 Selection of methods

The methods considered were observation, focus groups, semi-structured interviews, and a quantitative questionnaire.

Focus groups were considered to be an appropriate method for simultaneously serving two purposes: informing the quantitative survey and developing an understanding of pharmacists' attitudes and understanding of ethics in their practice. The defining characteristic of a focus group is that it generates data through the interaction of group members, and uses the dynamics of group discussion to stimulate the disclosure, formulation and comparison of participants' views.[19] Focus groups are suited to getting several perspectives about the same topic.[20] The aim was to generate broad discussion with reasonable depth that would reveal pharmacists' understanding of ethics in pharmacy practice. Respondents are selected to be members of the focus group according to some common quality. In this study all the participants were either qualified pharmacists or pre-registration pharmacy students. The rationale is that the focus group setting is likely to bring about, in a relatively short time frame, verbal and non-verbal expression of the attitudes, beliefs, feelings, experiences and reactions to others' attitudes and beliefs. In

[19] Kitzinger, J (1995) 'Qualitative research: introducing focus groups' *British Medical Journal* 311: 299-302; Barbour, R. and Kitzinger, J (1999) 'Introduction: the challenge and promise of focus groups' in Barbour, R. and Kitzinger, J. (eds.) *Developing Focus Group Research* (Gateshead: Sage Publications); Bowling, A. (1997) *Measuring Health: A Review of Quality of Life Measurement Scales* (Buckingham: Open University Press); Bowling, A. (2002) *Research Methods in Health: Investigating health and health services* (Oxford: Oxford University Press)

[20] Krueger, R.A. & Casey, M.A. (2000) *Focus Groups. A practical guide for applied research* (Thousand Oaks, CA: Sage Publications)

revealing the nature of alternative viewpoints and arguments focus groups can display the complexity of problems and their solutions and thus are particularly suited to exploring participants' framework of ideas about ethics.

It was considered that the quantitative survey was the most appropriate way of answering the quantitative research questions concerning how often pharmacists encounter certain ethical dilemmas in their work.

Observation was carried out between October 2003 to April 2004 in one hospital (visiting seven departments) and two community pharmacies. At the time this was not considered to be research but rather an exercise in education and orientation. Nevertheless, the division between education and qualitative analysis is arguably artificial, and to an extent the observational work contributed indirectly to the research findings.

Semi-structured interviews with key members of the pharmacy profession were also considered as a method of data gathering. Their value would have been in the volume and detail of the data, and in the subject of the interview, as the participant would be asked questions relating to policy. This method was not used because it was considered to be time-consuming and, although interesting, would not have addressed the research aims directly.

Semi-structured interviews with practising pharmacists would have generated data that would arguably have been more open than those gathered from focus groups, because of the higher level of privacy in individual interviews. Perhaps focus groups and semi-structured interviews could have been used in conjunction to provide a basis for the questions asked in a simple quantitative survey, and to achieve a deeper understanding of pharmacists' perception of ethics and triangulation of data. A full discussion of the lessons learned over the course of this research can be found at the end of Chapter Four.

2.3. Methods used

The empirical research was carried out using focus groups and a questionnaire in order to find out what ethical dilemmas pharmacists come across, how they go about resolving them and what their understanding of ethics is. The qualitative focus groups were designed to inform the quantitative survey. The philosophical analysis that followed then built on the data that was collected in two ways. First, there was an assessment of the significance of the empirical data as a whole. Second, there was philosophical analysis provoked by questions that arose from the data.

2.3.1 Qualitative: Focus Groups

Focus groups were run during the period between October 2004 and April 2005.

2.3.2 Makeup of focus groups

Following a pilot focus group with four hospital pharmacists, three focus groups were run with pre-registration pharmacy students, community pharmacists and pharmacists on a course to become supplementary prescribers, respectively. Pre-registration pharmacy students were chosen partly because they had not been involved in pharmacy for very long and it was thought they might represent views about pharmacy ethics that would not be

captured in the other focus groups.[21] As can be seen from Table 2.1, which shows the makeup of each focus group, the number of participants in each focus group was low. Ideally, the focus groups would have been made up of more participants, and there would have been a hospital pharmacy group, a community pharmacy group and a primary care practice pharmacy group. However, to a great extent problems with recruitment dictated the selection of focus group participants. This is explained further in the next section.

Table 2.1 Table showing the number of participants in each focus group

Pharmacy type	Number in focus group
Practising community pharmacists	4
Practising pharmacists attending a supplementary prescribing course	4
Pre-registration pharmacy students	3

[21] Early plans included conducting a comparative study between pre-registration students and more experienced pharmacists, but this idea was later abandoned for simplification and because it was not considered necessary for meeting the research aims. By this time the pre-registration focus group was organised and it was considered that the data would be useful for other reasons (such as that already mentioned) that did meet the original aims.

2.3.3 Recruitment

Participants were recruited from educational courses at the Department of Medicines Management at Keele University. The Department of Medicines Management provided the administrative means for contacting the participants by post. Each student on three different courses was sent a letter explaining the background of the research and details of the focus group procedure, and was invited to take part in the focus groups. Once a participant had initially agreed to participate, she was sent further information, including an information sheet. Participants in the community pharmacy focus group were offered the incentive of a discount on accommodation for the night before their residential course at Keele University. Participants in the supplementary prescribing focus group were offered the incentive of an evening meal after staying beyond the time of their residential course at Keele University. Participants in the pre-registration student focus group were not offered a special incentive.

The focus group venues were chosen to be convenient for the participants, who were attending study days at university venues and so did not need to travel any extra distance to participate in the focus groups. A hospital focus group was considered difficult to arrange in the time frame, especially given that the pilot had been with hospital pharmacists and so a focus group for the research would have meant a second wave of recruitment within the same small population of hospital pharmacists who attended study days at Keele University. Hospital pharmacists had been chosen for the pilot group because it was the first study day to take place.

It was thought that if recruitment levels were so low with the convenience of the focus groups co-ordinating with participants' existing arrangements then it would prove even more difficult to recruit outside the university. This was perhaps confirmed when

trying to recruit for a locum pharmacist focus group. Several attempts were made over a long period of time to recruit locum pharmacists through a locum agency, but this was unsuccessful.

The low number of participants in the focus groups did not seem to compromise the discussion and the resulting data were rich and useful. However, the poor response did mean that the selection process did not match the ideal, and in several ways the selection was led not by the research aims but by practical considerations.

2.3.4 Focus group format

Questions and vignettes were used to stimulate discussion in the focus groups. In each focus group I opened up the discussion by asking participants what 'ethics' meant to them. I used further questions as prompts for discussion, or for clarification purposes. I gave the participants several vignettes in each focus group to encourage participants to talk about situations that were of particular interest to me given the research aims.

The vignettes were composed after discussion with academic pharmacists who had experience both in working in pharmacy practice and with research of this kind, and who were already aware from their own experience of situations in which ethical problems could arise. The vignettes displayed in Figure 2.2 were used in the focus groups and will be referred to by name in later discussion of the focus group data.

Figure 2.2 Eight text boxes showing the vignettes used in the focus groups

Illegal Prescription

(Used in the community focus group and in the supplementary prescribing focus group)

Should you dispense an illegal prescription (not signed, incorrect dosage) when you know the dose to give (patient is a regular), surgery is closed, doctor is not contactable and patient urgently needs medication, which doesn't fall under 'emergency supply'?

Found Tablet

(Used in the community focus group, supplementary prescribing focus group and pre-registration student group)

You are asked by a concerned father to identify a tablet found in his son/ daughter's bedroom.

i) You recognise the tablet as a contraceptive

ii) You recognise the tablet as an anti-depressant

Self-Prescribing Doctor

(Used in the community focus group and in the supplementary prescribing focus group)

A doctor self-prescribes medication you strongly suspect she is abusing.

HIV and Zidovudine

(Used in the pre-registration student focus group)

You are working in a hospital. A woman in her forties approaches the dispensary and asks you what the drug Zidovudine is used to treat. The woman seems familiar, and you think you may have seen her with one of the patients, a seventeen-year-old girl who was admitted with a chest infection, and whom you know is HIV positive.[1]

Hospital Patient Enquiry

(Used in the pre-registration student focus group)

You work in a hospital and are working your way through a ward one afternoon, checking the records, when a patient asks you to answer some questions about her health. She is a woman in her sixties and was admitted to hospital for investigation of jaundice. There is a strong family history of gallstones. She is awaiting test results, but is wondering why she has been waiting quite so long for them. She is being given diamorphine. She says the medical staff are avoiding her questions and won't give her a straight answer. She pleads with you to tell her what's going on.

Independent Prescriber's Incentives
(Used in the supplementary prescribing focus group)

You feel pressurised by the independent prescriber to prescribe medication you don't consider to be entirely appropriate. You are aware that the independent prescriber is being offered heavy incentives by drug companies to prescribe certain drugs.

Prescribing Outside The Clinical Management Plan
(Used in the supplementary prescribing focus group)

Your independent prescriber says that she trusts you to occasionally prescribe for conditions outside of the plan and suggests that you do this.

Follow-up appointment
(Used in the supplementary prescribing focus group)

A patient has returned for a follow-up appointment. There has been little or no change since the previous appointment, where you gave advice about losing weight. You spent a long time discussing this advice with the patient last time. However, in discussion today it becomes clear that your advice was not followed and that the patient had made no attempt to do so. Indeed, she is questioning the point of following your advice. You need to make a decision about further treatment.

2.3.5 Conduct of focus groups

In all focus groups I was the facilitator/ interviewer. Jane Wilson, a philosophy doctoral student, was the scribe in the pilot focus group and the community pharmacy group. Monique Jonas, an academic philosopher, was the scribe in the supplementary prescribing focus group.

I ran a pilot focus group with a group of four participants from hospital pharmacy in order to test the discussion questions and vignettes. I then examined the results and made minor revisions to the format.

The community and supplementary prescribing pharmacy focus groups took place in private rooms. The focus group with pre-registration students took place in a large dining area where no one else was seated, but catering staff moved in and out of the room at the far side. The participants were out of earshot of the catering staff, but noise from the catering work interfered with the recording. In all focus groups conducted, participants sat around a table, with the microphone in the middle and the cassette recorder controlled by either the scribe or me. The equipment was discreet. All participants were offered refreshments before, during and after the focus groups.

Ground rules were agreed before the focus group discussion started. These were simply that each participant would respect the confidentiality of each of the other participants. It was also asked that, for the sake of the recording, participants spoke clearly, and avoided talking over each other. All participants had been provided with an information sheet and all were asked to sign a consent form. Focus group discussions were tape-recorded and written notes were taken. The recordings were later transcribed. Each group comprised three or four members and discussion lasted between an hour and a half and two hours. Each of the focus group discussions started with the announcement that the tape recorder was being switched on, and with the question of what ethics mean to participants in a work context. After this general discussion came to a natural pause, the participants were given the vignettes to discuss. The vignettes were given out one at a time on pieces of paper.

2.3.6 Data storage

Data were stored on audiotape and paper in a filing cabinet in my locked office. Clerks transcribed the tapes, which were sent in the post by recorded delivery. The transcripts were sent to me by email. All computer-based files were password protected.

2.3.7 Qualitative data analysis

I worked broadly by the principles of grounded theory for data gathering and analysis, so that the process was systematic and flexible to ensure the best chance of developing theory that most accurately explained the social phenomena presented in the data. The method of data gathering and analysis did not follow Glaser and Strauss' original model exactly, [22] but in principle was very similar. Where my research diverged from the Glaser and Strauss model was in the fact that I did not achieve full saturation of data, something that is mentioned in discussion of the limitations of my research in Chapter Four. Adhering to the principle that the researcher should be as free from the influence of pre-existing theories on this subject as possible, I carried out the relevant literature search on empirical research into pharmacy ethics after the data analysis. I started note taking and analysis after the first focus group, with much toing and froing between the data and the analysis. The data gathering and analysis were simultaneous in the sense that analysis started after the first focus group, and continued beyond the final focus group. I re-visited the existing data to develop and re-assess the coding categories I had identified and theory I was developing.

[22] Glaser, B. G. & Strauss, A. L. (1968) *The Discovery of Grounded Theory: Strategies for Qualitative Research* (London: Weidenfeld and Nicolson) and Straus, M. A. (1987) *Qualitative Analysis for Social Scientists* (Cambridge: Cambridge University Press)

I had the advantage of having little previous experience of pharmacy practice, and therefore no particular orientation towards the research questions. It is, of course, impossible for any researcher to carry out her work in a vacuum, and arguably it would be useless and uninformative to do so. However it was beneficial to start with a degree of ignorance in this particular subject in order that the data would dictate the direction of the findings.

The analysis began with coding the data, starting first with a hard copy and then using the computer programme NVivo as the complexity of themes grew. The process of data analysis started during data collection with discussions with friends and colleagues, but the first stage of the more formal and deliberate analysis was to become familiar with the data by repeated re-reading of transcripts. Themes emerging from the data were identified and grouped. In the simplest way, a theme became apparent in the data by the mention of certain words or phrases by a participant in the discussion. A single instance of a phrase or word was sufficient to be noted as a databite. For example, a participant might have mentioned 'confidentiality' just once, which I then considered a theme.

Where participants mentioned concepts using different words or phrases, I linked these as part of the same theme. For example, if one participant mentioned 'interests of the patient' and another mentioned 'what's best for the patient', I considered these part of the same theme. While it is recognised that there may be differences in meaning in these phrases, grouping them together was essential to the analysis, otherwise any of my comments on the data would effectively have been a duplicate of the original raw data. It could equally be the case that a participant meant two subtly different things by the same phrase or word. I had to be sensitive to the context in which the words and phrases were used. Themes were inevitably linked and, as the process of analysis continued, some themes collapsed into one another. Other themes proved to be more complex and intricate

than I had originally thought. Breaking the data down and then categorising pieces of the data as specific themes involved identifying relationships that were not explicitly in the data. Some assumptions were made, but as far as possible I was aware of these assumptions and where my assumptions were more liberal I made note of this. An example of categorising in this way is the grouping of 'what's best for the patient' with 'with somebody who is terminally ill ... you don't want them screaming out with pain just because you are being bloody minded about not giving them a prescription' as the theme 'patient's interests'. There is nothing explicit in the second phrase to firmly indicate the participant is talking about the interests of the patient, but the content suggests he is. Even so, the content is not enough here. The interpretation that the participant is talking about patient's best interest is also informed by the context of the discussion by this participant. In isolation, this phrase could just as easily be put into the category 'the aim of stopping people disturbing others by screaming'.

Themes can be classed as 'member-generated' and 'observer-generated', a distinction recognised by Lofland.[23] Member-generated themes come directly from the participants and can be found in the phrases and concepts they use. For example, it is the pharmacists who mention confidentiality, making it a member-generated theme. Observer-generated themes are formed from the understanding of the researcher. For example, 'perceived difference between ethics and morality' is an observer-generated theme because no participant mentioned this directly.

As Sim and Wright point out, there are differing opinions among analysts over whether, and in which cases, member-generated or observer-generated themes are more appropriate.[24] In this project, both categories were used. This is because of the two-fold

[23] Lofland, J. (1976) *Doing Social Life: The qualitative study of human action in natural settings* (New York: John Wiley)
[24] Sim, J. & Wright, C. (2000) *Research in Health Care: Concepts, designs and methods* (Cheltenham: Stanley Thornes)

nature of the research questions: to find out what pharmacists think about ethics and to offer a philosophical perspective on this. The observer-generated themes, for example 'ethical subjectivism and relativism', did not come from the participants themselves, but were formed from my philosophical understanding of the data. To exclude observer-generated themes from this analysis would be to lose the identification of hidden and implicit philosophical assumptions among pharmacists.

In presenting an argument or story about the data, it was imperative evidence was provided to support any conclusions. Substantial amounts of the data and the analysis (at varying stages) were not used in the final write-up and analysis. During the analysis, the aims of the doctoral work were kept in sight, which meant it was necessary to abandon themes if they were deemed irrelevant to the subject of the research. This selection was itself part of the analysis. The analysis focused on answering questions about how pharmacists perceived ethics, which included understanding participants' relationships with rules and key ethical concepts. The first topic, participants' relationships with rules, arose from the data independently. The second topic, participants' understanding of key ethical concepts, was in part instigated by me, since the broad subject was of interest to the research question. This meant I had been looking out for mention of these concepts. Even so, it was the participants who produced each instance of data concerning this topic, which in turn informed the conclusions.

2.4 Quantitative: questionnaire

The research involved gathering quantitative data to discover the frequency of problems pharmacists face in their work and to identify any associations between the sector pharmacists worked in and the decisions they made. The questionnaire was directly

informed by the data from the focus group discussions, except for in the case of primary care practice pharmacy. For this questionnaire the questions were formed on the basis of suggestions from primary care practice pharmacists known to members of the steering group because a primary care practice focus group was not run. The questionnaire was mostly quantitative, though it included a small number of open-ended qualitative questions. The qualitative data from the questionnaire were not analysed for the purpose of this thesis because of time limitations. The qualitative data from the questionnaire were mostly about the questionnaire itself, or general comment about ethics being a difficult aspect of work. Some of these data have been used anecdotally in the thesis.

The survey was carried out between June 2005 and October 2005.

2.4.1 Questionnaire design

Three types of questionnaires were distributed. Each was aimed at one of three specific sectors of pharmacy practice: community, hospital and primary care practice. Each questionnaire contained demographic questions about the participant's age, year of qualification and sex.[25] There were also demographic questions relating to particular sectors. Hospital pharmacists were asked which grade they were,[26] whether the hospital was NHS or private, whether the hospital was community, district or teaching, and the size of the hospital (measured by number of beds and number of full time pharmacists). Primary care pharmacists were asked whether they were qualified as supplementary prescribers and what proportion of their time was spent working directly with patients.

[25] In error, the question asking the sex of the participants was omitted from the questionnaire for primary care pharmacy at practice level.

[26] This was an ambiguous question in the survey, because it was not clear whether the questionnaire asked which grade pharmacists worked at or which grade they were employed at.

Community pharmacists were asked whether the pharmacy they worked in was a single independent outlet, a small chain, a medium-sized chain, or a large multiple. They were also asked to give the location of the pharmacy in terms of whether it was in independent premises, or part of a post office, supermarket or health centre. As a measure of the level of deprivation of the area, community pharmacists were asked what percentage of their prescriptions were exempt. All pharmacists were asked whether there was a consultation area in the premises they worked in and, if so, its size and location.

The main parts of the three questionnaires were made up of scenario-based questions developed from real situations described in the focus groups and from ideas generated for the vignettes. The purpose of these questions was to find out how often certain problems occurred in pharmacy practice and how pharmacists dealt with these problems or, if they had not encountered such problems, how they thought they would deal with them. Each scenario-based question followed the same format, which fell into two parts: a situation was briefly described and then participants were asked how often this had happened to them in the last year. The possible answers were set at ordinal level. The second part of the question gave a choice of (usually) two options. These were choices between two 'decision' statements, designed to allow participants to indicate what they had done when they had faced the situation described, or what they would do if they were to find themselves in such a situation. Figure 2.3 shows an example taken from the community pharmacy questionnaire. Appendix 1 contains all three questionnaires.

Figure 2.3 Question 2 of the Community Pharmacy Questionnaire

2. You are presented with a prescription for something like an opioid analgesic. You see the prescription is not signed. You know the GP but cannot contact him/her.

a. How often has this happened *to you* in the last year?

At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know
☐	☐	☐	☐	☐	☐	☐

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You refused to dispense the medicine from the prescription
☐ You dispensed the medicine

The questions were designed to give participants limited options in their replies in order to keep the questionnaire simple and to quantify the data. It was anticipated that if the questions had been open, the number of types of answers would have been very large. The aim of the questions was to find out what pharmacists do or would do in certain situations, *all things being equal*. This was explained in the covering letter and in the instructions at the start of each questionnaire. Some questions may not have been applicable (for example when the question was about locum work and the participant did not work as a locum), in which case 'N/A' was included as an option.

Each questionnaire contained a question about the main considerations the participant gave to certain factors that could influence her judgment when making decisions about ethical problems (see Figure 2.4). The question was divided into two parts. The first asked participants to rank each factor according to how much consideration they gave it. The answer options were ordinal and set on a 5-point adjectival rating scale. The scale ranged

between giving 'no consideration' to giving 'a great deal of consideration' about certain potentially influential factors. Participants were also invited to specify any other consideration not mentioned in the list. The second part of the question asked participants to specify which one factor they considered most important in the list.

As already mentioned, each questionnaire also provided the opportunity for qualitative data as the last page included an invitation for participants to add any comments.

The questionnaire was first piloted on five pharmacist volunteers. The volunteers were colleagues of members of the project steering group, who were contacted by email and asked whether they would like to participate in the pilot, and were each then sent an electronic copy of the questions to be included in the survey. The questionnaire was in this way tested for comprehensibility of instructions, ease of use and appropriateness of questions. With the help of the project steering group, I then examined the results and feedback and redesigned the questionnaires. The revised questionnaire was then piloted on fifty pharmacists in the Shropshire and Staffordshire Strategic Health Authority. Details of the sampling strategy are given in the following section. The results of the pilot indicated a need for further changes, mostly to the format to make it more readable. Changes were also made to the introductory section of the questionnaire to explain why the questions were formatted as they were, since it was thought the restrictive nature of the options for the participants' answers might discourage people from participating. The most significant change was to produce three separate questionnaires, printed on differently coloured paper, each of which was relevant to one of the three sectors of pharmacy practice. This made each questionnaire simpler and smaller, and meant the instructions for completing the relevant sections were less complicated.

Figure 2.4 Question 25 of the Community Pharmacy questionnaire

25 a. Thinking over the scenarios you have just reviewed, what were the main considerations when making a decision in your work? Please indicate how important you regard each of these factors when facing a problem by ticking one of the boxes marked 1-5 on the table below. The scale below indicates the meaning of 1-5.

1	2	3	4	5
No consideration	Little consideration	Some consideration	Quite a lot of consideration	A great deal of consideration

Consideration	1	2	3	4	5	N/A	Most important
Patient's interests: health							
Patient's interests: non-health e.g. financial, social/ personal							
Keeping within the law							
Keeping within the guidelines of the RPSGB							
Financial interests of yourself							
Financial interests of the company you work for							
Your reputation							
Your relationship with the patient							
Your relationship with the relevant prescriber							
Your relationship with pharmacy colleagues							
Patient's relationship with the prescriber							
Whether you will be struck off							
Other (please specify and rate)							

b. Please indicate which <u>one</u> of the above is most important to you when making decision in your work by ticking the appropriate box in the column labelled 'most important'.

2.4.2 Participants, population and sampling strategy

The chosen region was the Shropshire and Staffordshire Strategic Health Authority. This area is considered fairly typical of Great Britain demographically in terms of the number of pharmacists and the inclusion of rural and urban populations.[27] At the time of the distribution of the survey, the region contained approximately 684 registered practising pharmacists,[28] approximately 120 community pharmacies[29] and twenty-five hospitals.[30] The area encompassed one large conurbation (Stoke-on-Trent), rural areas and several small towns. The number of postal questionnaires sent was 522. They were sent to all registered pharmacists in the Shropshire and Staffordshire Strategic Health Authority.[31]

There were several methodological advantages to gathering data from one regional area. The sector of pharmacy was assumed to be the more pertinent factor when concerning pharmacy ethics rather than geographical location. Since the RPSGB register of pharmacists does not specify sector of pharmacy work, participants could not be selected on this basis. Random selection from the whole of Great Britain would have been more complex. By taking a specific area of Great Britain and including every pharmacist in the area, each sector of pharmacy work could be represented in the survey. It was thought that a further advantage of this method was that pharmacists were more likely to participate in a localised survey than a national one. The higher the response rate the more reliable the

[27] Based on the expert opinion of Professor Stephen Chapman and Professor Alison Blenkinsopp
[28] The number in the postal address list from the RPSGB of all registered pharmacists in the SSSHA.
[29] http://www.yell.com
[30] Shropshire and Staffordshire Health Authority (via email enquiry)
[31] The original postal address list from the RPSGB included 684 names and addresses, comprising all registered pharmacists in the SSSHA, including those who had retired. A more up-to-date list was compiled by the RPSGB to exclude as many retired pharmacists as possible. This list was made up of 572 names and addresses and was the list I worked from.

results. After consultation with a statistician, Professor Julius Sim, the sample size was judged large enough to draw conclusions about the pharmacy population of Great Britain.[32]

The questionnaire was intended for pharmacists practising in community, hospital and primary care at practice level. The sectors academic pharmacy, industry, and primary care at strategic level were not included because it was thought that the nature of ethical problems faced by primary care pharmacists at strategic level would have been of a different type (for example about resource allocation) and would have widened the range of findings to a less manageable degree. Pre-registration students were not included because the survey was designed to answer questions about frequency of occurrence of certain ethical problems, and it was thought that pre-registration students would not have been exposed to pharmacy for long enough to address this question. Also, pre-registration students work in a variety of settings in their placements and so their experiences of problems in the workplace may not reflect the usual work environment of pharmacists.[33] It was decided that the aims of the research could be met by including community, hospital and primary care practice pharmacists in the survey.

2.4.3 Distribution process and handling of data

The list of names and addresses of registered pharmacists in the Shropshire and Staffordshire Strategic Health Authority was acquired from the RPSGB. Each pharmacist included in the mailing was sent three questionnaires. Each of the three questionnaires was relevant to one sector of pharmacy practice. Of the two pilots that were run, the first was sent to academic and practising pharmacists known to members of the project's steering

[32] Number of registered pharmacists in England, Scotland and Wales in 2002 was 41075.61 (Hassell, K. (2004) *Pharmacy Workforce Census 2003: Main Findings* http://www.rpsgb.org.uk/pdfs/census0309.pdf p8)
[33] These reasons are not applicable to the focus groups, which were used to address different aims.

group. The second pilot was sent to the first fifty pharmacists on the RPSGB's list of registered pharmacists in the Shropshire and Staffordshire Health Authority. The list was in alphabetical order, so the pilot population was selected on an arbitrary basis, making sampling random.[34] The feedback from the pilots were used only in developing the questionnaire for the actual research; the pilot data were not used for any other research purpose.

For the actual survey, all registered pharmacists in the Shropshire and Staffordshire Strategic Health Authority who were not involved in the pilot survey were contacted by post. They received a letter and information sheet explaining the nature of the research. Included were the researcher's full contact details. The questionnaire was entirely anonymous. Consent for use of quotations from the qualitative section of the questionnaire was assumed given that the participant had returned the questionnaire. This was made clear in the covering letter sent to participants.

The letters and information sheets were written on headed paper, with Keele University's Centre For Professional Ethics (where I was based) and Department of Medicines Management (where two of the members of the steering group were based) both named on the headed paper. The addressee for the return questionnaires and postcards was given as 'Zuzana Deans, Pharmacy Practice Research Project'. It was thought that mentioning the Department of Medicines Management and restating in the address that the project was a 'pharmacy practice research project' would encourage pharmacists to participate because the project was obviously relevant to their practice. It was thought that emphasis on the project being a PhD, or being based in the Centre For Professional Ethics might lead pharmacists to falsely think the project was not relevant to their practice.

[34] Although this was a random selection in this research as an isolated study, it is possible that these same pharmacists were selected in the same way for other studies and, as a result, pharmacists selected for the pilot study may be of a group that participates more frequently than most in studies of this kind.

Two reminders were sent after six weeks and then after a further five weeks. The return date for the completed questionnaires was extended by nearly two months, with the revised date given in the first reminder letter. In order to send reminders only to those who had not already returned their questionnaire, and to ensure anonymity, each potential participant was given a questionnaire and a postcard bearing a unique number corresponding to her name and address. The respondent was asked to post her questionnaire and postcard separately. After the postcard had been returned, the participant would not be contacted again. Those who had not returned their postcards were sent reminder letters. The postcard reply system meant that reminder letters could be targeted at those who had not yet returned a questionnaire, had not yet confirmed their ineligibility[35] or had not yet expressed their desire not to participate. All this could be done without the researcher being able to link any respondent to her completed questionnaire.

All those invited to take part in the survey were asked whether they would like to receive a summary of the results. It was explained that this did not affect the anonymity of their questionnaire.

Completed questionnaires were stored in a filing cabinet in the researcher's locked office. The data were transferred onto the computer programme SPSS by clerks. The files were password protected.

2.4.4. Quantitative data analysis

The quantitative data analysis involved a combination of simple descriptive statistics and statistical analysis.

[35] Reasons a pharmacist may not be eligible to participate included being retired, or working in a sector other than hospital, community and primary care at practice level.

2.4.4.1 Descriptive statistics

Basic frequencies were presented for most of the questions in the form of tables and clustered bar graphs to address the main research questions, which were:

- How often do particular problems occur in pharmacy practice?
- What decisions do pharmacists make when faced with these problems?

In addition, the following question was addressed:

- Do pharmacists working in different sectors make different decisions regarding ethical problems?

2.4.4.2 Statistical analysis

Statistical analysis was carried out by way of parametric and non-parametric tests using SPSS (12.0.1 for Windows). Two broad null hypotheses were tested using Pearson's chi-square, Fisher's exact and Mann-Whitney U tests where appropriate. The broad null hypotheses were:

1) There is no association between the sector pharmacists work in and the decisions they make when faced with certain ethical problems.
2) There is no association between the sector pharmacists work in and how important they consider certain factors when faced with an ethical problem.

Appendix 2 gives full details of all the null hypotheses that were tested in order to test the broader null hypotheses (e.g. There is no association between the sector pharmacists work in and the decisions they make when faced with the following ethical problem: 'A patient hands you a prescription. Ideally, you would receive further information about the prescription from the prescriber').

Data from the primary care practice questionnaire were not included in determining the validity of null hypotheses 1 or 2 because the number of respondents (15) was considered too small to form reliable inferences. However, there is descriptive presentation of the data from the primary care practice group, and tentative speculation is made about what the results might indicate.

Chi-square tests were run for association between two nominal variables. The Fisher's exact test was used in cases in which the expected frequency in more than 20% of cells was less than 5. Alpha was set at $p \leq 0.01$ (two-tailed) in order to control the type I error rate, in view of the fact that multiple hypotheses were tested. This means it is likely that 1 of 100 tests run would be of type I error, so further tests of null hypotheses should be carried out before any firm conclusions are drawn.[36] Where an outcome variable was on an ordinal scale, a test for mean was not applicable so a non-parametric Mann Witney U test for differences in medians was used.

[36] A type I error occurs when one falsely rejects the null hypothesis (in other words, when one concludes that there is an association between factors when in fact the results presented have occurred through chance). The statistical tests are designed to calculate the likelihood of the observed results occurring by chance. It is usually accepted that if there is a 5% or less chance of the observed results occurring by chance then one can conclude that there is an association, and the null hypothesis is rejected. In my research the standard was set to 1% or less because a high number of tests were run, thus raising the chance of a null hypothesis being rejected in error. To set the standard too low could lead to the occurrence of a type II error, in which a null hypothesis is confirmed when in fact there is an association.

2.5. Philosophical

As a discipline, philosophy is based on reason and its practise involves, among other things, rigorous analysis of concepts, arguments and theory. Philosophical research is a largely intellectual activity that can operate with very little empirical data. This research project involved a combination of philosophical analysis and empirical data gathered using social science methods to reach an understanding of the ethical issues in pharmacy ethics.

The data gathered from the qualitative and quantitative research acted as a signpost for identifying the ethical problems in pharmacy practice and data provoked important philosophical questions about pharmacy ethics. More generally, the philosophical research also sought to answer questions about the appropriateness of the use of empirical research in pharmacy practice ethics.

This philosophical stage was designed to answer questions about the status and role of empirical data in constructing ethical theory, the role of philosophy in formulating policy codes of practice and the role of the individual in professional decision-making. Sociology and moral philosophy are arguably separated by an is/ought gap, sociology describing what we *do*, moral philosophy contemplating what we *ought* to do. Policy must walk a bridge across this gap, a bridge that I later argue is best constructed by empirically informed philosophy.

2.6. Research ethics approval

The Ethics Committee of the Centre For Professional Ethics, Keele University Research Ethics Sub-Committee and the Multi-centred Research Ethics Committee (MREC) gave a favourable opinion of the whole research project. It was agreed by the Shropshire and Staffordshire Local Research Ethics Committee that the observation was purely educational and had no research element. As such, the observation work did not need to undergo any research ethics committee review.

The research was open and so avoided any possible accusation of unethical covert research. Informed consent was obtained in both the focus groups and the questionnaires. The major considerations for the ethics committees were confidentiality and the potential for participants becoming distressed during focus group discussions.

Confidentiality of participants' data from the questionnaires was guaranteed since the questionnaires were anonymous; there is no way of linking participants to any particular questionnaire.[37] There was a potential problem in safeguarding the confidentiality of the participants in the focus group. To encourage confidentiality, ground rules of mutual respect for confidentiality were agreed before each discussion began.

It was decided before the start of the research that if participants revealed unlawful conduct or bad practice by her or another identifiable person advice would be sought from members of the project steering group to make a decision about whether to break the promise of confidentiality.

It was agreed by MREC that if a participant in a focus group had become distressed, either by the topic of discussion or by comments from peers, and, as the facilitator/ interviewer, I became aware of any distress, I would offer comfort to the

[37] The exception to this was when participants wrote their name on the questionnaire uninvited.

participant and/or terminate the discussion or interview. This incident did occur in one of the focus group discussions. The participant wanted to continue with the focus group. She was among friends in the group who were able to comfort her.

Chapter Three: Analysis of qualitative data

3.1 Overview

One of the central aims of this project was to gather empirical data on practising pharmacists' perception of ethics in their work. This included finding out what kinds ethical problems pharmacists faced, and gaining insight into their attitudes towards and awareness of ethics in their profession. This chapter examines and discusses the qualitative data gathered in focus groups using the social science methods described in the previous chapter, 'Methods'. In later chapters, the examination will become more philosophical and critical, and will focus on a selection of the topics raised by the participating pharmacists.

The analysis that follows picks up on some of the themes in the data that give insight into what pharmacists perceive ethics to be, how they perceive their role as moral agents, and how their understanding of ethics impacts on their practice. Pharmacy regards itself as a profession[38] and as such has a code of ethics its members are largely expected to follow. Arguably, one of the marks of a professional is to exercise autonomy when making decisions about one's work, and so in order to be professionals pharmacists must be autonomous and responsible when dealing with ethical problems they come across, breaking rules if necessary.[39]

Data from the focus groups show that pharmacists are anxious about rules but are sometimes willing to break them when the interests of the patient are considered to outweigh the possible negative consequences of breaking the law. This requires judgement,

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[38]The Royal Pharmaceutical Society of Great Britain refers to pharmacy as a profession. http://www.rpsgb.org.uk visited 19/07/06. This is discussed in greater detail in Chapter Six, 'Professionalism'.

[39] The tension between acting autonomously and acting in such a way that is in accordance with one's professional obligations is explored in Chapter Six, 'Professionalism'.

which in turn requires a reasonable understanding of the ethical components of particular situations. For pharmacists to make autonomous ethical decisions, they must be aware of and understand the ethical dimensions of particular situations. The findings show that although qualified pharmacists displayed a wealth of experience of ethical problems in their work, this experience was not accompanied by very much debate, analysis or evidence of knowledge of theoretical underpinnings of ethics and there was evidence that pharmacists lacked an understanding of what ethics was beyond the basics and sometimes used terms inappropriately. Pharmacists seemed to adopt a patchwork approach to ethics in their work, relying on a combination of common sense, official guidance, strict rules, professional obligations and professional autonomy. There was also evidence that ethical judgement was skewed by prejudice, and sometimes by a desire to follow rules.

This chapter is made up of three parts. It begins with an examination of participants' understanding of what ethics is. Without exception, those who talked about ethics on a metaethical level saw ethics as subjective and/ or relative. While participants' views can be identified this way, there were no signs of these positions being reached by participants through consideration of philosophical theory. Instead, their beliefs seemed to be based on commonsense views and on liberal attitudes of tolerance for others. Contrary to this, there was also evidence of pharmacists adopting hard and fast moral principles they admitted to being stubborn about.

The second part discusses the theme of rules that ran through each focus group. This is significant to pharmacy ethics partly because of participants' association of ethics with the law and their understanding of an ethical problem as one in which ethical motivations conflict with the law. The analysis pays close attention to rules also because obedience of, and resistance to, rules give indication of the role rules play in pharmacy practice. If pharmacists are rule-driven they are arguably not acting as professionals, but

for actions to be ethical and professional rules must be broken for the right reasons with sound judgement. The arguments behind this will be explored in the final substantive chapter.

The third section is a systematic examination of participants' understanding of some key ethical concepts in their work, an examination that demonstrates the complexity of some of the practical ethical problems pharmacists face, and exhibits the patchwork nature of the application of ethics in pharmacy practice.

Each participant who was a qualified community pharmacist was given a unique label: Pharm1, Pharm2 and so on. Pre-registration students were given the labels Pre-reg1, Pre-reg2 etc. This ensures anonymity of the participants. The quality of the recording of the focus group of pharmacists who were in training to become supplementary prescribers was extremely poor and at times it was difficult to identify the speaker. Because of this the label '?' is used to denote a speaker of the Supplementary Prescribing group.

The analysis that follows looks closely at the relevant data from the focus groups, starting with data concerning what pharmacists perceived ethics to be.

3.2. Perception of what ethics is

Sound ethical judgement and the ability to defend a professional decision arguably require a critical and reflective approach to problems. There was some evidence of this in the focus group discussions, but there were also signs of participants making decisions without much reflection. Participants also perceived ethics as relative and/ or subjective, a philosophical view that, in its more simple form, can be reached with minimal analytic or critical thinking. Cooper's research in this area showed that pharmacists used several forms of reasoning with variety both between and within individuals. According to Cooper, when

pharmacists made ethical decisions they sometimes followed the rule of treating others as one wishes oneself to be treated, and also appealed to previous experience, common sense, religious belief and to the possible consequences of certain actions.[40]

Participants in the focus groups tended towards story telling and giving examples rather than talking about ethics in the abstract and sometimes seemed uncertain as to what ethics was. When participants mentioned ethics in conceptual terms, they used metaphors and similes, which seemed to indicate participants lacked the vocabulary for talking about ethics directly. For example, participants talked of ethics as a "maze" (Pharm3), the Code of Ethics as a "straight road" (Pharm1) and of some of the policy on emergency hormonal contraception as a "grey area" (Pharm2).

There were four main conceptualisations of ethics in the focus groups. First, there were many instances in which ethics was seen as instrumental in justifying breaking the law or other rules. Second, and contrary to the first, ethics was occasionally perceived as almost synonymous with regulation. Third, it was implicit in the discussions that the participants mostly thought ethics was a relative or subjective concept. Fourth, pharmacists also seemed to make a distinction between 'personal morality' and 'professional ethics'. In addition to these four conceptualisations of ethics there was also evidence of pharmacists making decisions based on prejudices they held. The existence of prejudice is not incompatible with the principle that professionals are able to make judgements independently, and that some policies on supply of medication (e.g. emergency hormonal contraception) are subject to a conscience clause. In other words, making decisions as an autonomous professional, or exempting oneself from a general policy because of one's personal opinions or religion, requires making judgements based on one's individual understanding and viewpoint. If the line between viewpoint and prejudice is difficult to

[40] Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham p203

determine, this might mean that pharmacists make decisions based on prejudice rather than sound judgement.

This section examines the participants' four types of perception of ethics as outlined above and moves on to the related matter of prejudice among participants.

3.2.1 Ethics as instrumental for justifying rule-breaking

Participants saw ethical predicaments as including situations in which the law came into conflict with other interests, whether those interests were of the patient, the pharmacist, the general public or something else. Ethics was seen as something that justified breaking the law and other rules, as if ethics was a set of acceptable, unchallengeable principles that extended beyond rules.

> *"Rules are there but rules are there to be broken sometimes. Ethics is a way of justifying breaking the rules."*
>
> *Pharm1*

Here, 'ethics' is talked about as an instrument, as a 'way' of justifying breaking the rules. Ethics is being spoken of not as a set of motivations for doing something but rather as an ace card that can be pulled out in a difficult situation.

3.2.2 Ethics as regulation

There were a few incidents of possible confusion between law and ethics in the focus groups but on the whole pharmacists understood law and ethics to be separate things. The following is an example of confusion over the distinction between law and ethics. This participant was asked whether she would dispense emergency hormonal contraception (EHC) to a girl under the age of sixteen if it were legal to do so and if there were no conscience clause for the pharmacist to appeal to.

> *"I don't think the law... I don't think ethics will allow you to actually force that upon you."*
>
> *Pharm4*

The confusion does not arise from thinking 'law' and 'ethics' are exactly the same things, and in fact the participant changes from the use of the former to the latter. Rather, the confusion is in using 'ethics' in this way at all. 'Ethics' is being used to mean something that might allow or disallow certain actions, rather than as a set of moral reasons for behaving in a particular way, and the quick change from 'law' to 'ethics' illustrates the close relation this participant perceives between law and ethics. It is worth noting, though, that 'ethics' is sometimes used to mean 'professional code of ethics', and it is possible this pharmacist was confusing law with the code of ethics, rather than confusing law with ethics per se.

Similarly, this participant's answer to the interviewer's question as to what was meant by an 'ethical dilemma' revealed that law and ethics were understood as ultimately separate, but closely linked.

"[It] could be really hard to make a decision because you might be doing the right thing in one person's eyes but not in another. Again it's all law as well."

Pre-reg2

Even though both quotations above give evidence that participants recognised some distinction between law and ethics, the distinction was not very clear for concepts whose definitions are in fact quite separate. That pharmacists sometimes confuse law and ethics is compatible with Cooper's findings: "For many pharmacists, not only were many of their problems legally related, but their very definition of ethics appeared to be synonymous with law and procedures."[41]

As the participant quoted above acknowledges, ethics is a controversial subject and there is an array of opinions about it. Participants fully recognised this, and translated varied opinion into varied truth about ethics. The section that follows looks more closely at participants' views of ethics as relative and subjective.

3.2.3 Ethical subjectivity and relativity

It seemed from the focus groups that participants confused a lack of agreement about moral issues (i.e. a variety of opinion) with the idea that morality is subjective or relative (i.e. a variety of truth). The confusion between variety of opinion and variety of truth is examined in depth in the later chapter, 'Use of Empirical Data in Applied Ethics'. This current

[41] Cooper, R.; Bissell, P. & Wingfield, J. (2006) 'Dispensing with drama? The ethical problems of community pharmacists.' *The International Journal of Pharmacy Practice: Supplement 2* B26

section examines empirical data that relate to pharmacists' understanding of the nature of ethics.

The participants' opinions on what they ought to do (which, it is assumed, includes what they ought to do ethically) were varied, and this was something they became aware of over the course of the focus groups. At the beginning, the participants appeared to be in agreement but as the discussion went on their ideas unfolded and it became apparent that opinions within a group of four were diverse. The participants attributed this to differences in personality and upbringing, religion and professional standards, and understood judgement as being an 'individual thing'.

The following conversation occurred towards the end of one of the focus groups as the participants were discussing what they had discovered during the session:

> *"I think it's been quite interesting that we started off with one thing that we all agreed on and we all said this is happening to us, this is a common problem, this is what we do, we all do the same thing. From then we just kind of 'whoosh!' We've all gone down different roads."*
>
> *Pharm1*

> *"I think it's a lot to do with personality."*
>
> *Pharm3*

> *"No one pharmacist is the same, I think."*
>
> *Pharm2*

"[It's] an individual thing."

Pharm3

"Every pharmacist is different, got different ways of doing stuff."

Pharm2

"... upbringing comes in to play a lot, so does your moral sense of everything."

Pharm3

"...[No] one pharmacist is the same. Everyone does [things], you know, in a different way, or sees things in a different light. A lot of, you know, religious or moral issues, you know, come into it as well and probably professional standards as well."

Pharm2

All these explanations of why participants had different answers to work-related problems share the fundamental point that judgement is dependent on the individual. Explanations included that the means of judgement stem from individual personality, values and upbringing. Participants were talking about their understanding of how they reached the ethical decisions they did, which may be more fairly labelled as a conversation about socio-psychological influences rather than a metaethical discussion.

Within this exchange about the influences on judgement there is mention of a 'moral sense of everything' and 'moral issues', which is a clearer indication that participants considered ethics to be subjective. The implication is that these participants

held the belief that morality is opinion-based and that there is no objective right or wrong. It is not clear whether participants could be classed as having the view that ethics is subjective, or relative to a community. During the exchange quoted above there is evidence that would fit both explanations.

In the quotation that follows, Pre-reg1 displays a similar, though perhaps more complex, understanding of ethics as subjective and relative. By using the phrase 'your ethical issues' to mean 'opinion about what is the right thing to do' Pre-reg1 seemed to be suggesting that ethical judgement is opinion-based.

> *"My understanding of ethical dilemmas is when you when you're faced with a situation where there isn't necessarily the right or wrong answer and instead [is] more like a judgement call and you have to decide, you know, based on your ethical issues as well as the general public's, you know the ideal moral situation really so it's kind of, there isn't normally, like, a set right or wrong answer this is what you have to do and maybe guidelines and things for that situation specifically."*
>
> *Pre-reg1*

This quotation is taken from the very start of the focus group, in which the participants were asked what they understood by 'ethical or moral dilemmas in pharmacy'. The answer could have different interpretations. One reading of the quotation is that the pre-registration student is uncertain of what to do in the absence of guidelines, and that ethics is something to think about when there are no specific guidelines to follow. A second interpretation is that the pre-registration student takes a common view of ethics, which is that ethics is subjective ("there isn't necessarily the right or wrong answer") and

determined by popular opinion, with an overriding personal judgement ("you have to decide, you know, based on your ethical issues as well as the general public's"). A third interpretation is that the participant meant a combination of the two. In other words, the quotation may express the view that in a situation with ethical features, in the absence of clear regulatory guidelines a pharmacist has to make an ethical judgement that will be based on a mixture of popular and personal opinion.

If morality were relative, the question would remain of whom or what morality was relative to. One participant was concerned about whether what she was doing was morally right in relation to other pharmacists. For her, the population from which a consensus should be drawn was the population of pharmacists.

> *"When you think of ethics the first word that comes to my mind is 'dilemma'. It's always to do with dilemmas, its always the problem of what you believe in moral issues and law*[42] *and... there's always something to think about and [I wonder if what I do is] different from another pharmacist and I think that's something to think about always: whether I'm doing the right thing or not!"*
>
> Pharm4

Participants talked of acting in agreement with colleagues, as if reaching a consensus meant reaching the right ethical answer. It is characteristic of relativism to regard the opinion of the moral community as providing the answer to normative questions. In this case clearly it is the pharmacy community that is regarded as the relevant moral opinion-holders. Pre-reg1 had spoken of a wider moral community that included the general public

[42] Notice the coupling of morality with law, a feature of participants' conceptualisation of ethics discussed in the previous section.

and in doing so had a more democratic approach. Pharm4 differs in that she seems to regard pharmacists as the ones whose opinions matter. This could be due to accessibility of advice, or due to a sense of professional values being created by the professionals, or Pharm4 may regard pharmacists as the experts on the matter. In practice though pharmacists might not have access to colleagues when faced with an ethical dilemma. This is most likely a problem in the community sector of pharmacy, where pharmacists often work in isolation. Cooper's research showed isolation among community pharmacists led to lack of assistance and communication which, Cooper suggests, could, among other things, lead to an inability to articulate the ethical values of the profession.[43]

> *"[In] community [pharmacy] you might possibly be there on your own where the decision has to be yours...[You] can obviously try and contact friends and colleagues and things but in that situation you might have to make that decision there and then on your own and base it on your ethical beliefs as opposed to a general consensus."*
>
> *Pre-reg1*

The following quotation shows an exception to the norm of pharmacists attempting to reach agreement with their peers. This particular participant reported that she asked her husband (presumably another pharmacist) for advice, but did not always take it if her personal judgement was that he was wrong.

> *I'll often ring (it's my husband, it's not as if I'm annoying somebody) I'll ring him and say, 'Oh, what do you think about this?' and he'll say what*

[43] Cooper, R. op. cit. p256-264

he would normally do and providing I'm happy with that I will do that. But on occasions I will, you know, I'll say well I'm, like, happy doing that and I'll play it my way."

?

This quotation reveals that reaching agreement with colleagues is not always the most important aim when making decisions, and that sometimes the individual's judgement, whatever that may be based upon, is what drives the decision.

3.2.4 Distinction between 'personal morality' and 'professional ethics'

Participants in two of the focus groups brought up the question of how much personal opinion should enter into a professional decision. In one of these groups there was disagreement about the extent to which professional judgement should be influenced by personal values. One school of thought was that it was a pharmacist's duty to separate herself from a situation in order to make a sound decision.

"It's a moral thing and sometimes you've just got to take that moral issue away from yourself."

Pharm3

This separation is between the patient and the personal value-judgements of the pharmacist. In the focus group discussion some participants said they made value-judgements while some claimed they preferred to be value-neutral. When discussing the 'Found Tablet' vignette, in which a concerned father asks the pharmacist to identify a

tablet found in his daughter's or son's bedroom, some participants said their solution to the problem depended on what the tablet was for, whether it was a contraceptive or maybe an antibiotic that could be used to treat a sexually transmitted infection. As one of the participants pointed out, taking these kinds of things into consideration when deciding whether to breach the patient's confidentiality would be to make a value judgement based on the type of tablet.

> *"We are making our judgement on, we're putting our values on the tablet."*
>
> *Pharm1*

The participant who believed it important for a pharmacist to separate his own moral stance from the situation felt that it was not the role of the pharmacist to pass judgement on a patient.

> *"My daughter's that age as well and ... Yes, she could be [having sex], yet she may not be. I don't know, but it's not for me to moralise. And if they come to me for the morning after pill and I'm in a position to give it then I will do it."*
>
> *Pharm3*

> *"I'm not here to moralise for them."*
>
> *Pharm3*

This pharmacist seems to be making a point about the types of moral judgements pharmacists should be making: i.e. ones that err on the side of respecting patient autonomy and are free from prejudice. But this itself is an ethically motivated point. The pharmacist is using the word 'moralise' as if making a moral judgement is to be illiberal, intolerant or unfairly judgemental. In the same way, the word 'judgement' was often used negatively in the focus group. This quest for tolerance is one of the possible motivations for being a relativist but, as discussed later in Chapter Five ('The use of empirical data in applied ethics'), moral relativism does not necessarily follow from being tolerant towards others.

It is clear that some other participants in the focus groups did not agree with the use of EHC by girls under the age of sixteen without a prescription because they had a moral objection to it. It is worth noting that Pharm3, who says it is not his job to 'moralise' on behalf of patients requesting EHC, did not say he disagreed with the use of EHC by girls under the age of sixteen without a prescription. It may well be that Pharm3 agrees with, rather than is neutral towards, the use of EHC in this way. This is noteworthy because he may be claiming tolerance of the use of EHC *because* he agrees with its use, rather than *in spite of* any personal views he has of it. In other words, it could be that Pharm3 has made a moral judgement (that in certain circumstances EHC should be used by girls under the age of sixteen without a prescription) that brings into question his 'moral neutrality' towards girls requesting EHC.

The second school of thought was that personal values inevitably play a part in the decisions a professional pharmacist makes. The following quotation comes from a participant who recognises the influence of pharmacists' personal opinions:

> *"She [a colleague] was a female pharmacist; she didn't see anything wrong with it [supplying EHC to a girl under age]. I could understand*

why. Obviously everyone's got different opinions about dispensing contraceptives, I think, to certain age groups as well."

Pharm2

The quotation above hints at the possible significance of being a female when making decisions about the supply of EHC. Perhaps the supply of EHC is seen as a feminine issue, or perhaps the pharmacist quoted above believes the female pharmacist was in a better position to be empathetic towards the girl requesting EHC. A few participants noted this compulsion for pharmacists to make decisions based on their social perspectives. For example, one pharmacist said she found it impossible to separate her role as a mother from her role as a pharmacist when making decisions about the supply of EHC:

"I can't separate myself from being a pharmacist and a mother and... I need to make my judgement; everything will be based around my own values, my own beliefs and also as a professional."

"Ok. Well, I find it very hard [to agree to supply emergency hormonal contraception to a girl under the age of sixteen without a prescription], I mean, because of my own values, I suppose, yeah."

Pharm4

Given the nature of pharmacy practice, most pharmacists need to make ethical decisions and thus need to make moral judgements. Moral judgements need not themselves be problematic. Indeed, they are essential to solving ethical problems. The question is what the basis of these moral judgements ought to be: personal opinion or objective judgement?

The first school of thought, that pharmacists should be able to separate their personal moral values from a situation, is not incompatible with the view that pharmacists need to make ethical decisions; an ethical judgement can be made without influence of personal opinion. The second school of thought, that pharmacists cannot help but let their own personal values influence their decisions, is compatible with relativism and subjectivism, but also leaves the door open for prejudice. Allowing opinions to influence decisions means these decisions could be based on prejudice or unchecked moral beliefs.

3.2.5 Prejudice

Pharmacists' responses to the 'EHC' vignette, in which a twelve-year-old comes into the pharmacy asking for EHC, insisting she will not see another health professional, showed how judgements were made about people who request EHC. The supply of EHC was an area of pharmacy that participants attached strong personal opinions to. As well as thinking people under the age of sixteen should not be having sex, some pharmacists believed that the supply of EHC would encourage sexual promiscuity and unprotected sex. This attitude has been observed before. The result of interviews with pharmacists carried out for research by Bissell, Anderson, Savage and Goodyear showed that there "were concerns about the use of EHC as a 'regular' form of contraception and that increased availability might cause a rise in the number of episodes of unprotected sexual intercourse and consequently, sexually transmitted infections."[44] There is no evidence that this is in fact the case.

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[44] Bissell, P.; Anderson, C.; Savage, I.; Goodyear, L. (2001) 'Supplying emergency hormonal contraception through patient group direction: a qualitative study of the views of pharmacists' *The International Journal of Pharmacy Practice* 9: Supplement pR57
See also Bissell, P. and Anderson, C. (2003) 'Supplying emergency contraception via community pharmacies in the UK: reflections on the experience of users and providers' *Social Science and Medicine* 57: 2367-2378

The belief was expressed in the focus groups that people under the age of sixteen should not be having sex, and that having sex at a young age was linked to a changing culture of children growing up quickly and drinking at a young age. These participants felt so strongly about this that they said they would not supply EHC to a person under the age of sixteen.

> *"[A]t that age they should be playing with toys not doing adult things. [They should be playing] Scrabble or going to a little disco thing, or doing some Quasar shooting aliens, you know ... I think you begin to see the wider picture and you can, I don't know, it just becomes a bit more, it becomes a bit more of a moral issue, I think, because you read, you watch the news about all these infections, one in seven, you know, education, young kids drinking."*
>
> *Pharm2*

> *"If we don't encourage this kind of behaviour maybe less of this will happen,[but] maybe more will go underground."*
>
> *Pharm4*

Pharm4 expresses some uncertainty in what might happen if pharmacists did not supply EHC to girls under the age of sixteen; she is unsure whether fewer girls will request EHC through the pharmacist, or whether post-coitus contraception or abortive means will be available 'underground' instead. Pharm4 clearly expresses that she draws a link between the availability of EHC through pharmacists and 'encouraging this kind of behaviour', which I take to mean underage sex. That Pharm4 regards that in making a treatment

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and Bissell, P.; Savage, I. & Anderson, C. (2006) 'A qualitative study of pharmacists' perspectives on the supply of emergency hormonal contraception via patient group direction in the UK' *Contraception* 73; 3: 265-270 and Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham p162

available for supply a pharmacist is encouraging anything at all is noteworthy in terms of the pharmacist's position, real or otherwise, as a role-model or as someone who approves or disapproves of certain behaviours. The question of whether to supply EHC to a girl under the age of sixteen was seen as becoming 'a bit more of a moral issue' given the perceived rise of unruly behaviour of young people. Pharm2 was allowing her understanding of the social context of teenage behaviour to influence her decision over supply of EHC. Another presumption that came to light during discussion of EHC was that the supply of EHC would encourage underage sex. The following exchange reveals that such prejudice is not an isolated case.

> *"I just think if it promotes, or not promotes, but encourages things, allows these things to happen then younger children think, well, we can easily go to the pharmacy and get something like that and therefore I think it just sort of encourages this kind of behaviour.... [C]hildren [should] be children for a longer period of time, but that's just me."*
>
> *Pharm4*

> *"No, it's not just you. [Laughs]"*
>
> *Pharm3*

In light of the whole conversation and the views Pharm3 expressed throughout the course of the focus group, and the way in which he said, 'No, it's not just you', it was clear that Pharm3 was implying that these values were widespread among pharmacists in relation to the supply of EHC.

There was also evidence of unjustified value judgements being made about people who use an oral contraceptive pill or antibiotics to treat sexually transmitted infections. For

example, when presented with the 'Found Tablet' vignette, some participants responded by saying they would not want to disclose the information if the tablet was a contraceptive or an antibiotic. One pre-registration student said she thought that, in the instance of the tablet belonging to the enquirer's daughter, it would be acceptable to identify the tablet if it was a painkiller, because in that case the daughter had not necessarily had sex, and so had not done anything morally wrong.

> *"[If it's an aspirin] she hasn't really done anything wrong."*
>
> *Pre-reg2*

Prejudices are a form of personal opinion and judgement, and participants overwhelmingly regarded ethics as being a matter of personal opinion and judgement. Since participants on the whole believed personal opinion was the basis of moral decision-making, it is possible that prejudice will influence decisions. As is evident from participants' discussion of the supply of EHC, some unsupported presumptions did sometimes drive decision-making. In a study conducted by Hibbert, Rees and Smith pharmacists showed awareness of their prejudices against some patients, admitting sometimes to tell drug addicts that they would have to 'order in' certain medicines when in fact this was not the case.[45]

[45] Hibbert, D.; Rees. J. A. & Smith, I. (2000) 'Ethical awareness of community pharmacists' *The International Journal of Pharmacy Practice* 8: 82-87

3.2.6 Summary of 'Perception of what ethics is'

On the whole, participants took a common-sense approach to ethics. To them, ethics meant two things: (i) regulation and (ii) subjective and/ or relative morality. Whether the first interpretation of ethics is correct is a question of definition and semantics. Whether the second is correct is open to philosophical debate. Certainly, participants' understanding of ethics as subjective and /or relative appeared to lack sophistication of philosophical relativism and subjectivism; participants did not give reasons for their position, rather it seemed to be a straightforward belief. There was little evidence of participants having challenged or questioned their ideas about it.

3.3 Pharmacists and rules

The theme 'rules' was a prominent subject in the focus group discussions, with participants understanding an ethical problem as one in which ethics came into conflict with the law. Other studies confirm that pharmacists are concerned about the rules of the profession and the law.[46] There are many possible explanations for the law playing a dominant role in the focus group discussions, including the following three: the fact that four of the vignettes used involved a legal component; the common partnering of the words 'law' and 'ethics' in pharmacy literature and education programmes; and the fact that pharmacists are held responsible for their practices and are subject to strict disciplinary procedures if they are in breach of the regulations. Acting morally may sometimes require pharmacists to act

[46] Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham; Hibbert, D.; Rees. J. A. & Smith, I. (2000) 'Ethical Awareness of Community Pharmacists' *The International Journal of Pharmacy Practice* 8: 82-87 and Benson, A.; Cribb, A. & Barber, N. (2007) *Respect for Medicines and Respect for People: Mapping pharmacist practitioners' perceptions and experiences of ethics and values* (London: Royal Pharmaceutical Society of Great Britain)

contrary to the law and guidelines. Making the decision to do so requires judgement of individual situations. Data from the focus groups reveal some of the factors that came into consideration when making such decisions. Overwhelmingly, the reported factors in favour of breaking the rules were ethical in nature. The motivations given for abiding by the rules were mostly amoral, even when there were arguably moral reasons for breaking those rules.

The data suggest participants were comfortable with rules, and were keen to act in accordance with them. Rules would be broken if the patient's interests conflicted with the rules and were regarded by the individual pharmacist as sufficiently strong to weigh more heavily than the unfavourable consequences of breaking the rule. The data show varying judgements of the point at which a patient's interests were sufficiently great to motivate breaking a rule, and varying judgements of the point at which rules were sufficiently strict to act as a disincentive for acting in the patient's best interests.

Pharmacists are subject to rules of law and rules within the RPSGB Code of Ethics. Participants talked of keeping within rules and of breaking rules, and the discussion to follow will deal with these in turn. Participants had different reasons for abiding by the rules. One motivation to obey the rules was a fear of getting into trouble. Another reason for acting in accordance with rules was out of respect for the purpose of rules within a profession and society.

In terms of breaking rules, no pharmacist revealed any sign of fraud, or a desire to break rules for the sake of it, but instead mostly reported acting against the law for the sake of the patient. There were two exceptions to this. One was a case in which a pharmacist reported being put under pressure by the GP to issue medication without prescription.

"[T]he doctor rang me and he was actually begging me over the phone, being, you know, really unnice [sic]...[He asked me], the doctor himself. What do you do? So you know, I had to agree to dispense it."[47]

Pharm2

The second exception was one participant's comment that, for the sake of business, pharmacists sometimes broke rules and dispensed from prescriptions that are not signed.

"We're professionals but we're also businessmen. Put it that way."

Pharm1

This quotation reveals the participant's awareness of the conflict between professionalism and the drive to make money. Hibbert, Rees and Smith reported that community pharmacists found some ethical dilemmas were created by a conflict between business considerations and professional responsibilities.[48] Similarly, Cooper found some community pharmacists felt a conflict between the pressure to sell goods, best clinical practice, and the patient's independent choice.[49] As will become clear in the discussion, participants were anxious not to do anything that would jeopardise their licences. This provokes important philosophical questions about the boundaries of professionalism.

How participants understood their relationship with rules varied between individuals. All participants expressed a willingness and history of breaking the rules for the sake of the patient, but there was disagreement over which circumstances justified

[47] Dispensing medication without a prescription, but under the agreement of a doctor, is not illegal. However, it seems that in this instance Pharm2 believed it to be against the guidelines.
[48] Hibbert, D.; Rees. J. A. & Smith, I. Op. cit. p85
[49] Cooper, R. op. cit. p156-157

breaking the rules. There were three ways in which participants reported themselves to behave when faced with an ethical problem that involved rules. They can be classed as: following rules in a considered manner; breaking rules; and obeying rules to avoid getting into trouble.

3.3.1 Following rules in a considered manner

Acting in accordance with the rules was expressed by some participants in terms of respecting the reasons behind the rules. It was clear that in some cases rules were being followed for considered reasons, rather than just for the sake of it. The following quotation is one participant's explanation of why he would not supply EHC to a girl who was underage, which is that he believed he had no right to go against the product licence.

> *"I would be breaking the product licence and I haven't got the right to break the product licence."*
>
> *Pharm1*

This same participant explained that his respect for the rules was a respect for the foundation of the rules and the process by which the rules were formed. Here, he is talking about dispensing EHC under a Patient Group Direction[50] to a twelve-year-old-girl.

[50] "Patient Group Directions (PGDs) are documents which make it legal for medicines to be provided to groups of patients - for example emergency contraceptive - without individual prescriptions having to be written for each patient. PGDs are authorised by health authorities and NHS Trusts, and are only available in certain areas." http://www.nhs.uk/England/Pharmacies/Pgd.cmsx visited 21/07/06

"[I]f you've got a PGD [Patient Group Direction] then there's an ethical way that you can supply it [EHC] and that ethical way has been sorted out by a group of experts and you've taken part in the decision process that you are going to do it."

Pharm1

The participant had faith that the policies in place would be ethical because a group of experts, along with input from pharmacists, had decided them.

Rules were also respected as making up a system that ensured consistency in the profession. When asked about the RPSGB's Code of Ethics, there was appreciation among pharmacists that the Code provided a professional standard:

"I suppose there ... will need to be some kind of guidance, rigid guidance, because otherwise everyone would deviate all over the place."

Pharm4

The quotation suggests an appreciation of the role of consistency in the profession. It is not clear what this participant would think would be wrong with deviation. The data on obeying rules to avoid getting into trouble offer insight into how varied pharmacists' views on this are, and the data about breaking rules offer some insight into what might motivate a pharmacist to deviate from the rules.

3.3.2 Breaking rules

As already mentioned, with two exceptions, participants talked only of breaking the rules in the interests of the patient. Making the professional judgement to break the rules is an exercise of professional autonomy. As will become clear with the presentation of the data, deciding to break the rules was, for these participants, a case of weighing up the patient's interests with the possible consequences to the pharmacist if caught breaking the rules. This is captured nicely in the following quotation about making a decision about whether to supply a controlled drug to a needy patient when it would have been illegal to do so:

> *"You've got to weigh it up... the ramifications if you do and if you don't."*
>
> *Pharm3*

The kinds of ramifications mentioned were to do with patient welfare and being disciplined by the RPSGB and/ or the criminal justice system. The motivations for obeying the rules will be examined in section 3.3.3 'Obeying rules to avoid getting into trouble'. This current section examines the motivations for breaking the rules.

Motivation for breaking rules was mostly patient-orientated. For example, this participant talks of being flexible with the rules when a prescription is made out for a specific brand of medication the pharmacist does not have.

> *"Give her [the patient] an alternative brand at least. ... Sometimes you just have to be a bit more flexible. You can't be that rigid, obviously, you have to think about the patient as well."*
>
> *Pharm2*

The reasons the participant gives for dispensing a different brand to the one prescribed were for the benefit of the patient. Similarly, an example was given of breaking the rules to supply medication without a prescription to a patient who had run out of her medicine.[51]

> *"[It] is, strictly speaking, illegal. But we'll do it."*
>
> *Pharm7*

This willingness to break the rules was common (the controversy occurred in discussion about when the rules should be broken). When talking about the RPSGB Code of Ethics, one pharmacist commented on the liberal interpretation he gave to the guidelines in some cases.

> *"...sometimes you've got to be a bit more rubbery about the way you apply [the rules]."*
>
> *Pharm3*

Participants spoke of rule breaking as the responsible thing to do in some cases, recognising the importance of professional autonomy, which was also framed in terms of professional judgement.

> *"[There have been] certain situations where we've had to bend the law. You're sort of making your own professional judgement to that case."*
>
> *Pharm2*

[51] Pharmacists can make emergency supplies of a previously prescribed medicine at the request of patients. However, correspondence in the *Pharmaceutical Journal* (2006 Letters to the editor 277; 7414: 219) suggests that there are quite widely varying interpretations of what constitutes an 'emergency'.

"[When a patient needs medication but the prescription is completed incorrectly and patient is] pretty desperate for it ... it does put you in that kind of a situation for where you have got to use your professional judgement to over-rule the guidelines and laws."

Pharm2

For this participant, professional judgement was needed for knowing in which situations it would be right to act against the rules and there were cases in which breaking the rules was seen as the professionally responsible thing to do.

3.3.3 Obeying rules to avoid getting into trouble

Obeying rules was the default position for participants; they needed good reason to break the rules. The two identified disincentives for breaking the rules were: a respect for the rules *as rules*, which was discussed in section 3.3.1, and to avoid getting into trouble. As discussed in the previous section, the most reported motivation for breaking rules was to look after the patient's best interests. Opinions on whether rules should be broken in particular circumstances varied according to how much respective weight pharmacists gave to the interests of the patient and the risk of getting into trouble for breaking the rules. These findings largely agree with those from interviews carried out by Benson. Benson's research found that for pharmacists the "default assumption is one of adherence to rules. However there is also a strong value attached to the exercise of professional and personal agency, commonly justified on the paternalistic grounds of being *in the patient's best interests*. That is, 'rules' are broken on the grounds of an individual's professional

judgement about harms/ benefits in relation to *the patient's best interests.*"[52] In Benson's interviews community pharmacists also "raised concerns about being reported to the RPSGB where the 'rules' had been broken, especially for infringements of the law and/or professional code of ethics...some hospital pharmacists referred to the potential for litigation."[53]

When discussing ethics, pharmacists used language indicative of obeying rules. In addition, in some cases participants acted in accordance with the rules through a lack of recognition of the ethical dimensions of a problem. For example, in place of considering problems as ethical ones, pharmacists at times acted in accordance with the rules without giving reason other than the fact that a rule applied. This quotation comes from responses to the 'Found Tablet' vignette.

> *"you can't tell them [the father] at all."*
>
> *Pharm2*

The phrase 'not allowed' was used fairly often throughout the focus groups. As an example, this quotation comes from a response to the EHC vignette.

> *"We're not allowed. Under product licence we're not allowed to supply it."*
>
> *Pharm1*

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[52] Benson, A.; Cribb, A. & Barber, N. (2007) *Respect for Medicines and Respect for People: Mapping pharmacist practitioners' perceptions and experiences of ethics and values* (London: Royal Pharmaceutical Society of Great Britain) p7

[53] Ibid. p15

The use of the phrase 'not allowed' may indicate that in some cases rule following is regarded as obedience to rules. Obedience to rules also accompanied ethical reasons for doing something. Again, this response was to the 'Found Tablet' vignette:

> *"Well, it's patient confidentiality, isn't it? I would go to the records to see if the patient is one of my patients and if I had dispensed it... You can't tell them [the father] because of the Data Protection Act."*
>
> *Pharm3*

One of the reasons Pharm3 gave for not identifying the tablet is that, if the patient were her patient, she would be bound by the Data Protection Act.[54]

One of the motivations for pharmacists acting in accordance with the rules was to avoid getting into trouble. For example, when asked whether a pharmacist should supply a controlled drug to a patient without prescription, this participant was concerned about police involvement:

> *"What do the police do? Come in and look and go through [your records]?"*
>
> *Pharm2*

The theme of getting into trouble ran throughout discussion of ethics and decision-making, and the threat of the pharmacy inspectors seemed to linger behind many decisions.

[54] Note that this participant answered a simplified version of the vignette. If the daughter was not a patient of the pharmacist, or if the pharmacist did not know for certain whether she was, it is unlikely the Data Protection Act would apply. The Data Protection Act does not state obligations of confidentiality towards patients whose recorded information a pharmacist does not have. Further, it is not certain whether a moral principle of confidentiality would apply. The philosophical 'confidential information versus public information debate' is outlined later in this thesis.

One story of breaking the rules in extreme circumstances was muttered beneath the sensitivity of the recording equipment, perhaps from fear of creating evidence that could be used in a case against the participant.[55] The following quotations are samples of participants speaking about the need to obey rules to avoid getting into trouble. There is no ethical dimension to the reasons given:

> *"You have to be careful...I heard from someone, probably through the grapevine, about a doctor prescribing [hydrocortisone cream] for a baby, for the face. The skin peeled off and I think the doctor got into trouble for it."*
>
> *Pharm2*

Speaking generally, one participant said:

> *"It's licences. You just can't go beyond that judgement, you know, it's just asking for trouble."*
>
> *Pharm3*

This participant gave her reasons for not disclosing confidential information:

> *"You can't tell them [an enquirer] at all; you can get into trouble for that."*
>
> *Pharm2*

[55] The outline of the story was recorded in written notes only.

When discussing whether to supply EHC outside the Patient Group Direction, one pharmacist showed his concern for being caught out by the consumer advocacy group, Which:

> *"I would be breaking the product licences and I haven't got the right to break the product licence and I know that sounds really harsh but I think there's been some Which thing that they've gone around pharmacies."*
>
> *Pharm1*

This is a reference to Which studies involving several 'mystery shopper' visits to pharmacies to check whether pharmacists met their professional body's standards in relation to sales and advice on over-the-counter medicines.[56] These reports were controversial and have had far-reaching effects in that some pharmacists expect that any customer could be a mystery shopper from Which.

A pre-registration student was worried she might bring the profession into disrepute if she supplied EHC to someone who was under age who had an adverse reaction to it.

> *"[Y]ou're breaking the law you're putting your own profession at stake cause if she has a bad reaction to it or something or if her mum finds out she can sue you for, you know, selling something that... she's under age for."*
>
> *Pre-reg2*

[56]Which? (2004) *Which Report: Pharmacists* http://www.which.co.uk

All of these extracts show how worried the participants were about getting into trouble, rather than being concerned about doing the morally right thing. Pre-reg2 also had a concern for the profession's reputation and potentially letting down the profession. This contrasts with the attitude expressed by some (and sometimes the same) participants who were conscious of their professional moral responsibilities to sometimes break the rules for the sake of the patient.

Although rule-breaking and rule-obeying was often a case of measuring the consequences of being caught breaking the law against the best interests of the patient, some rules were considered unbreakable. One of the participants spoke of a situation he had found himself in, in which a pregnant woman was in need of methadone but did not have a valid prescription. The pharmacy was closing and the doctor's surgery was shut, and the pharmacist made the decision to make the supply, explaining, "It's not something that I did lightly" (Pharm3). The situation described was extreme, and the consequences for the patient if she did not receive methadone from the pharmacist were potentially very grave: the patient may have resorted to finding heroin from the streets, through possibly dangerous means, and may have been supplied with impure drugs, which may have put her and her unborn child in danger. After explaining that he had made the supply, the participant was met with disagreement from a fellow participant:

> *"I'd have let that go!"*
>
> *Pharm2*

> *"Every time I see CD [controlled drug] I just think I've just met up with the CD inspector and he ... has been in the job for ages and he is a policeman ... and has taken two pharmacists*

from the area where I am working to, he has shut two pharmacies down this year already and has taken five pharmacists to court for the company I work for. ... CD is such a serious issue and that's when you mentioned about CDs I just thought, I'm not sure whether I would do anything of that sort."

Pharm2

The reaction from Pharm2 was that she understood the predicament of Pharm3, insisting during the discussion that she appreciated his reasons, but considered the law surrounding the supply of controlled drugs to be so strict that she would not break it, even under circumstances in which the patient's welfare arguably relied so heavily upon a supply. In the light of the Shipman case, in which GP Dr Shipman murdered many of his patients with controlled drugs, the resulting changes in practice guidance may have made some professionals less likely to override the law because of patient interests. The Shipman case was mentioned during the focus groups in such a way as to suggest it was a well-discussed worry. In this particular instance, Pharm4 was referring to the 'self-prescribing doctor' vignette.

"It depends on what it is, if it's a CD or something like that...then the Shipman case, and blah, blah, blah."

Pharm4

Even with the shadow of the RPSGB inspector falling on every decision, the threat of the inspector and the police is not always enough to prevent rule-breaking and

participants said that at times they would break the rules even at the risk of getting into trouble:

> *"[As I was doing it] I just thought I'm not really supposed to do this because I could get into trouble if an inspector comes in because you should really write that out properly."*
>
> *Pharm2*

In this case the pharmacist was breaking the rules because she was being put under pressure to do so by the GP. There was no mention of the interests of the patient.

Making a decision to act in accordance with the rules or break them requires judgement on a case-by-case basis. It was generally regarded by participants that breaking the rules would be acceptable to the RPSGB if doing so could be justified.

3.3.4 Justification for breaking the rules

Justifying breaking the rules was often framed by participants in terms of acting professionally. As professionals, pharmacists use their judgements in individual cases where guidelines do not exist, or are regarded as inappropriate. This participant is explicit that being able to judge when to act independently is one of the roles of a professional:

> *"I suppose in a way we're professionals because then we can, we make our judgements, I mean if you are not then, you ... just all play by one rule."*
>
> *Pharm4*

It is interesting to see this point made by Pharm4 in relation to the view she expressed previously that the Code of Ethics existed to prevent deviation of behaviour (see section 3.3.1). The two views are not incompatible, but highlight the tensions within the concept of professionalism. When it came to deviating from the rules participants placed emphasis on the importance of being able to justify the decisions they had made. The following quotations come from a discussion about whether it would be acceptable to supply medication without a prescription:

> *"The whole problem is justification, if you can actually justify your stance, it's just in my professional decision."*
>
> *Pharm1*

> *"I could just say 'Oh, I know it's against the law but that's due to this reason I believed I had to.'"*
>
> *Pharm2*

These quotations suggest participants saw their professional autonomy as sitting higher than the law or rules. The participants did not mention how they would judge whether their reasons for going against the rules and guidelines were sound. Rather, they usually talked of justifying their judgements by giving simply *a reason*, rather than by giving a *reasoned argument* as to why their actions were suitable. This might seem more like opinion-giving than argument-forming. This quotation, taken from a discussion about supplying controlled drugs without prescription, illustrates the lack of objectivity involved in justifying an action:

"[Y]ou can just say, 'It was my professional judgement and I thought in this situation...' 'Cause I'm training someone in the dispensary at the moment ... and I've read there's guidelines and rules but you can use your professional judgement to kind of bypass it and say... I thought, you know, I believe for these reasons why I did it and that was just due to my judgement that I made this decision and that's why I done it.'"

Pharm2

Again, there is a sense in which ethics and professional judgement are instrumental. This attitude was not true of all participants, and Pharm1 explained that he believed the judgement must be defendable objectively.

"I think as long as you are aware that you're making your decision and you have to be able to justify it in case it needs to be judged at some point, because you could be justifying something that was completely wrong but you didn't realise was wrong and you could still think, 'Oh, well I've justified it, so it's OK.' But it's not always even the right decision."

Pharm1

According to Pharm1, self-awareness and assessment of the rationale of the reasons for doing something should lead to sound decision-making.

3.3.5 Summary of 'Pharmacists and rules'

The prominence of rules as a topic in the focus groups is a good indication of how pre-occupied participants were with rules. Ethics and the law were closely associated, and an ethical problem was seen as one in which ethics conflicted with the rules. Participants were willing to break rules, overwhelmingly for the sake of the patient, but following the rules was the default position, and one that some participants stuck to quite firmly.

The following section looks more closely at participants' understanding of the ethical concepts brought up in the focus groups and illustrates the extent to which participants were engaged with practical ethics.

3.4. Key ethical notions

The purpose of this section is to build up a picture of how participants understood certain ethical concepts. Data show a degree of confusion over the use of some terms, and discussion often lacked depth and breadth, but on the whole participants had a good grasp of specific dimensions of ethical problems. Only those ethical notions that arose naturally during discussion feature here in a systematic description and analysis of what participants said about individual patient interests, public interests, confidentiality, public information, and rights and obligations in turn.

3.4.1. Individual patients' interests [57]

The RPSGB's standards at the time these focus groups were carried out required that pharmacy practice was patient-centred, with the Code of Ethics emphasising that at "all times pharmacists must act in the interests of patients."[58] The subject of the patient's best interests was mentioned several times during each focus group discussion, with the phrase 'patient's best interests' used by participants to mean the interests of an individual patient as opposed to a collective group. Participants spoke of patients' interests as if acting in the patients' best interest ranked as the highest principle, though there are data to show participants did not in fact regard this principle as highly as they sometimes claimed.

> *"[I]t's all a case of weighing up what you think's best for the patient."*
>
> *?*

The above quotation may be an expression of an ideal that could exist without external pressures. Other reports from participants showed that a patient's interests were regarded as important, but not always as the priority. The three factors that competed with an individual patient's interests were interests of the pharmacist (commercial and whether they would be struck off), other patients' conflicting interests, and legal obligations. In some incidents in which the best interests of the patient came into conflict with the law pharmacists were prepared to act illegally. In fact, interests of the patient were by far the

[57] The following discussion is about instances in which participants believed they were or were not acting in the patients' best interests. Whether the participants' actions would in fact have been in the patients' best interests is not discussed here. For example, a participant who refuses to supply hydrocortisone cream for use on the face may believe she is acting in the patient's best interests. Whether in fact she is is a separate question.

[58] Royal Pharmaceutical Society of Great Britain (2005) *Medicines, Ethics and Practice: A Guide For Pharmacists* (London: Pharmaceutical Press) p85

most common reasons participants gave for breaking the law, though it is important to note that often the law was given grater priority.

The following quotations illustrate the fact that participants weighed up the interests of patients with the pressure to act within the law.

> *"But with somebody who is terminally ill then you don't want them screaming out with pain just because you are being bloody minded about not giving them a prescription [because it has been completed incorrectly]."*
>
> *Pharm1*

> *[On dispensing medication without a prescription:] "[You do] what's best, I mean what you consider [is best] for the patient. I mean obviously if it's sleeping tablets you might play it a bit differently. But, you know, if it's your water tablet that they've been on for donkey's years, then... [you give] them two tablets, you know, to tide them over 'til their prescription comes in."*
>
> *?*

The quotations above demonstrate that participants were willing to break the law for the sake of the patient. The second example given is of a fairly minor breach of the law, though as is seen in the first example (which is to dispense a controlled drug from an unsigned prescription) and in section 3.3.2, participants were sometimes willing to break more serious laws when in the patient's best interests.

Patients' best interests extended to the long-term social interests of the patient. The quotation below, which is a response to the 'EHC' vignette, illustrates the need pharmacists might feel to break the law for the sake of the broad interests of the patient. Although it is not evident from the quotation, Pre-reg1 was talking about doing something she knew would be illegal and was considering the long-term effects of teenage pregnancy for the individual in light of the fact that it would be illegal to supply EHC in these circumstances.

> *"I think I probably would supply it to the twelve-year-old because from my point of view what I probably think the consequences of her getting pregnant at twelve and what effect that is gonna have on the rest of her life and the whole cycle, you know. Twelve: what can you provide for a child at twelve years old? And I think I would supply it but I would educate her very strongly about the consequences... I think in this case I [would] probably be thinking more of the fact that having a baby at twelve, that risk of her getting pregnant at twelve."*
>
> *Pre-reg1*

This quotation shows how the participant was considering competing demands of the law and the welfare of the patient to decide that she would act in favour of what she considered to be the best interests of the patient in these particular circumstances.

In many instances, particularly when breaking the law would be a serious offence, participants did not always give priority to the best interests of the patient. The first of these quotations comes in response to the 'EHC' vignette. Clearly, the interests of the patient does not feature, just the fact that it would be illegal to supply EHC to a girl under sixteen without a prescription and outside a Patient Group Direction.

"Well if she gets pregnant though, I guess that's not really my problem I guess. It's horrible, cause you'd be breaking the law."

Pre-reg 3

Speaking more generally,

"It's often a compromise ... you know, the law, what's best for the patient, what's best for you."

?

This suggests that the law and the interests of the pharmacist can sometimes take precedence over the interests of the patient. Further evidence that the law is a powerful force for participants to act in ways that are not in the patient's best interest was given in section 3.3.3.

While legal obligation provided the single most obvious reason to act against an individual patient's best interests, the conflicting interests of other patients also came up in discussion, but only once. The participant was talking about how a methadone treatment programme might affect other customers.

"[Y]ou're duty bound really to help that person [patient on methadone treatment] in the best way you can but at the same time you've got other customers that might be uncomfortable with it [dispensing of methadone] or whatever."

Pre-reg2

There are two possible interpretations of this comment. One is that the participant was referring to other patients as other 'customers' and was purely concerned about their interests. The second interpretation in that the participant was referring to the fact that customers might be put off using the pharmacy if they are uncomfortable with the methadone treatment programme and the pharmacist might lose business as a result. Research has shown that community pharmacists who have not provided methadone treatment programmes tended to have negative attitudes towards services for drug misusers.[59]

There is reason to suggest that decisions made in pharmacy practice might be made under influence of business aims and at the expense of the patient's interests. This participant suggested commercial pressure in community pharmacy might cause pharmacists to make patients a lower priority than in a hospital setting, though it must be noted that this is an observation or supposition on the part of Pre-reg2, rather than an account of her own direct experience.

> *"[In hospital pharmacy] the patient is the number one priority whereas in community, ... there's a fine line between patient care and then, like, business orientation."*
>
> *Pre-reg2*

On the whole, patient interests were regarded highly but, as is shown in comments such as problem-solving being about finding a compromise between the law, patient interests and self interest, the aim of acting in the best interests of the patient was not unconditional. Often, patient interests were given a lower priority than legal obligations and the interests

[59] Matheson, C.; Bond, C. M. & Mollison, J. (1999) 'Attitudinal factors associated with community pharmacists' involvement in services for drug misusers' *Addiction* 94; 9: 1349-1359

of the pharmacist. How highly a participant ranked patient interests varied between individuals. As was seen in section 3.3, some participants were willing to break serious laws (for example those surrounding the supply of controlled drugs) for the sake of the patient, while others set the boundaries lower. This was dependent on two factors: how much regard the individual had for the law, and how much regard she had for the patient's interests. It is difficult to make a judgement on this, but what is certain is that participants weighed the seriousness of the law against the interests of the patient, although they reached different conclusions.

3.4.2 Public interests

As mentioned at the beginning of the previous section, 'patients' interests' was seen by participants to mean individual patients' interests. A distinction can be made between the interest of the patient and the interests of the public in two ways. First, the public interests may include the interests of individuals who are not patients. Second, public interest is collective, while patient interests can be individual.

Concern for public interests was not a strong theme in the focus group discussions, but the subject did arise in relation to National Health Service (NHS) resources in the following ways. When asked about the 'Self-prescribing Doctor' vignette, in which a doctor is self-prescribing medication the pharmacist strongly suspects she is abusing, participants said it depended on whether the prescriptions were private or from the NHS. There was a sense in which participants felt they had a duty to report repeated self-prescribing if it was at the expense of the NHS, presumably because NHS funds are intended for the use of the public, justly allocated and endorsed through policy. This

participant was commenting on a situation she had been in, in which a doctor had been self-prescribing medication the participant suspected she was addicted to.

> *"[If] she starts prescribing from hospitals she's actually using the hospital's facilities and rather than going to her own GP for it, and after about three months I think I wasn't happy with it anymore. ...[This] person was abusing the NHS system in a sense, you know, because I just think that whatever you want you shouldn't be abusing the NHS system by doing your own thing."*
>
> *Pharm4*

Speaking in response to the 'Self-prescribing Doctor' vignette:

> *"If it was NHS I wouldn't [dispense something self-prescribed], obviously, but if it's private then, it's private, in't it? ... I don't see anything wrong with it 'cos it's, you're [the self-prescribing doctor] paying for that."*
>
> *Pharm2*

Participants also said they would be more reluctant to substitute a named brand of medication for the same medication of a different brand if the prescription was NHS than if it was private.

> *"I wouldn't do that [substitute a named brand of medication for the same medication of a different brand] with NHS prescription but privates I do and if it is brand or generic then I can actually discuss that with them. I'm a bit more flexible with privates but NHS-wise, I think*

that maybe in London you've got more stores open around as well, phone around, but I'd be more reluctant if it's NHS prescription to do what you do [substitute a named brand of medication for the same medication of a different brand]."

Pharm4

The factor influencing this decision seems to be that there are wider public interests tied up with the NHS than with private prescriptions, and participants felt a moral obligation to act in the interests of the public.

Pharmacists' contracts are with the NHS, and a possible interpretation of the data is that pharmacists understood the terms of their contract literally and were less likely to be flexible with NHS prescriptions as a result. Since pharmacists do not have the same contractual obligations with private prescriptions, they may have been more willing to enter discussions with the patient about what can be dispensed from the prescription. This interpretation of participants' eagerness to follow the prescription tallies with the findings that participants were, in many circumstances, dedicated to the law.

3.4.3 Confidentiality

'Confidentiality' was a term participants seemed comfortable using and mostly the term was appropriately applied. However, understanding of the term was not very rich. Although the ethical dimensions of confidentiality were recognised by some participants, and it was appropriately applied at times, there were occasions when the moral dimensions of the notion were lost in favour of the regulatory demands for confidentiality, and there

were cases in which confidentiality was overlooked entirely. Further, the blurry conceptual boundaries of confidentiality seemed to cause problems for participants when trying to see the difference between confidential information and public information.

Understanding confidentiality as a professional obligation, or a rule to be followed, rather than as a moral obligation was common. This is illustrated in the following quotation, in which a participant said she would keep patient confidentiality because she had been specifically told (presumably by the professional body or in the education programme) to respect patient confidentiality.

> *"We're specifically told that you know you shouldn't break [the] patient's confidentiality."*
>
> *Pre-reg1*

This drive for respecting confidentiality is a drive to act within the rules, rather than a drive to act ethically. This kind of response tallies with the findings of participants' pre-occupation with rules. Thinking about confidentiality as a rule rather than as an ethical principle is to miss the point, namely that a pharmacist ought to keep her promise that she will protect information about a patient that the patient wants kept secret. Stories from participants showed that the consequences of misunderstanding confidentiality in this way meant the principle was open to being breached. For example, when discussing the 'Found Tablet' vignette, participants recognised that confidentiality was one of the main principles at stake, and although they decided they would not disclose the information themselves, some said they would direct the father to a source of information that would identify the medication for him. This falls short of acting in order to preserve the confidentiality of the

patient, and in fact would cause the same effect on the patient as breaching confidentiality would.

> *"[T]hey usually tell you to refer to a drugs information helpline, don't they, 'cause they're good at identifying [drugs]."*
>
> *Pre-reg2*

When the participant quoted above was asked why she would refer the enquirer to the drugs information helpline, she replied that she believed the helpline employees would be allowed to divulge more information than a pharmacist would. Interestingly, a case could be made for the pharmacist in the 'Found Tablet' vignette being morally obliged to disclose information about the identity of the tablet, and such a decision could possibly be backed with reference to the RPSGB Code of Ethics as it was at the time the focus groups were conducted, which states that confidentiality may be breached "where necessary to prevent serious injury or damage to the health of the patient, a third party, or to public health".[60] However, Pre-reg3 did not appeal to an obligation of this sort, and in fact during the course of all the focus groups, no participant mentioned an obligation to breach confidentiality to prevent harm. Rather, confidentiality seemed to be breached unknowingly.

Confidentiality was being treated as a rule that had different applications with different professionals. The participant seemed to regard confidentiality as a rule that related to her and restricted her behaviour, rather than as a principle that related to moral values, including a respect for the fact that information about the patient is private.

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[60] Royal Pharmaceutical Society of Great Britain (2005) *Medicines, Ethics and Practice: A Guide For Pharmacists* (London: Pharmaceutical Press) p87

Confidentiality was not just seen in regulatory terms; participants talked about confidentiality using moral terms. The following exchange about the 'EHC' vignette illustrates this.

> *"[It] is an under age daughter having sex, I mean the parent will have the right to know, but the doctor may not want the parents to know."*
>
> *Pharm4*

> *..."But a parent's right to know isn't really your right to tell them."*
>
> *Pharm1*

These two opposing views, one focusing on the parents and the doctor, the other showing loyalty to patient confidentiality, are essentially about the conflict between the right to know and the right to confidentiality. Pharm1 favours confidentiality, and Pharm4 favours the parents' right to know.[61] Pharm1's point is that the pharmacist is not the person to be divulging the information about a patient. Even if it was the parent's right to know that their daughter was having sex and taking EHC, it was not necessarily the pharmacist's right to divulge this information. The participants are discussing the ethical dimensions of the case, and the role confidentiality plays as an ethical principle, rather than as a rule.

However, there was no consistency in this. Although the term 'confidentiality' seemed a familiar one among participants, and the data show participants discussing the obligations of confidentiality as an ethical principle, and also its presence as a rule in the Code of Ethics, there was also evidence of confidentiality being overlooked.

[61] As an aside, note that Pharm4 allows the doctor the ultimate decision over this. Although Pharm4 believes the parents ought to be informed of their daughter's treatment, her opinion is that the doctor's judgement ought to over-ride her own. This is possibly because she believes the doctor will have access to more information than she does as a pharmacist. It is also possible the doctor is seen by the pharmacist to carry more weight in these types of decisions.

Treating patient information as confidential was sometimes seen as optional, as if the pharmacist could make a judgement on whether confidentiality ought to be applicable. The main principle of confidentiality is to not disclose information about a person that that person wishes to be kept secret. This element of confidentiality was overlooked at times. For example, one participant's response to the 'HIV and Zidovudine' vignette (in which a mother of an HIV positive patient admitted to hospital with a chest infection asks what Zidovudine is for) was to either investigate the relationship between mother and daughter to gauge whether to disclose the information, or to divulge the information because the enquirer would be likely to find out eventually anyway.

> *"[In] theory its gonna be very difficult for her daughter to keep it from her for very long if she's got HIV anyway. ...*
>
> *I mean you could, ... in theory follow it up ... [If] you know there's a seventeen year old girl who's been admitted with a chest infection, who you know is HIV positive, if you know her name you could go and find out who her nurse is and see if she knows anything about the parent daughter relationship or, you know, the chest clinic or wherever she's been seen."*
>
> *Pre-reg2*

This participant considered the personal relationship between the patient and the enquirer to affect her decision about whether to disclose information about the patient. She did not consider that she would have a moral obligation to keep an agreement of confidentiality with the patient, but rather that she could disclose patient information at her discretion. In other words, the principle of confidentiality does not feature in the above extract.

Over the course of the focus groups, participants told stories of when they had unwittingly breached confidentiality. It was as if the discussion about confidentiality had made them look differently at past situations. As an example, this is a story told by one participant:

> *"[It] was probably about a year ago that [I received] an initialled prescription by this doctor. She was using the hospital's prescription and writing her own medication for some anti-depressants and I mean, initially it was just one month and then, after that, the dose was just increasing quite significantly, ... to about 60 mg. Normally you would take 20 mg, so [it had] just gone up very high and it was on a hospital prescription so she's prescribing for herself, handwritten on a green prescription, and I was doubting whether, you know, she was using it or abusing it...*
>
> *[After] about three months I think I wasn't happy with it anymore. I'm not sure whether I've done the right thing but [I] actually rang the hospital up and spoke to the chief pharmacist there and I didn't say what medication it was for, I just said, you know, there's somebody that's unofficially using, writing prescriptions, using all these in large quantities.... [They] weren't aware of it at all, so I don't know whether they would be tracked back to this person... She hasn't come back, so she must have sussed that out, that I'd said something, but I didn't know whether I was breaking the patient's confidentiality now, just thinking about it."*
>
> *Pharm4*

It was not until the focus group that the pharmacist realised she had not considered the confidentiality of the patient when she had reported the patient to the patient's employer. Although participants talked as if they regarded confidentiality highly, in practice it may have been far more difficult to recognise when the principle was applicable, and how best to reasonably keep it.

Participants at times took a very cautious approach to confidentiality, reporting to guard it closely, to the extent of suggesting that even saying that some information was confidential might arouse suspicion and break confidentiality to an extent. For example, when discussing the 'HIV and Zidovudine' vignette, participants were in part keen to keep details of the patient's medical history away from the enquirer, to the point of avoiding the question altogether and trying not to make her suspicious by even telling her the information is private:

> *"[I]f you say, 'Oh I'm not at liberty to say' or something she's gonna think, 'Ooh, there's something wrong there.'"*
>
> *Pre-reg2*[62]

Participants considered the best strategies for maintaining confidentiality, and were talking of treating it very seriously at times. Participants' approaches to confidential information about patients were very varied, and there was no consensus, despite it appearing initially to be a simple principle participants recognised. The concept is particularly difficult to apply in pharmacy practice because the accepted understanding of the type of information that is confidential is challenged by the unique situations pharmacists find themselves in.

[62] The discussion among the pre-registration group was exploratory in nature. Participants expressed different viewpoints to each other, offering gentle arguments against each other's points. Individuals sometimes changed their minds over the course of the discussion; as a result, some of the quotations from individuals appear to be contradictory.

Participants were conscious of this. When discussing whether to disclose patient information, participants often raised the point that some information about a patient is also publicly available general information. The following is an example of a pharmacist disclosing information about a patient as a result of disclosing publicly available general information:

> *"I've actually had somebody phone up, asking me what a particular tablet was for. [I told her]. But I was sorry afterwards, because it turned out that her husband was having an affair and had picked up an STD and... she saw the leaflet. I was sorry."*
>
> *Pharm3*

In this case, the pharmacist disclosed general information and in doing so disclosed information about an individual patient. Caution in favour of patient confidentiality might mean guarding general publicly available information. The following quotation relates to the vignette 'Found Tablet':

> *"[I]f he [the father] tells you, even if it wasn't over-the-counter, if he did specify that it is his daughter's thing you still shouldn't really say really, if he actually tells you, 'It is my daughter's' ... even though you blatantly know it's aspirin ... that [is] still breaking confidentiality isn't it?"*
>
> *Pre-reg1*

Loyalty to patient confidentiality in this kind of situation depends on at least two things: that even publicly available general information that happens to relate to an individual should not be disclosed; and that the pharmacist's judgement of whether the tablet is a

harmless over-the-counter medicine is irrelevant. This relates back to the discussion about value judgements and value-neutrality. If confidentiality is non-negotiable, then value-neutrality of the pharmacist is an essential component. Unlike Pre-reg2, who thought that factors such as the relationship between the patient and the enquirer affected whether confidentiality applied, Pre-reg1 regards confidentiality as an absolute principle and not subject to case-by-case judgement. Reaching this conclusion might require ethical judgement, but after that the principle is fixed.

Analysis of the data has shown that participants regard confidentiality as a regulation and as a moral principle. The need for confidentiality was not always recognised, and it was seen by some as a negotiable principle, which led to it being effectively disregarded. The application of confidentiality is not straightforward in pharmacy practice because information about a patient's treatment, and so possibly information about an individual patient, can also be publicly available information. The following section examines more closely participant's views about the problems surrounding publicly accessible information.

3.4.4. Public access to general information

The discussions that took place during the focus groups brought up the question of where the lines lie between public information, information attached to a particular patient, and public information that happens to be linked to an individual. Information that is classed as general information is not confidential, for example the role of the anti-viral drug Zidovudine. Information is confidential when it is associated with a particular patient, for example the fact that a patient is using Zidovudine and what that patient is using

Zidovudine for. This makes an enquiry about the identity of Zidovudine ambiguous. The enquirer may be asking a general question that happens to relate to an individual patient. Further, this information can be accessed from other sources. This predicament was recognised by the focus group participants, as is demonstrated in the following quotations:

> *"But surely if somebody wants to find out what it is they can easily tap into the Internet nowadays and find out exactly what they are."*
>
> *Pharm4*

> *[In reference to the 'HIV and Zidovudine' vignette] "But ... most times now people just go on the Internet and find out now."*
>
> *Pre-reg1*

The fact that some information is general information was seen as a practical barrier to keeping information about particular patients confidential.

> *[In reference to the 'Found Tablet' vignette] "The thing is ... [A]nyone could phone [the drugs information line]... at the end of the day and say, 'Oh you know, can you tell me what this is?' so I don't know, I don't know how, I'm not quite sure how this system works in that sense because the father - ok, even if it was a contraceptive - the father could phone and say, 'Oh I just found this tablet among my tablets, can you tell me what it is?', so I don't [know]."*
>
> *Pre-reg1*

The confusion this participant expressed over knowing what she ought to do is indicative of the complex nature of the problem, including the complication that the pharmacist may have a responsibility not to disclose the information even if that information could be found elsewhere. A consequence of this is that it is not clear how the guidelines would apply. The participant refers to patient confidentiality and patient access to public information as a 'system'. This participant's confusion is rooted in her not knowing how this particular situation fits into existing guidelines.

3.4.5 Obligations and rights

Mostly, rights and obligations were understood in two ways: first as legal and professional and, second, as ethical. This section looks at each in turn. Participants appeared to be confident in talking about rights and obligations in both contexts, although there was clumsy expression and some confusion over use of the terms, which is perhaps indicative of participants lacking familiarity with the concepts.

The following quotations reveal participants' sense of professional and legal obligations to report wrongdoings. In this case, participants were talking of reporting a doctor who was self-prescribing medication he or she was suspected of abusing.

> *"If there's a pattern ... then obviously you'd have to report it to the authorities, or to the company's pharmaceutical superintendent, or the inspectors, or the police, but I think you'd have to go through your own company [first]."*
>
> *Pharm2*

"I ought to report it to the authorities if I think somebody's abusing the system."

Pharm1

The obligation expressed is to follow the correct procedural route, and tallies with pharmacists' inclination to adhere to rules. Similarly, when pre-registration students were asked why they should not break confidentiality, the answers were put in terms of professional obligations not moral obligations.

"It's just your role; it's part of your role."

Pre-reg1

As discussed in section 3.3.1, legal obligations were not always seen as a matter of following procedure for procedure's sake. There was a sense in which the rules had been set for good reason, and to follow them was itself a moral obligation.

Participants talked of moral obligations and rights apart from any professional, legal or procedural obligation. In this particular instance, the participant recognises the patient's right to autonomy, with the pharmacist having an obligation to stay out of a patient's business to a certain extent. In this scenario a girl seemed to be lying about the circumstances under which she wanted EHC:

"I know we have, like, a gut feeling that actually they're not telling you the truth, but if they get the questions right, then you have no business to [refuse to supply the contraception]."

Pharm2

However, one participant believed she had a right to refuse to supply EHC to a girl she thought was lying about her circumstances.

> *"[You] have the moral right to say [to the patient you believe she is lying]."*
>
> *Pre-reg3*

Moral rights were also thought to apply to pharmacists. In the case of the patient lying about the circumstances in which she wanted EHC, Pre-reg3 seemed to believe the pharmacist also had rights, namely to reveal she believed the patient was lying. However, it is possible Pre-reg3 actually meant the pharmacist would have an *obligation* to reveal she believed the patient was lying. In earlier discussion, Pre-reg3 had confused the terms 'rights' with 'obligations'.

> *"[Y]ou still have a right to give them...the service [when a patient requests EHC but the pharmacist has a conscientious objection to supplying it]."*
>
> *Pre-reg3*

Here, 'right' is used in place of 'obligation'. In this instance, it seems obvious Pre-reg3 meant 'obligation' and was confusing her terms.

Participants recognised problems with conflicting rights and obligations. For example, there may be a moral obligation for the pharmacist to act in the patient's best interest even when this might come into conflict with the pharmacist's religious beliefs. Here, the participant was talking about the supply (or direction towards an alternative supply) of EHC.

"[You] have got a moral obligation to the patient but then your religious beliefs might be different."

Prereg2

This raises an interesting question about the extent to which a professional ought to put her personal convictions to one side. This is explored in greater detail in Chapter Six.

Talk of rights and obligations was at times confused. Participants used obligations to mean professional obligations as well as moral obligations, but did not speak as clearly about obligations in the moral context.

3.4.6. Competence of patient

Competence was seen by participants as measurable by the Gillick Competency Test and by common sense. Participants took a practical approach to assessing competency and did not see age as necessarily being the deciding factor. Competence of the patient was raised in relation to supplying EHC, since competence is one of the criteria for supply. Some participants were happy to supply EHC to girls under the age of consent as long as the patient was competent to make the decision.

"As long as they're ... competent."

Pharm3

"Or they're mentally capable, or if for some reason you feel ..."

Pharm2

"If they've got the balls to come and see me [then I'll make the supply]."

Pharm3

The approach to competence was commonsensical. As one participant observed, some adults who ask for EHC seem less competent than some of the girls who are under the age of sixteen.

> *"I've come across eighteen-year-olds who I don't think's competent, but they're eighteen, so, and I've come across really young who've, you know, got their heads screwed on."*
>
> *Pharm3*

Age was not the measure of competence, rather participants judged competence on the fact the patient had the initiative to go to the pharmacist and to what extent the patient seemed to be sensible. Not all accounts of competence were as commonsensical and there were signs that judgement of competence might have slid into judgements of character. One participant referred to competence as 'mental capability'. The following comment was made in response to the 'EHC' vignette.

> *"[I]t all depends on a lot of factors like if ... she thinks she's mentally capable I think a lot of it is, is whether you've got the attitude ... of a twelve-year-old...[If] she's twelve but, like, has got the attitude of a sixteen-year-old, [and] is quite in control of what she's doing ... and [is] prepared to take steps not to let happen again ... then maybe I would consider [supplying it]"*
>
> *Pre-reg2*

In the above quotation, the participant moved quickly from talking about mental capability to talking about the attitude of the patient. Although Pre-reg2 talks of the level of *maturity* of the attitude, which may be likened to levels of competence, assessment of attitude about intentions for future sexual activities is a far cry from assessment of competence. Indeed, the quotation suggests instead that the decision whether or not to supply will be subject to a value judgement about whether the intended future behaviour of the patient will be acceptable to the pharmacist.

While participants were generally comfortable with the term competence, there were signs that it was not clear to all participants exactly what it involved, which could have consequences for judgement of competence and decisions made about it.

3.4.7 Summary of 'Key ethical notions'

Analysis of the data has shown that participants are fairly comfortable using ethical terms, though sometimes the words are misapplied. There were one or two ethical concepts that were misunderstood and misapplied. Perhaps most notable was the misapplication (or non-application) of 'confidentiality'. Confidentiality is a key principle explained in the Code of Ethics, and yet participants' understanding and application of it were questionable. This may in part have been due to the awkward nature of confidentiality in practice, but the extent of the misunderstandings or disregard for confidentiality implied that the misuse was due to fundamental misunderstandings rather than the conceptual complexities of confidentiality.

3.5 Concluding remarks

These findings show that participants' understanding of ethics in pharmacy is based largely on commonsense, with participants referring to ethics as relative and subjective. The metaphoric language used by participants to describe ethics in the abstract illustrates their uncertainty over what ethics is. The word 'ethics' seemed to take on several meanings, being used sometimes to mean the Code of Ethics, sometimes regulation, sometimes morality, and sometimes a tool and justification to break the rules.

The frequent reference to rules in the focus groups was striking, particularly since it was made clear from the outset that the subject for discussion was ethics. While it might be expected that rules would be included in discussions about ethics, in these focus groups rules were so prominent it seems that rules and ethics were understood by participants to be very closely linked. This link was sometimes conceptual (e.g. understanding ethics as regulation), or practical (e.g. recognising that sometimes ethical obligations conflict with legal ones). Participants' association of law with ethics was so strong as to sometimes understand ethics as a relationship in which moral obligations conflict with legal obligations, rather than seeing an ethical dilemma as a problem in which two ethical obligations are in conflict.

Participants spoke of 'getting into trouble' for breaking rules, and this fear of being struck off acted as a strong disincentive for breaking the law. Even so, participants were willing to break the rules, usually for the sake of the patient. Mostly, such a decision was made by weighing the consequences of breaking the law against the interests of the patient. However, it seemed that when the consequences for breaking the law were perceived by the pharmacist as very grave, the patient's interests were given less consideration. For example, one participant said she would not consider supplying methadone outside the

legal requirements for prescriptions for a person misusing drugs, even under circumstances in which it would arguably be in the patient's best interest to do so, and when it would arguably be dangerous for the patient not to do so.[63] Participants did not mention any reason other than the law for not to make the supply of methadone in such circumstances, but it is possible that participants' responses to this particular situation could have been due in part to the fact that there may be other options available for the patient, for example Accident and Emergency (A&E) or Out of Hours Service (OOHS), and also partly because not supplying methadone in these circumstances is unlikely to be life-threatening. Such a decision would also have to be weighed against the likelihood of the patient actually going to A&E or OOHS rather than to a street dealer. One of participants of the Supplementary Prescribing focus groups explained how he had re-directed a patient to a hospital when the patient had demanded methadone without a prescription and had become threatening. In this case the pharmacist gave the patient money for the taxi fare to the hospital.

Having examined participants' understanding of particular ethical notions that are applicable to pharmacy ethics, it seems that although some terms were used with confidence there was only a basic, and non-reflective understanding of some of the key ethical notions of pharmacy practice. This was particularly notable in regard to confidentiality, with participants failing at times to recognise when it came into play, and sometimes missing the moral dimensions of confidentiality. Again, these broad findings are echoed in Benson's research, which shows that pharmacists have "Limited familiarity with ethical language and concepts (especially autonomy and justice)."[64] Although Benson and my findings are largely in agreement over the general point about familiarity with

[63] It is worth remembering that one participant told of how he supplied methadone illegally to a patient when it was considered to be in her best interests.

[64] Benson, A.; Cribb, A. & Barber, N. (2007) *Respect for Medicines and Respect for People: Mapping pharmacist practitioners' perceptions and experiences of ethics and values* (London: Royal Pharmaceutical Society of Great Britain) p2

ethical language and concepts, the focus groups I conducted highlighted confidentiality, rather than autonomy or justice, as the most confused concept that was brought up.

In all, the data from the focus groups revealed that participants adopted a commonsense approach to ethics, which did not involve a great deal of reflection or critical thought towards the subject. Evidence for this claim can be found in the level of understanding of key ethical notions, a pre-occupation with rules and participants' unsupported view of ethics as relative and/ or subjective.

Chapter Four: Quantitative data analysis

4.1 Overview

The previous chapter gave insight into pharmacists' perception of ethics, revealing participants' understanding of particular ethical concepts. The focus groups also fed into the design for a quantitative questionnaire, which was devised to discover how common some of the ethical problems in practice were, to answer the question of what most pharmacists decide to do (or what they would do) when they faced these problems, and what most pharmacists considered the most important factors when making such decisions.

The findings presented here are from the three questionnaires sent to community pharmacists, hospital pharmacists and primary care practice pharmacists. Results are presented in such a way as to answer the original aims of the quantitative empirical research. In addition, tests were run for statistical association between the sector pharmacists work in, the decisions they make and how important they regard certain factors when faced with an ethical problem. The discussion section of this chapter considers possible reasons for the results, including some discussion about how inter-professional relationships may affect decisions, and how the respective work settings of each sector might affect their exposure to, and handling of, certain ethical problems. The results will provide some basis for discussion in the concluding chapter of the thesis. As explained in Chapter 3, because of the low number of pharmacists working in the primary care sector, the number of questionnaires from primary care practice pharmacists was too small (15) to make reliable inferences.

Results show general agreement in regard to what pharmacists would do in certain situations within and across sectors. Test results indicate few differences in decision-

making between the sectors. There was mostly agreement, except when it came to reporting a colleague for unethical behaviour. Differences between sectors lay in how much consideration pharmacists gave to their own financial interests and the financial interests of the company, trust or hospital they worked for.

Explanations for the results relating to the scenario-based questions can only be speculated at this stage, and section 4.6 (Discussion) offers possible avenues of explanation, pointing out possible consistencies and inconsistencies between answers.

The respondent population was fairly representative of the national pharmacy population, with no statistically significant difference between the proportions of pharmacists from hospital, community and primary care practice between the respondent sample and the national pharmacy population. Details of the demographic makeup of the respondents are given in this chapter, with a breakdown of age, sex, year of qualification and, where applicable, the hospital pharmacy grade, hospital type, proportion of time spent with patients, community pharmacy ownership type, and community pharmacy position. Most of these data are then compared to the national pharmacy profile.

Appendix 1 includes the three questionnaires, which should be referred to for full details of the questions.

4.2 Response rate

The sample size was 552 and the number of returned questionnaires was 255. After taking into account the number of pharmacists who had retired, had changed address or who did not work in community, hospital or primary care at practice level, the sample was a maximum of 472 (see Table 4.1). The 32.8% that did not return the postcards may have also included pharmacists to whom the questionnaire did not apply. Using conservative calculations, the response rate was 54%.

Table 4.1. Table showing the number of returned postcards.

	Number of postcards	Percentage of postcards sent with questionnaires
Postcards sent with questionnaires	522	100
Postcards returned with 'I have completed the questionnaire and sent it separately to this postcard.'	225	43.1
Postcards returned with 'I do not wish to complete the questionnaire.'	54	10.34
Postcards returned with 'I have not completed a questionnaire because I am a pharmacist working in a sector other than community, hospital or primary care at practice level.' Those who added a note to say they had returned, or whose colleagues informed me of a change of address are included in this category	50	9.58
Postcards returned blank	22	4.22
Total returned	351	67.24

Unfortunately, there are no available data on the number of pharmacists working in each sector of pharmacy in the SSHA. Nationally, the sector proportions are as displayed in Table 4.2, which shows that community pharmacists were slightly under-represented, and

hospital pharmacists slightly over-represented in the questionnaire. Possibly, primary care practice pharmacists were well represented, the uncertainty lying in the fact that the national census grouped primary care pharmacists at practice and strategic levels together, while the primary care questionnaire was for primary care pharmacists at practice level only. Despite the fact that community pharmacists were under-represented and hospital pharmacists under-represented, the proportions of respondents in each sector do not differ statistically from national figures, and the sample can therefore be considered representative (χ^2=3.323 df=2, p= 0.190).[65]

Table 4.2. Table showing response rates to questionnaires in relation to each pharmacy sector. Percentages have been rounded to the nearest 1%.

	Respondent profile: number of pharmacists in sector	Respondent profile: proportion of pharmacists in sector	National profile: proportion of pharmacists working in each sector[66]
Community	175	69%	73%
Hospital	65	25%	20%
Primary care practice	15	6%	6%*
Total	255	100%	100%

* This figure includes primary care pharmacy at strategic level, which was not included in the questionnaire.

[65] In this instance, alpha was set at 0.05, as this was the only test being run for representation.
[66] Hassell, K.; Shann, P. (2003) 'Overview of the main census findings' *The Pharmaceutical Journal* 270: 314-315

4.3 Demographics

As laid out in Table 4.2, there were 175 respondents to the community pharmacy questionnaire, 65 to the hospital questionnaire and 15 to the primary care practice questionnaire. Table 4.3 shows the demographic characteristics of the pharmacists in each of the sectors surveyed.

Table 4.3 Demographic characteristics of pharmacy participants

Demographic characteristics	Community	Hospital	Primary care practice	Mean percentage across sectors
Age				
20-30 years	17 (10%)	16 (25%)	1 (7%)	14%
31-40 years	41 (23%)	21 (33%)	9 (60%)	39%
41-50 years	47 (27%)	16 (25%)	4 (27%)	26%
51-60 years	42 (24%)	11 (17%)	1 (7%)	16%
61-70 years	23 (13%)	0 (0%)	0 (0%)	4%
Over 71 years	2 (1%)	0 (0%)	0 (0%)	0%
Total valid responses	172 (100%)	64 (100%)	15 (100%)	100%
Sex				
Male	72 (41%)	19 (30%)	*	35%
Female	98 (56%)	44 (69%)	*	62%
Total valid responses	170 (100%)	63 (100%)	*	100%
Year of qualification				
2000-present	14 (8%)	14 (22%)	0 (0%)	10%
1990- 1999	30 (17%)	13 (20%)	2 (13%)	17%
1980- 1989	46 (26%)	23 (36%)	6 (40%)	34%
1970-1979	44 (25%)	12 (19%)	6 (40%)	28%
1960-1969	24 (14%)	1 (2%)	1 (7%)	7%
1950-1959	6 (3%)	0 (0%)	0 (0%)	1%
Total valid responses	164 (100%)	64 (100%)	15 (100%)	100%

* In error, primary care pharmacists were not asked their sex

The data of ages of those participating in the questionnaire did not reflect the general workforce population of Britain.[67] The data of pharmacists' ages given in the pharmacy workforce census carried out by Hassell and Shann are grouped into slightly different age categories from the data in the questionnaire, and so a close comparison cannot be made, though it would be reasonable to suppose the profile of the age of respondents of the questionnaire did not match the national profile. Table 4.4 shows the results from the workforce census. Looking at the workforce census it can be seen that the questionnaire was lacking respondents over 61 years.

Table 4.4 Table showing ages of pharmacists according to the workforce census.[68]

Age group	Percentage
29 years and under	16.1
30-39 years	25.6
40-49 years	23.1
50-59 years	14.8
60-64 years	6.1
65-69 years	5.9
70-79 years	5.7
80 years or older	2.7
Total	100

The sex of respondents of the community pharmacy questionnaire was close to reflecting the pharmacy workforce of Britain, since 47.4% of pharmacists in Britain are male and 52.6% are female[69] compared with 40.9% of community pharmacy participants being male and 55.7% female. The respondents of the hospital questionnaire were mostly female. This is fairly consistent with the 2002 census, which recorded 74% of hospital pharmacists as female.[70] Unfortunately there is no datum on the sex of participants in the

[67] Ibid.
[68] Ibid.
[69] Ibid.
[70] Hassell, K. (2003) 'The national workforce census (6): The gendered nature of pharmacy employment in Britain' *Pharmaceutical Journal* 270: 550- 552 p551

primary care practice questionnaire as this question was accidentally omitted from the questionnaire.

Table 4.5 Table showing distribution of types of community pharmacies in the questionnaire. Percentages have been rounded to the nearest 1%.

Pharmacy type	Profile of questionnaire respondents		National profile[71]
	n	%	%
Independent	25	(16%)	31%
Small multiple	29	(19%)	15%
Medium multiple	6	(4%)	10%
Large multiple	96	(62%)	44%
All valid responses	156	(100%)	100%

Table 4.6 Table showing distribution of positions held by community pharmacy respondents. Percentages have been rounded to the nearest 1%.

Position	
Owner manager	19 (11%)
Employee manager	69 (39%)
Second/ third pharmacist	36 (21%)
Locum	46 (26%)
All valid responses	170 (100%)

Table 4.7 Table showing distribution of positions held by community pharmacists according to the national census 2003. Percentages have been rounded to the nearest 1%. The total percentage is greater than 100% because some pharmacists work in more than one sector.[72]

Position	
Owner	18 %
Manager	28 %
Relief	10 %
Second	9 %
Locum	36 %
Other	5%
All valid responses	106%

Comparing the data on the positions held by community pharmacists answering the questionnaire with data from the national census, it seems that owner managers were

[71] Hassell, K.; Shann, P. op. cit.
[72] Ibid.

under-represented in the questionnaire while employee managers were over-represented. However, an exact comparison cannot be made, because the census data have 'owner' and 'manager' as separate categories, and also allows for dual position of pharmacists, while the community pharmacy questionnaire did not. Similarly, locum pharmacists seem under-represented in the community questionnaire, but again this may be because some community pharmacists hold dual positions. Even so, this would not account fully for the discrepancy in numbers, and so it would be reasonable to conclude that locums were under-represented.

In comparison with the national picture of community pharmacy jobs, independent pharmacies were under represented (national figure 31.4%), as were medium-sized multiples (national figure 10.1%), while pharmacists who worked for small multiples were over-represented (national figure 14.9%) and those working for large multiples were also over-represented (national figure 43.6%).

Table 4.8 Table showing data from the 2002 pharmacy workforce census[73] (note that the total is greater than 100 per cent because some respondents work in more than one sector) and the questionnaire.

Position	National profile	Respondent profile
Grade A-C	30%	16 (25%)
Grade D-E	49.6%	37 (57.8%)
Grade F or higher	10.6%	6 (9.4%)
Locum	8.7%	2 (3.1%)
Other	2.6%	N/A
All respondents	101.5%	64 (95.3%)

A comparison between the data from the hospital pharmacy questionnaire and the workforce census shows that those working at grade D or E were over-represented in the

[73] Ibid.

questionnaire at the expense of those at grade A, C and F. Locums were under-represented in the hospital pharmacy questionnaire.

Table 4.9 Table showing the characteristics of the hospital pharmacists questioned in the hospital pharmacy questionnaire worked in

Characteristic of hospital	
NHS	61 (95.3%)
Private	3 (4.7%)
Total valid responses	64 (100%)
Community	6 (16.2%)
District	32 (50%)
Teaching	21 (32.8%)
Total valid responses	59 (99%)

Percentages do not sum to 100 because of rounding.

Five primary care practice respondents were qualified as supplementary prescribers while the remaining 11 were not. It is worth noting that being qualified as a supplementary prescriber does not necessarily mean practising as a supplementary prescriber. Nationally, the number of pharmacists who are qualified as supplementary prescribers is 1066[74] while the number of pharmacists who have prescribed in the past twelve months is only 145.[75]

[74] Source: RPSGB Registration Section (October 2006)
[75] Source: Prescription Prescribing Authority (October 2006)

Table 4.10 Table showing the time primary care practice pharmacists spent directly with patients.

Proportion of work time spent directly with patients	Number of respondents
10% or less	7 (46.7%)
11-20%	4 (26.7%)
21-30%	2 (13.3%)
31-40%	1 (6.7%)
41-50%	0 (0%)
51-60%	0 (0%)
61-70%	1 (6.7%)
More than 70%	0 (0%)
Total valid responses	15 (101%)

Percentages do not sum to 100 because of rounding.

It is worth bearing in mind when reading the data from the primary care practice questionnaire that most (73.4%) respondents spent up to only 20% of their work time directly with patients.

4.4 Results from scenario-based questions

4.4.1 Frequency of occurrence

The results of the scenario-based questions are presented in tables and clustered bar graphs. Pharmacists were asked to indicate how often they had come across certain situations in their work. They were then asked to indicate, from a limited number of options, what they had done, or what they would do, in that situation. For clarity, Table 4.11 lists all the scenario-based questions asked and included in the analysis, and indicates which sector each question was given to. The tables shown in Tables 4.12, 4.13 and 4.14 apply to each sector respectively and list condensed versions of these scenario-based questions, and lay out the frequencies at which each occurred. Of the scenarios presented in the questionnaire, community pharmacists most often experienced the following (by 'most often' I mean that over 35% of respondents reported that the particular situation occurred once or twice a month, or more frequently): receiving unsigned prescriptions for medication such as paracetamol; receiving prescriptions that were lacking full information; being asked for EHC over the counter; being asked by a customer for over-the-counter treatment that is not necessary; receiving for disposal medication that is unused, unopened, and in date. The scenarios presented in the hospital pharmacy questionnaire occurred less frequently. Only two situations happened to 35% of respondents once or twice a month or more often. These were: receiving a prescription that was lacking full information and receiving for disposal medication that is unused, unopened, and in date. Primary care practice pharmacists reported the most commonly occurring problems to be, as with community and hospital pharmacists: needing further information about a prescription; receiving for disposal medication that is unused, unopened, and in date.

Table 4.11 Table showing, in full, the scenarios of the scenario-based questions

Scenario questions asked to community pharmacists only
You are presented with a prescription for something like paracetamol. You see the prescription is not signed.
You are presented with a prescription for something like an opioid analgesic. You see the prescription is not signed. You know the GP but cannot contact him/her.
A patient returns unused, unopened, in-date medication for disposal one day after it had been dispensed.
The prescription states a specific brand of drug. You do not have this in stock but you have a generic clinically equivalent brand in stock.
A doctor is prescribing, on NHS scripts, medication you suspect s/he is abusing, You've already talked to him. Her about it but s/he has clearly ignored you.
A doctor is prescribing, on private scripts, medication you suspect s/he is abusing, You've already talked to him. Her about it but s/he has clearly ignored you.
A customer asks for an over-the–counter treatment. After talking to the patient you come to the conclusion s/he does not really need the treatment, though it would do no harm for him/her to use it.
You receive a request to supply emergency hormonal contraception over-the-counter.
A patient comes in for his/ her methadone treatment but it is the day after the date specified on the prescription
A girl comes in and asks for emergency hormonal contraception. She says she is sixteen years old, but you suspect she is not. There is no Patient Group Direction for girls under sixteen.
After questioning, a patient makes it known s/he is going to use the medication s/he is asking to buy against guidelines (e.g. hydrocortisone cream for his/her face).
A customer asks to buy an over-the-counter medicine you suspect s/he might be abusing (maybe this appears likely after speaking to him/ her about it). The customer does not want an alternative.
Scenario questions asked to community and hospital pharmacists
You suspect a pharmacist you work with is using prescription medicine from the controlled drugs cabinet without a prescription. You've already talked to him/her about it but s/he has clearly ignored you.
A patient hands you a prescription. Ideally, you would receive further clarification/ information about the prescription from the prescriber.
As a locum you are told the usual pharmacist does things in a certain way, and are asked to work in that way too. You regard this as unethical.
Scenario questions asked to hospital pharmacists only
A paediatric consultant has asked you to dispense, for a child, a does of medicine that is outside the SPC limits, but us still not at toxic level. You speak with the consultant about it who confirms these are his/her wishes.
A member of the public comes to the pharmacy and asks for some medication for someone else who is waiting at home (e.g. his wide, who is in great distress). S/he tells you the person for whom the medication is for has used the medication several times before and is very familiar with it. The wait for A&E is extremely long.

Scenario questions asked to hospital and primary care practice pharmacists
A terminally ill patient asks you for a diagnosis or prognosis, telling you s/he doesn't feel the doctor is telling the whole truth. You know the full case history.
Hospital: A consultant asks you to dispense a drug for an unlicensed indication and tells you s/he knows it is used with great effect in America. Primary care practice: A consultant has asked the practice to dispense a drug for an unlicensed indication and tells you s/he knows it is used with great effect in America. The GP asks your opinion.
Scenario questions asked to primary care practice pharmacists only
A GP asks you for advice on whether to prescribe a relatively inexpensive, low-risk of harm medication that is not licensed and not on the formulary (e.g. low-dose naltrexone for secondary-progressive MS). There are no other treatment options.
A GP asks for your advise on a patient whose treatment is incompatible with his/her lifestyle. (as an example, the patient may be following treatment with warfarin while consuming varying and large amounts of alcohol. It could then be difficult to maintain the patient's INR within the target range. The patient may insist s/he will change his/her lifestyle to allow him/her to continue with warfarin but his/her behaviour is to the contrary).
A patient arrives at the desk very breathless asking for an inhaler, which s/he has run out of. The GP is out on call so is not available. Members of the administrative staff are asking you to authorise the prescription of a salbutamol inhaler.
A patient expects treatment and advice from you, but you do not think s/he is telling the full story to his/her GP. (as an example, a midwife may have referred a pregnant patient to join your pharmacy-led smoking cessation advice clinic. The patient has not told her GP she is attending you clinic, and is expecting you to write a prescription for nicotine replacement therapy treatment. You do not consider this wise and explain you think it is unlikely the GP will sign the prescription.)
Scenario questions asked to community, hospital and primary care practice pharmacists
The mother or father of a patient asks for confidential information about his/her fifteen-your-old son/ daughter' treatment.
You suspect a child, who is one of your patients, may be subject to abuse at home.
While speaking to a patient about his/her condition (e.g. epilepsy) you discover s/he has not, and will not, inform the Driving and Vehicle Licensing Authority even through his/her condition might affect him/her while driving (e.g. s/he has suffered a seizure in the last twelve months.
You feel something a colleague has done is unethical.
You feel something a colleague has done is unethical and you talk to your colleague, but still s/he does not change his/her behaviour.
You believe that withholding the truth from, or deliberately misleading, a patient would mean s/he would be compliant with a treatment you believe is very important to him/her.
Someone comes into the pharmacy/ phones you asking you to identify a particular tablet that does not belong to them. You are able to identify the tablet.
The husband or wide, or another close family member (other than the parent of a child under sixteen years) of a patient asks for confidential information about that patient's treatment.

Table 4.12 Table showing the frequency of occurrence of each possible dilemma faced by community pharmacists. Percentages have been rounded to the nearest 1% and exclude missing data, or those who answered 'don't know' or 'N/A'. The median category has been indicated by highlighting in blue the appropriate frequency count and percentage.

Abbreviated scenario	At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Missing / Don't know/ N/A	Total
Receiving an unsigned prescription for medication such as paracetamol	17 (10%)	57 (33%)	55 (32%)	23 (13%)	16 (9%)	4 (2%)	3	175
Receiving an unsigned prescription for medication such as an opioid analgesic	1 (1%)	10 (6%)	34 (20%)	48 (28%)	56 (56%)	20 (12%)	5	175
Asked to supply EHC over the counter	13 (8%)	51 (30%)	54 (31%)	38 (22%)	11 (6%)	5 (3%)	3	175
Having a prescription, about which ideally the pharmacist would receive further information/ clarification	17 (10%)	37 (21%)	56 (32%)	48 (27%)	12 (7%)	1 (1%)	4	175
Being asked by a patient for over-the-counter treatment s/he does not really need, but would do him/ her no harm	5 (3%)	22 (13%)	45 (26%)	65 (38%)	33 (19%)	3 (2%)	2	175
Patient returns unused, unopened, in date medication for disposal one day after it had been dispensed	1 (1%)	17 (10%)	49 (29%)	75 (44%)	24 (14%)	5 (3%)	4	175
Receiving a prescription for a specific brand of drug, which is not in stock, and having in stock a clinically equivalent brand.	0 (0%)	11 (6%)	51 (29%)	78 (45%)	35 (20%)	0 (0%)	0	175
A patient comes into the pharmacy for his/ her methadone treatment after the date on the prescription	2 (1%)	2 (1%)	22 (14%)	53 (34%)	60 (38%)	19 (12%)	17	175
A patient intends to go against the guidelines when using medication s/he intends to buy (e.g. hydrocortisone cream for face)	0 (0%)	5 (3%)	18 (11%)	73 (43%)	61 (36%)	13 (8%)	5	175
A patient asks to buy over-the-counter treatment the pharmacist suspects s/he is abusing	0 (0%)	7 (4%)	25 (15%)	83 (49%)	48 (28%)	6 (4%)	6	175
Husband, wife or other close family member (but not the parent of a child under 16) of a patient asks for confidential information about that patient's treatment.	1 (0.6%)	0 (0%)	10 (5.7%)	33 (18.8%)	90 (51.1%)	37 (21.6%)	0	175

Abbreviated scenario	At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Missing / Don't know/ N/A	Total
Being asked by a member of the public to identify a particular tablet that is not their own	0 (0%)	1 (1%)	4 (2%)	34 (20%)	103 (60%)	29 (17%)	4	175
Pharmacists believing that withholding the truth from or deliberately misleading the patient would mean s/he would be more compliant about his/ her treatment	1 (1%)	1 (1%)	11 (7%)	19 (13%)	70 (42%)	66 (39%)	7	175
Being asked by a girl who appears to be younger than sixteen but claims to be older for an over-the-counter supply of EHC	0 (0%)	1 (1%)	4 (2%)	24 (14%)	62 (37%)	79 (47%)	5	175
Colleague does something the pharmacist considers unethical	1 (1%)	0 (0%)	3 (2%)	18 (10%)	81 (47%)	70 (41%)	2	175
Colleague does something the pharmacist considers unethical and, after the pharmacist talks to him/her abut it, continues to act unethically	1 (1%)	0 (0%)	0 (0%)	5 (3%)	28 (16%)	138 (80%)	3	175
The mother or father of a patient asks for confidential information about his/ her fifteen-year-old son or daughter's treatment	0 (0%)	1 (1%)	1 (1%)	9 (5%)	63 (36%)	100 (58%)	1	175
A doctor self-prescribes, on NHS prescriptions, medication the pharmacists suspects s/he is abusing. The pharmacist has talked to the doctor about it but s/he has ignored the advice.	0 (0%)	0 (0%)	3 (2%)	0 (0%)	30 (18%)	137 (81%)	5	175
A doctor self-prescribes, on private prescriptions, medication the pharmacists suspects s/he is abusing. The pharmacist has talked to the doctor about it but s/he has ignored the advice.	0 (0%)	0 (0%)	1 (1%)	0 (0%)	31 (18%)	139 (81%)	4	175
The pharmacist suspects a child, who is a patient, may be subject to child abuse.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	26 (15%)	146 (85%)	3	175
A patient reveals that s/he has not reported to the Driving and Vehicle Licensing Authority his/ her condition that may affect his/her while driving.	0 (0%)	0 (0%)	0 (0%)	3 (2%)	15 (9%)	151 (89%)	6	175
Suspecting a pharmacy colleague of taking prescription medicine from the controlled drugs cabinet without a prescription	0 (0%)	0 (0%)	0 (0%)	0 (0%)	4 (2%)	168 (98%)	3	175

Table 4.13 Table showing the frequency of occurrence of each possible dilemma faced by hospital pharmacists. Percentages have been rounded to the nearest 1% and exclude missing data, or those who answered 'don't know' or 'N/A'. The median category has been indicated by highlighting in blue the appropriate frequency count and percentage.

Abbreviated scenario	At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Missing / Don't know/ N/A	Total
Having a prescription, about which ideally there would be further information/ clarification	28 (52%)	19 (35%)	7 (13%)	0 (0%)	0 (0%)	0 (0%)	10	64
Patient returns unused, unopened, in date medication for disposal one day after dispensing	2 (3%)	7 (11%)	10 (16%)	22 (36%)	13 (21%)	8 (13%)	2	64
Spouse or other close family member (but not the parent of a child under 16) of a patient asks for confidential information about that patient's treatment.	0 (0%)	0 (0%)	4 (6%)	10 (16%)	24 (39%)	23 (38%)	3	64
Member of the public asks the identity a particular tablet that is not their own	0 (0%)	0 (0%)	1 (2%)	13 (21%)	28 (46%)	19 (31%)	3	64
A colleague does something the pharmacist considers unethical	0 (0%)	0 (0%)	1 (2%)	3 (5%)	27 (46%)	28 (47%)	5	64
Asked by a paediatric consultant to dispense medication outside SPC guidelines	1 (2%)	7 (11%)	6 (10%)	29 (47%)	14 (23%)	5 (8%)	2	64
Being asked by a consultant to dispense a drug, which has been used with great effect in America, for an unlicensed indication	0 (0%)	0 (0%)	9 (15%)	20 (33%)	20 (33%)	12 (20%)	3	64
Believing that withholding the truth from or deliberately misleading the patient would mean s/he would be more compliant about his/ her treatment	0 (0%)	2 (3%)	1 (2%)	5 (8%)	19 (32%)	33 (55%)	4	64

Abbreviated scenario	At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Missing / Don't know/ N/A	Total
A colleague does something the pharmacist considers unethical and, after the pharmacist talks to him/her abut it, continues to act unethically	0 (0%)	0 (0%)	0 (0%)	1 (2%)	10 (16%)	51 (82%)	2	64
A parent asks for confidential information about his/ her 15-year-old child's treatment	0 (0%)	0 (0%)	0 (0%)	3 (5%)	14 (22%)	46 (73%)	1	64
Being asked by a member of the public for medication for someone else (e.g. wife), who is in great distress, and who has used the medication several times before. The queue for A&E is very long.	0 (0%)	0 (0%)	3 (4.7%)	4 (6.3%)	15 (23.4%)	41 (64.1%)	1	64
The pharmacist suspects a child, who is a patient, may be subject to child abuse.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (3%)	59 (92%)	3	64
Patient has not reported to the DVLA his/her condition that may affect him/her while driving.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	9 (15%)	53 (86%)	2	64
Suspecting a pharmacy colleague of taking prescription medicine from the controlled drugs cabinet without a prescription	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	62 (100%)	2	64
Being asked by a terminally ill patient for a diagnosis or prognosis	0 (0%)	0 (0%)	1 (2%)	7 (11%)	17 (27%)	37 (60%)	2	64

Table 4.14 Table showing the frequency of occurrence of each possible dilemma faced by primary care practice pharmacists. Percentages have been rounded to the nearest 1% and exclude missing data, or those who answered 'don't know' or 'N/A'. The median category has been indicated by highlighting in blue the appropriate frequency count and percentage.

Abbreviated scenario	At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Missing / Don't know/ N/A	Total
Husband, wife or other close family member (but not the parent of a child under 16) of a patient asks for confidential information about that patient's treatment.	0 (0%)	0 (0%)	0 (0%)	4 (27%)	6 (40%)	5 (33%)	0	15
Being asked by a member of the public to identify a particular tablet that is not their own	0 (0%)	0 (0%)	0 (0%)	5 (33%)	6 (40%)	4 (27%)	0	15
Being asked by a consultant to dispense a drug, which has been used with great effect in America, for an unlicensed indication	0 (0%)	0 (0%)	0 (0%)	6 (40%)	8 (53%)	1 (7%)	0	15
Being asked by a GP advice on prescribing low-risk, low-cost medication that is not licensed and not on the formulary (there is no other treatment option).	0 (0%)	0 (0%)	0 (0%)	4 (27%)	6 (40%)	5 (33%)	0	15
Being asked for advice on whether to maintain treatment as the patient wishes even though his/her lifestyle lessens the effect of the treatment, or to prescribe a less effective treatment compatible with the patient's lifestyle.	0 (0%)	0 (0%)	0 (0%)	3 (20%)	6 (40%)	6 (40%)	0	15
Believing that withholding the truth from or deliberately misleading the patient would mean s/he would be more compliant about his/ her treatment	0 (0%)	0 (0%)	0 (0%)	2 (13%)	4 (27%)	9 (60%)	0	15
A parent of a patient asks for confidential information about his/ her 15-year-old child's treatment	0 (0%)	0 (0%)	0 (0%)	0 (0%)	6 (40%)	9 (60%)	0	15
A colleague does something the pharmacist considers unethical and, after the pharmacist talks to him/her abut it, continues to act unethically	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (20%)	12 (80%)	0	15
The pharmacist suspects a child, who is a patient, may be subject to child abuse.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (7%)	14 (93%)	0	15
A patient reveals that s/he has not reported to the Driving and Vehicle Licensing Authority his/ her condition that may affect his/her while driving.	0 (0%)	0 (0%)	0 (0%)	1 (7%)	3 (20%)	11 (73%)	0	15
Being asked by a terminally ill patient for a diagnosis or prognosis	0 (0%)	0 (0%)	0 (0%)	1 (7%)	3 (20%)	11 (73%)	0	15

Abbreviated scenario	At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Missing / Don't know/ N/A	Total
Being asked to authorise a prescription of medication for an urgent case	0 (0%)	0 (0%)	0 (0%)	4 (27%)	2 (13%)	9 (60%)	0	15
A patient asks for advice and treatment when it seems s/he is not keeping his/her General Practitioner fully informed	0 (0%)	0 (0%)	0 (0%)	2 (13%)	3 (20%)	10 (67%)	0	15

4.4.2 Scenario-based questions – what pharmacists would do

Participants were asked to report how often they had found themselves in certain situations within the past year, and what they had usually done when they were in those situations. One of the features of the scenario-based questions was that pharmacists were asked what they *would* do in a particular situation, even if they had answered that they had never in fact been in that situation. This means that the results of any given scenario-based question include an amalgamation of what pharmacists who had been in that situation had done, and what pharmacists who had not been in that situation would do if they faced it.

Results to questions that were given to only one sector are shown in separate tables (Tables 4.15 - 4.17). In cases in which more than one sector of pharmacy was asked a question, all answers are given in bar graphs. Where only one or two sectors are represented, it can be assumed that pharmacists from only one or two sectors were asked the question.

Almost all of the answers to the scenario-based questions about what pharmacists would do are included here. Results from the scenario-based question aimed at hospital locums was excluded because it was sometimes answered by non-locums, and there was a greater number of respondents who answered the questions aimed at locums than respondents who indicated in the first section that they were locums (only two respondents of the hospital questionnaire answered that they were locums).

Similarly, results from the EHC scenario-based questions aimed at community locum pharmacists were excluded because the answers were confused and the results were deemed too unreliable. As in the hospital questionnaire, some non-locum pharmacists answered the question. Further, several locums answered that they had an objection to supplying EHC, when in answer to an earlier question they had indicated that they did have

an objection. It was thought that this was an indication that the question was confusing and that the results were unreliable.

Results from the first scenario-based question aimed at community locums were included. This scenario was about a locum being asked to work in a certain way that was normal for a particular pharmacy, but that the locum regarded as unethical. These results were included because it was possible to separate answers from locums from answers given in error by non-locums, and there was no reason to suppose the question itself had caused confusion.

Table 4.15 Frequency table showing community pharmacists' responses to scenario-based questions. Percentages have been rounded to the nearest 1% and exclude missing values and those who answered 'don't know' or 'N/A'.

Presented with unsigned prescription for something like paracetamol. The prescription is not signed.	Refuse to dispense	34	(20%)
	Dispense	134	(80%)
	Missing/ don't know	7	
	Total	175	
Presented with unsigned prescription for something like an opioid analgesic. The prescription is not signed.	Refuse to dispense	134	(81%)
	Dispense	31	(19%)
	Missing/ don't know	10	
	Total	175	
Customer asks for an over-the-counter treatment. After talking to patient you realise s/he doesn't really need it, though it would do him/her no harm.	Sell	23	(13%)
	Advise against sale	149	(87%)
	Missing/ don't know	3	
	Total	175	
Prescription states a specific brand. You do not have this in stock but you do have a generically clinically equivalent brand in stock.	Dispense	51	(29%)
	Not dispense	122	(71%)
	Missing/ don't know	2	
	Total	175	
Patient comes in for his/her methadone treatment but it is the day after the date specified on the prescription.	Refuse to supply	150	(98%)
	Supply	3	(2%)
	Missing/ don't know/ NA	22	
	Total	175	
Customer asks to but over-the-counter medicine you suspect s/he might be abusing. Customer does not want an alternative.	Sell product	23	(14%)
	Refuse to sell product	146	(86%)
	Missing/ don't know	6	
	Total	175	
After questioning, a patient makes it known that s/he is going to use medication s/he is asking to buy against guidelines (e.g. hydrocortisone cream for his/her face).	Refuse to supply	97	(59%)
	Supply	68	(41%)
	Missing/ don't know	10	
	Total	175	
Girl comes in asking for EHC. She says she is 16 years old but you suspect she is not. There is no Patient Group Direction for girls under 16.	Supply	86	(58%)
	Refuse to supply	63	(42%)
	Missing/ don't know / NA	26	
	Total	175	
You receive a request to supply EHC over-the-counter.	Personal beliefs affect supply	11	(6%)
	Personal beliefs do not affect supply	159	(94%)
	Missing/ don't know	5	
	Total	175	
A doctor is self-prescribing, on NHS prescriptions, medication you suspect s/he is abusing. You have already talked to him/her about it but s/he has clearly ignored you	Report doctor	116	(80%)
	Talk to doctor but do not report him/her	29	(20%)
	Missing/ don't know	30	
	Total	175	
A doctor is self-prescribing, on private prescriptions, medication you suspect s/he is abusing. You have already talked to him/her about it but s/he has clearly ignored you.	Report doctor	116	(81%)
	Talk to doctor but do not report him/her	27	(19%)
	Missing/ don't know	32	
	Total	175	
As a locum you are told the usual pharmacist does things a certain way, and are asked to work in that way. You regard this as unethical.	Do as normal for that pharmacy	8	(21%)
	Refuse to work in that way	30	(79%)
	Missing/ don't know	2	
	Total	40*	

* Non-locums were not asked this question. The total number of locum community pharmacy respondents was 40.

There are a few features shown in Table 4.15 worth noting. The majority (80%) of community pharmacists would dispense a drug such as paracetamol from an unsigned prescription if the prescriber could not be contacted. However, for medication such as an opioid analgesic, which is an addictive controlled drug, community pharmacists were far more reluctant to dispense from an unsigned prescription, with only 19% saying they would dispense.[76] The majority (87%) of community pharmacists would not sell over-the-counter treatment to a patient who did not really need it. The majority (98%) of community pharmacists would refuse to supply methadone to a patient a day after the date specified on the prescription, with only three pharmacists reporting either that they have supplied under these circumstances, or that they would supply if in this situation. Some (22) participants did not have a methadone treatment programme and so the question was not relevant to them. Most (59%) community pharmacists would refuse the supply of hydrocortisone cream for use on the face. Many (41%) would be willing to make the supply. Largely, if a doctor is self-prescribing medication she is suspected of abusing it makes no difference to pharmacists' decisions about what to do if the doctor is using NHS or private prescriptions; most community pharmacists (80%) would report the doctor if talking to her had not changed her behaviour. It is worth noting that most (79%) community pharmacists answered that these situations had never occurred in their work in the last year.

[76] It is worth noting that some opioid analgesics have less strict controls than others.

Table 4.16 Frequency table showing hospital pharmacists' responses to scenario-based questions. Percentages have been rounded to the nearest 1% and exclude missing values and those who answered 'don't know'.

A paediatric consultant asks you to dispense medication outside SPC guidelines	Agree to dispense	59 (100%)
	Refuse to dispense	0 (0%)
	Missing/ Don't know	5
	Total	64
A member of the public asks for medication for his wife, who has used the medication several times before and is very familiar with it. The queue for A&E is very long.	Supply medication	4 (7%)
	Explain why you cannot supply	52 (93%)
	Missing/ Don't know	8
	Total	64
A patient has not and will not inform the Driving an Vehicle Licensing Authority (DVLA) of a condition (e.g. epilepsy) that might affect him/ her while driving (e.g. s/he has suffered a seizure in the last 12 months)	Report patient	4 (8%)
	Talk to patient, knowing s/he is unlikely to inform DVLA	19 (37%)
	Tell medical consultant and take no further action	28 (55%)
	Missing/ don't know	13
	Total	64

All respondents to the question of whether to dispense medication for a child when the dose is outside the SPC guidelines were in agreement, choosing to dispense the medication. The suitable dose of medication varies from child to child, depending on factors such as the size and age of the child.

Most hospital pharmacists (93%) were in agreement that they would not supply medication to a member of the public for his wife, even if the wife used the medication regularly. Respondents were divided on whether to talk to a patient who had failed to report to the DVLA a condition that could affect her while driving. The divide was largely between those who would inform a medical consultant and those who would just talk to the patient knowing it was unlikely to have any impact, with only four respondents who would report the patient to the DVLA.

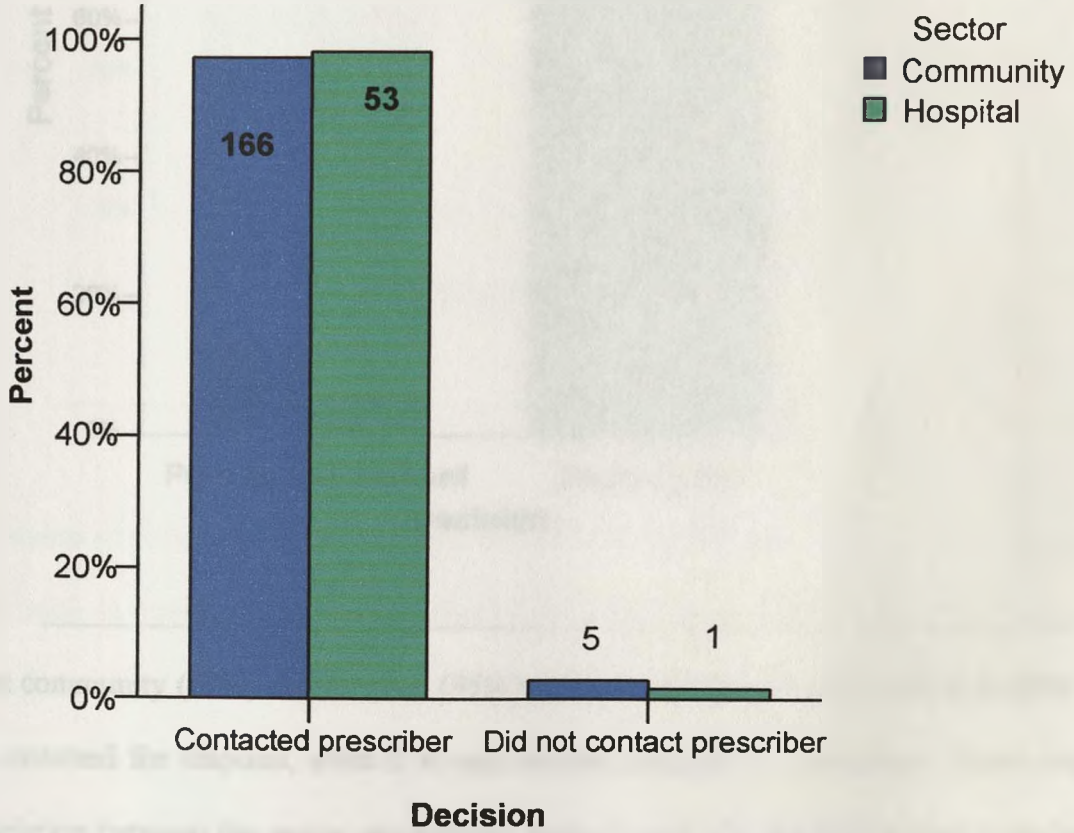
Table 4.17 Frequency table showing primary care practice pharmacists' responses to scenario-based questions. Percentages have been rounded to the nearest 1% and exclude missing values and those who answered 'don't know'.

GP asks advice on whether to prescribe inexpensive, low-risk medication that is not licensed and not on formulary. There are no other treatment options.	Advise against prescribing Advise medication should be dispensed Missing/ don't know Total	2 12 1 15	(14%) (86%)
Patient at desk very breathless. GP not available. Members of administrative staff ask you to authorise prescription of salbutamol inhaler.	Authorise prescription Do not authorise prescription Missing/ don't know Total	7 8	(47%) (53%)
Patient expects treatment advice from you, but the patient is not keeping the rest of the healthcare team involved in decisions (e.g. a midwife may have referred a pregnant patient to join a pharmacy-led smoking cessation advice clinic. The patient has not told her GP she is attending the clinic and expects you to authorise a prescription for nicotine replacement therapy).	Refuse to write prescription Write prescription Missing/ don't know Total	15 0 0 15	(100%) (0%)
GP asks for treatment that is incompatible with patient's lifestyle (e.g. the patient may be following treatment with warfarin while consuming varying and large amounts of alcohol. It could then be difficult to maintain the patient's INR within the target range. The patient may insist s/he will change his/her lifestyle to allow him/her to continue with warfarin but his/her behaviour is to the contrary)	Advise to continue with treatment Advise GP to prescribe less effective treatment Missing/ don't know Total	5 9 1 15	(36%) (64%)

There appears to be a divide of opinion among the primary care practice pharmacists over most of the scenario-based questions shown in Table 4.17. The differences may be exaggerated by the fact that there were so few respondents, but there is consensus among respondents that a prescription should not be given without open dialogue with the GP. The example that was given in the questionnaire was of a pregnant patient who had been referred to a pharmacy-led smoking cessation advice clinic. The patient had not told her GP she was attending the clinic, and wanted a prescription for nicotine replacement therapy treatment, which the pharmacist thought would be unwise and not something the GP would agree to. A few respondents noted that it is not a problem if a breathless patient comes to the desk as the pharmacist has the option of issuing an emergency supply.

The following clustered bar graphs show the results from the scenario-based questions that were asked across sectors. In some cases, the questions were common to just two sectors, and some questions were asked to pharmacists in all three sectors. Where a test for association was carried out to test the relevant null hypothesis, the p value is stated (where data for all three sectors are shown, any test for association excludes the primary care respondents, owing to their low numbers). Table A2.1 in Appendix 2 shows the test results in greater detail.

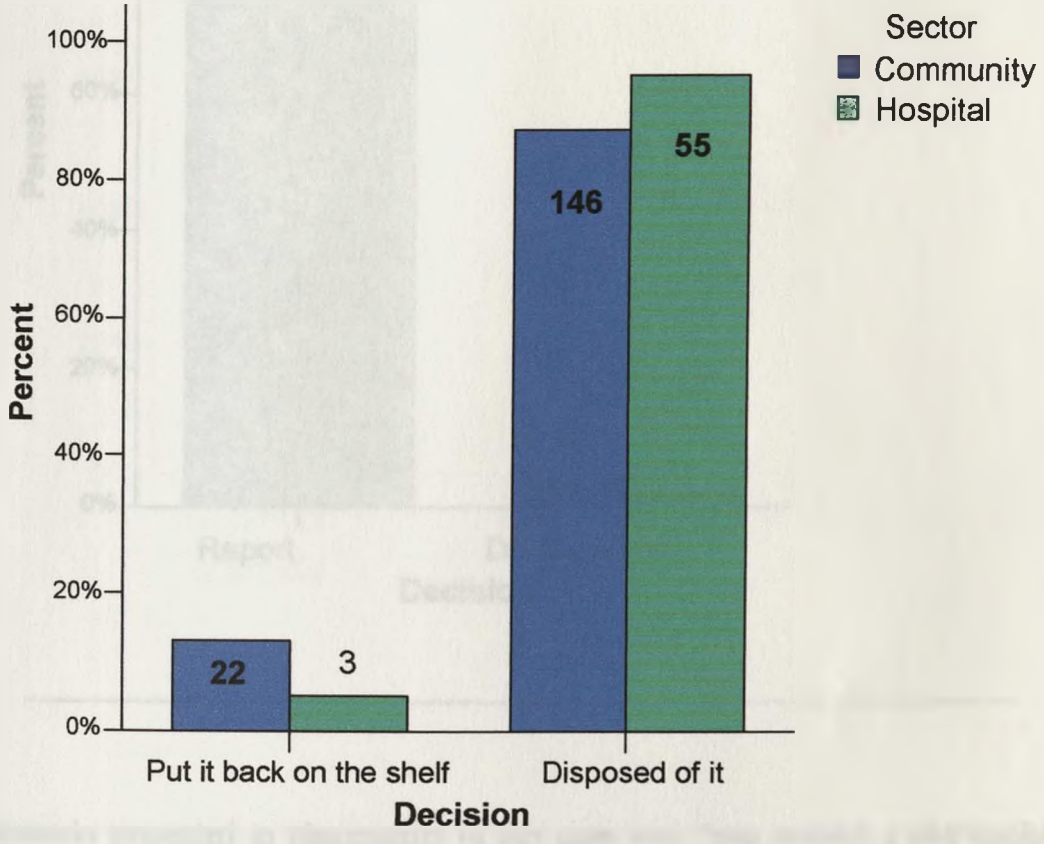
Figure 4.18 Clustered bar graph showing percentage of community pharmacists (n=172) and hospital pharmacists (n=54) who would contact or not contact the prescriber for further information about a prescription. Frequencies are shown in or above the bars.



There was no association between the sector pharmacists work in and whether they would contact the prescriber or not if presented with the following scenario: a patient hands you a

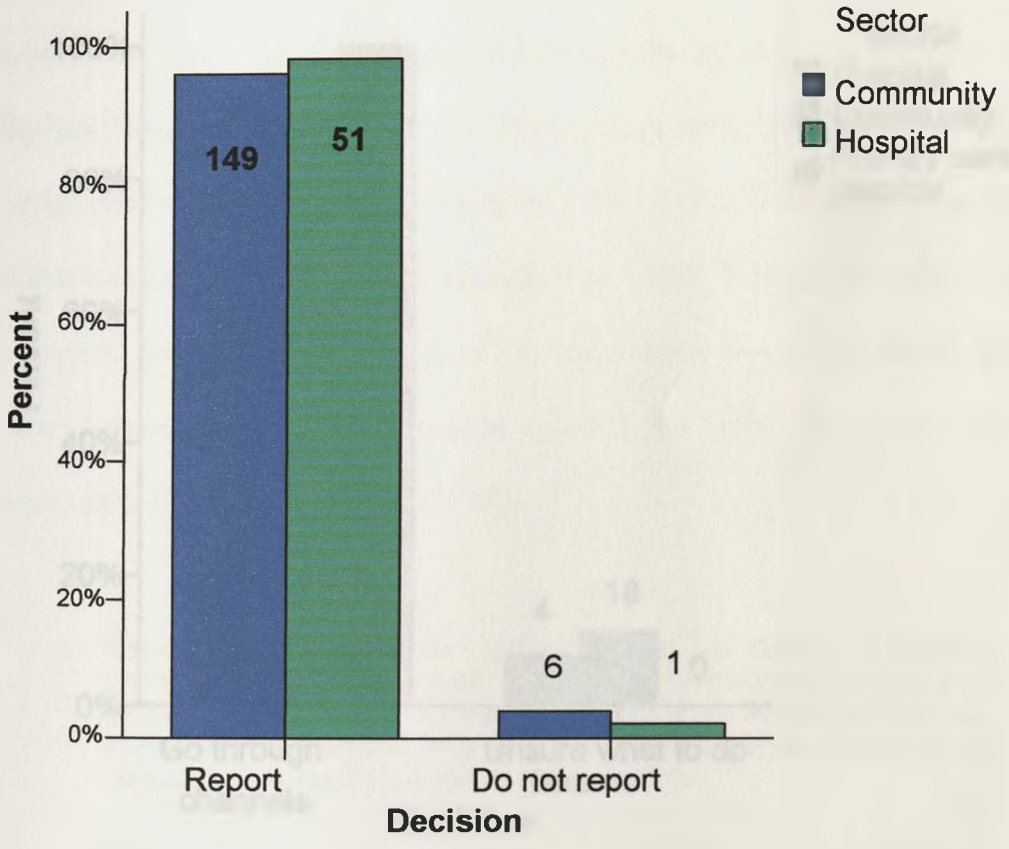
prescription. Ideally, you would receive further clarification/ information about the prescription from the prescriber (Fisher's exact test, p> .999).

Figure 4.19 Clustered bar graph showing the percentage of community pharmacists (n=169) and hospital pharmacists (n=58) who would re-shelve or dispose of returned, unused, in-date, unopened medication. Frequencies are shown in or above the bars.



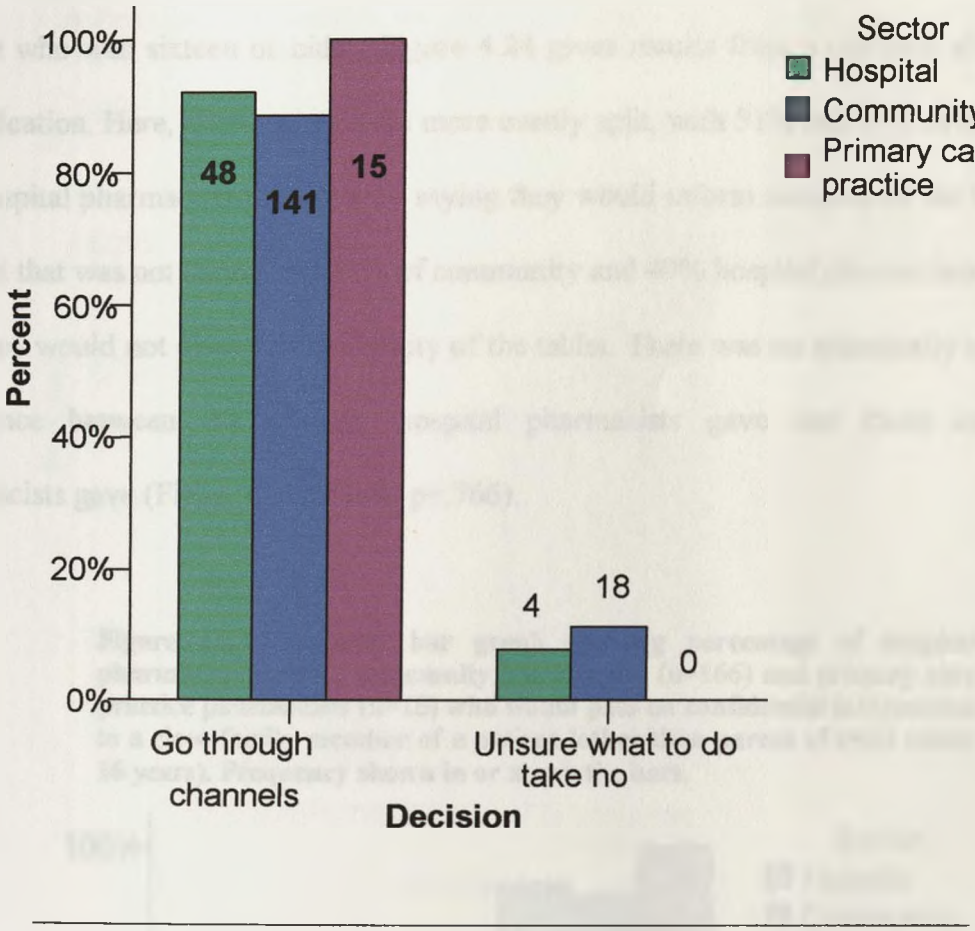
Most community (87%) and hospital (95%) pharmacists would dispose of medication that was returned for disposal, even if it was in-date, unused and unopened. There was no association between the sector pharmacists work in and whether they would re-shelve or dispose of the returned medication (χ^2= 2.751; df=1; p=.097).

Figure 4.20 Clustered bar graph showing percentage of community pharmacists (n=156) and hospital pharmacists (n=52) who would report a colleague who was taking prescription medicine from the controlled drugs cabinet without a prescription. Frequencies are shown in or above the bars.



The scenario presented to pharmacists in this case was: 'you suspect a pharmacist you work with is using prescription medicine from the controlled drugs cabinet without a prescription. You've already talked to him/her about it but s/he has clearly ignored you.' Most community and all hospital pharmacists reported that this had never happened to them (98% and 100% respectively). There was no association between the sector pharmacists work in and whether they would report their colleague or take no further action (Fisher's exact test, p= .682).

Figure 4.21Clustered bar graph showing percentages of hospital pharmacists patient who would go through appropriate channels or be unsure what to do if they suspected a was a child was subject to abuse at home. Frequencies are shown in or above the bars.



Participants were asked about the frequency of the following scenario and the decisions they would make: 'you suspect a child, who is one of your patients, may be suffering abuse at home'. This scenario was mostly reported as hardly ever or never having arisen in practice (98% community; 100% hospital and 100% primary care practice). Most pharmacists said they would report suspected child abuse, though 11% of community pharmacists and 8% of hospital pharmacists respectively said they would not know what to do in such a situation, and so would take no action. There was no association between community and hospital sectors and what pharmacists would do if faced with this problem (χ^2= .552; df=1; p= .457).

Figures 4.22, 4.23 and 4.24 show the results arising from questions concerning confidentiality. In all sectors, more pharmacists gave, or would give, confidential information to the parent of a child fifteen-years-old than to a close family member of a patient who was sixteen or older. Figure 4.24 gives results from a question about tablet identification. Here, pharmacists were more evenly split, with 51% and 51% of community and hospital pharmacists respectively saying they would inform someone of the identity of a tablet that was not theirs, and 49% of community and 49% hospital pharmacists reporting that they would not disclose the identity of the tablet. There was no statistically significant difference between the answers hospital pharmacists gave and those community pharmacists gave (Fisher's exact test, p=.766).

Figure 4.22 Clustered bar graph showing percentage of hospital pharmacists (n=54), community pharmacists (n=166) and primary care practice pharmacists (n=15) who would pass on confidential information to a close family member of a patient (other than parent of child under 16 years). Frequency shown in or above the bars.

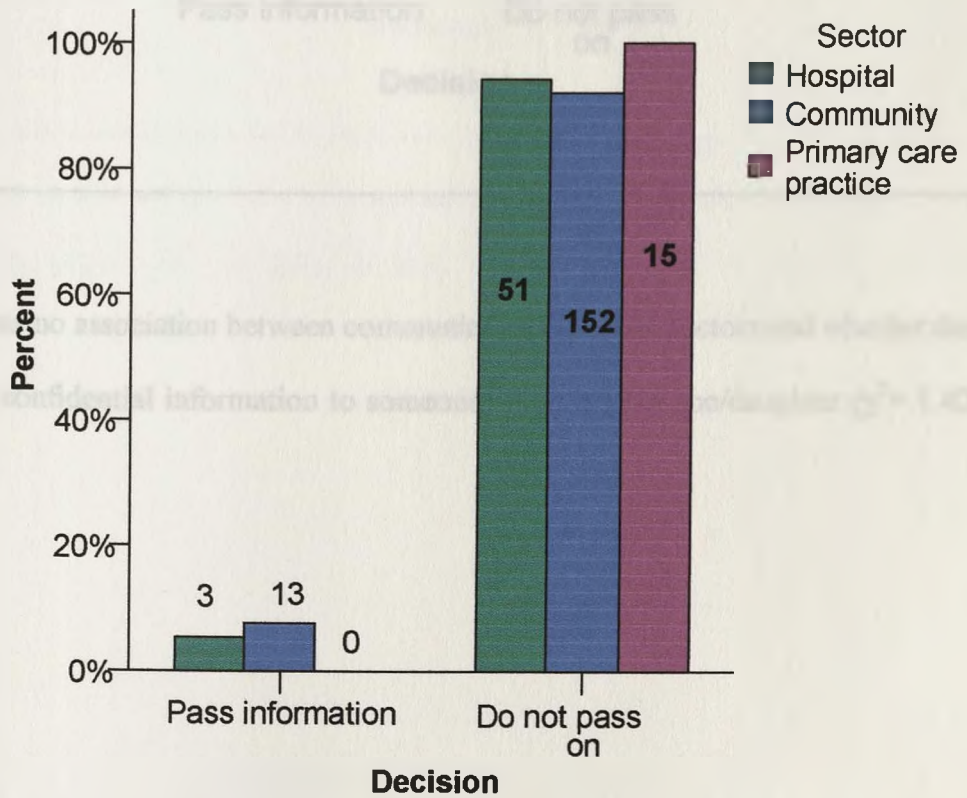
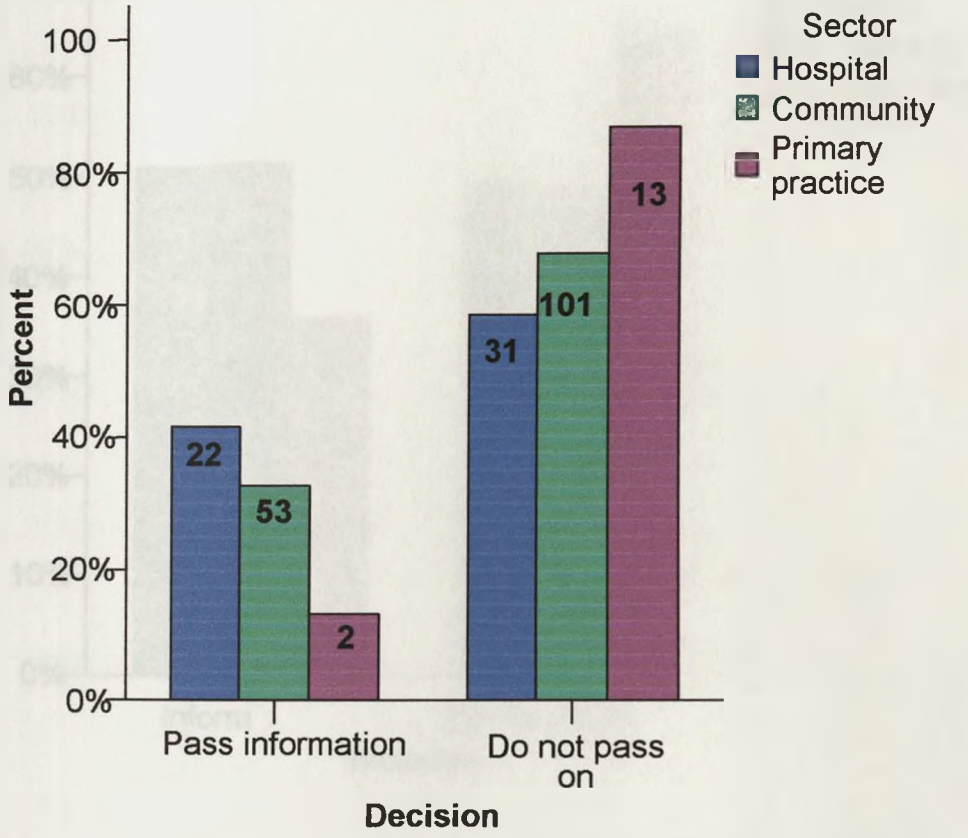
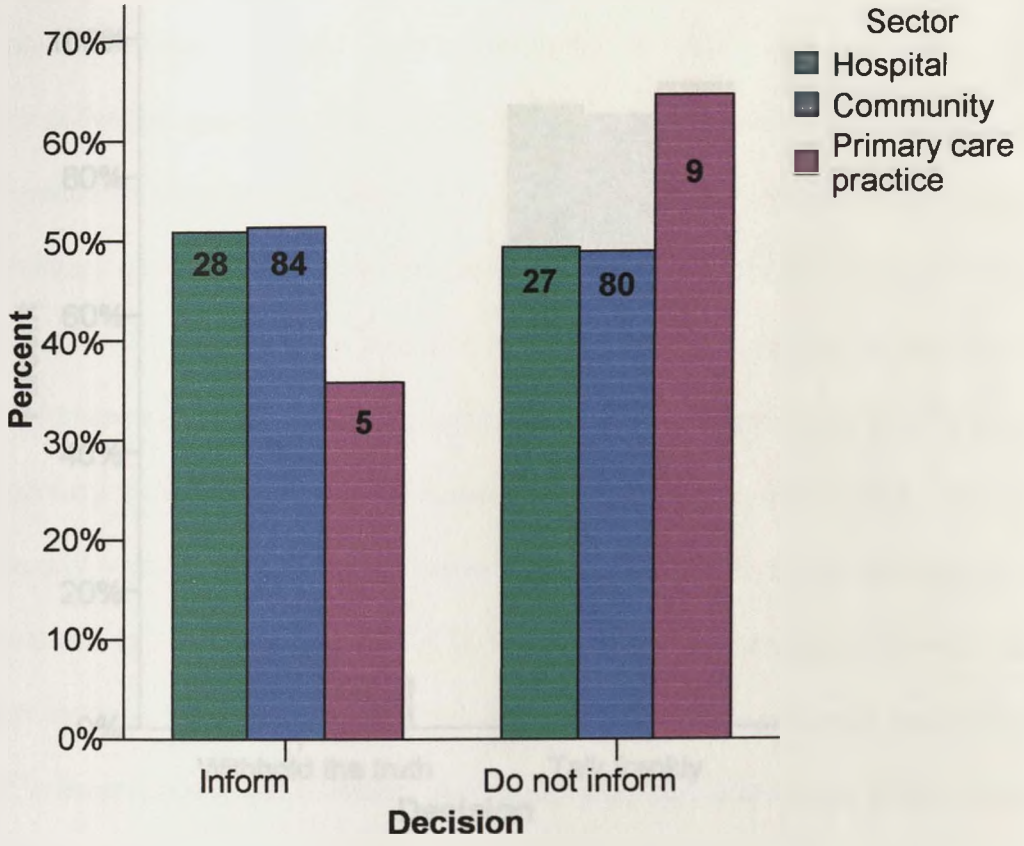


Figure 4.23 Clustered bar graph showing percentages of hospital pharmacists (n=53), community pharmacists (n=164) and primary care practice pharmacists (n=15) who would pass on or not pass on confidential information to a parent about their 15-year-old child's treatment. Frequencies are shown in the bars.



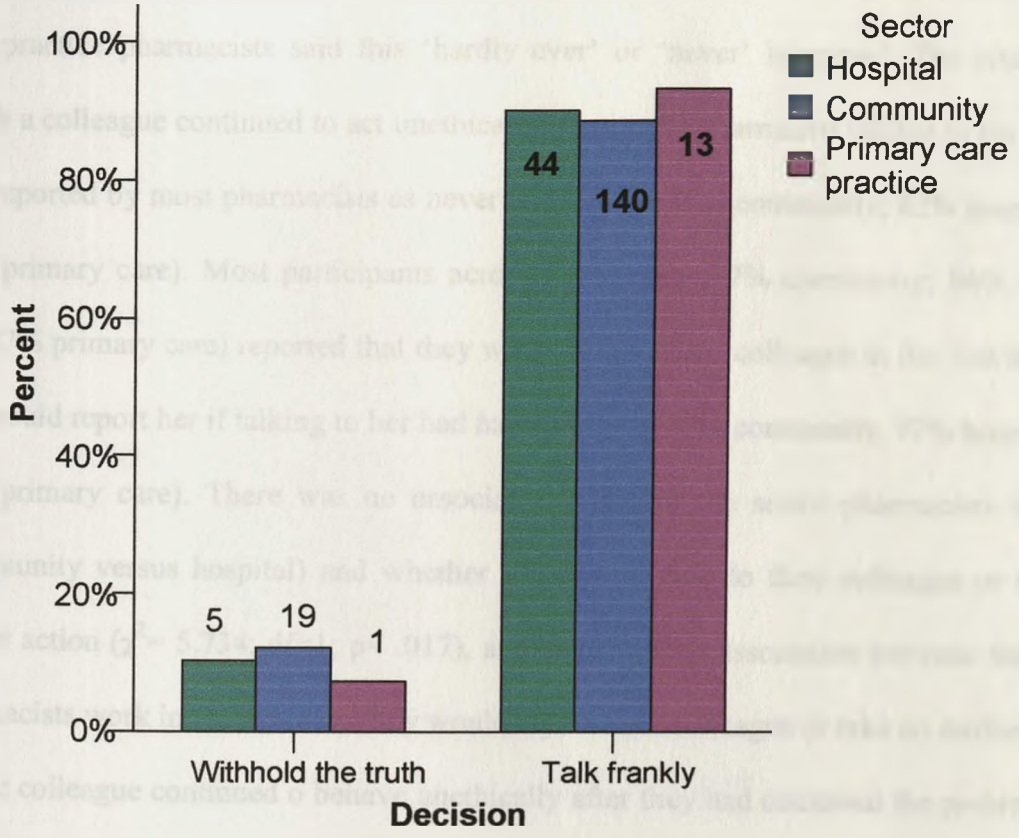
There was no association between community and hospital sectors and whether they would pass on confidential information to someone about his/her son/daughter (χ^2= 1.427; df=1; p=.323).

Figure 4.24 Clustered bar graph showing percentage of hospital pharmacists (n=55), community pharmacists (n=165) and primary care practice pharmacists (n=14) who would inform or not inform someone of the identification of a tablet that did not belong to them if the pharmacist was able to identify the tablet. Frequencies are shown in the bars.



There was no association between community and hospital sectors and whether they would identify the tablet (χ^2= .002; df=1; p=.968).

Figure 4.25 Clustered bar graph showing percentage of hospital pharmacists (n=49), community pharmacists (n=160) and primary care practice pharmacists (n=14) who would withhold the truth or talk frankly to a patient if it were believed that if the patient were misled s/he would be compliant with treatment that was very important to her. Frequencies are shown in or above



There was no association between community and hospital sectors and whether they would withhold the truth from or deliberately mislead a patient (χ^2= .112; df=1; p=.738).

The two scenarios in which a colleague is behaving unethically were mostly reported as not arising in pharmacy practice. In regard to the situation in which a colleague is acting unethically, 86% of community pharmacists, 86% of hospital pharmacists and 80% primary care practice pharmacists said this 'hardly ever' or 'never' happened. The situation in which a colleague continued to act unethically despite the pharmacist talking to her about it was reported by most pharmacists as never happening (80% community; 82% hospital and 80% primary care). Most participants across the sectors (77% community; 94% hospital and 87% primary care) reported that they would talk to their colleague in the first instance, and would report her if talking to her had had no effect (70% community, 92% hospital and 93% primary care). There was no association between the sector pharmacists work in (community versus hospital) and whether they would talk to their colleague or take no further action (χ^2= 5.734; df=1; p= .017), and there was no association between the sector pharmacists work in and whether they would report their colleague or take no further action if their colleague continued o behave unethically after they had discussed the problem (χ^2= 3.43; df=1; p= .064).

Figure 4.26 Clustered bar graph showing percentage of hospital pharmacists (n=54), community pharmacists (n=167) and primary care practice pharmacists (n=15) who would talk to their colleague or take no action if colleague was acting unethically. Frequencies are shown in or above bars.

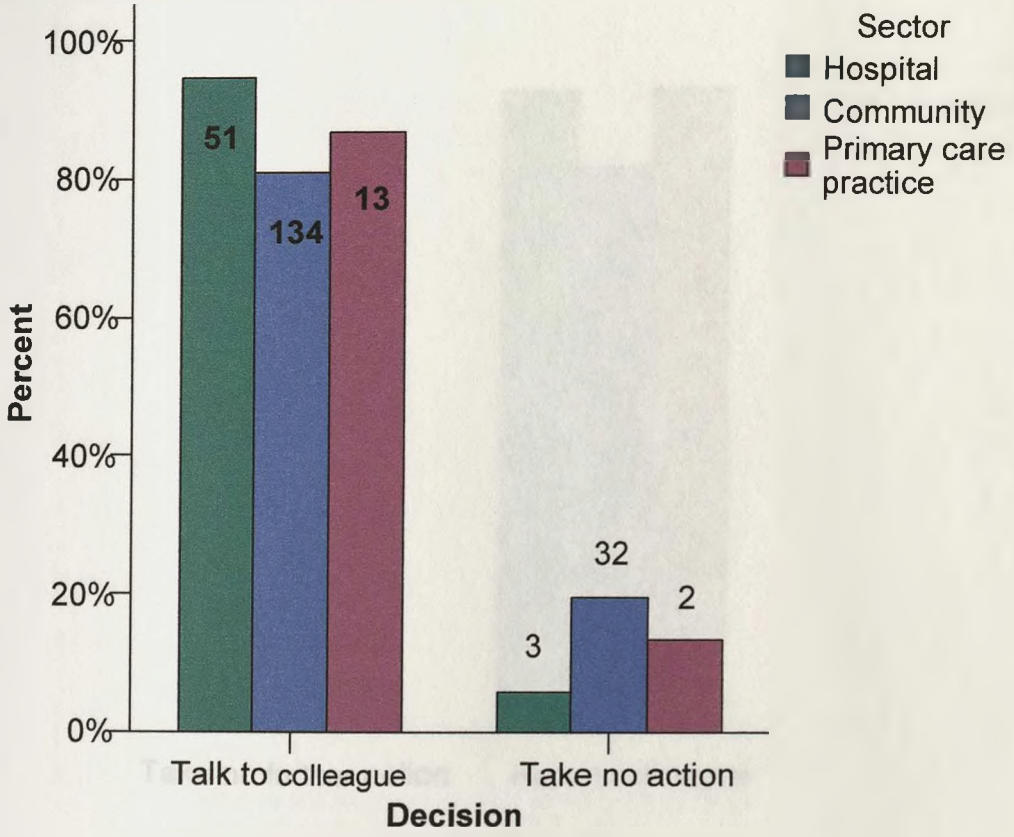


Figure 4.27 Clustered bar graph showing percentages of hospital pharmacists (n=52), community pharmacists (n=137) and primary care practice pharmacists (n=15) who would report colleague or take no further action if colleague was still acting unethically despite discussing the problem. Frequencies are shown in or above bars.

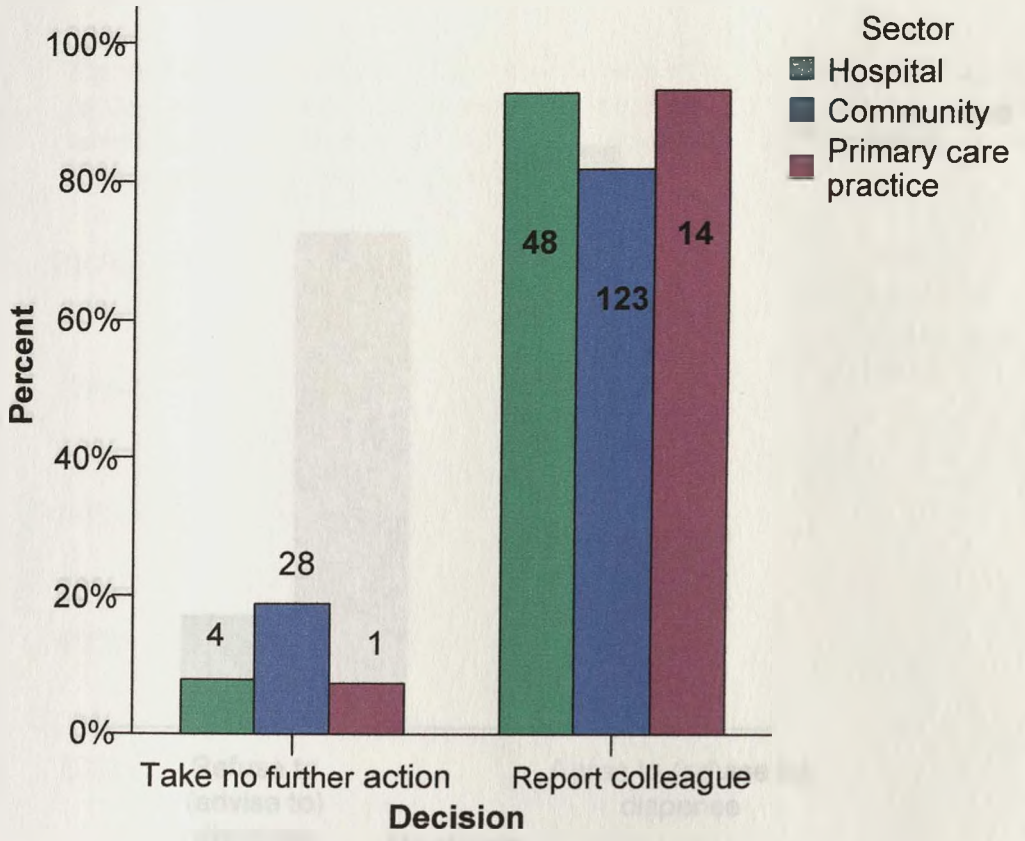
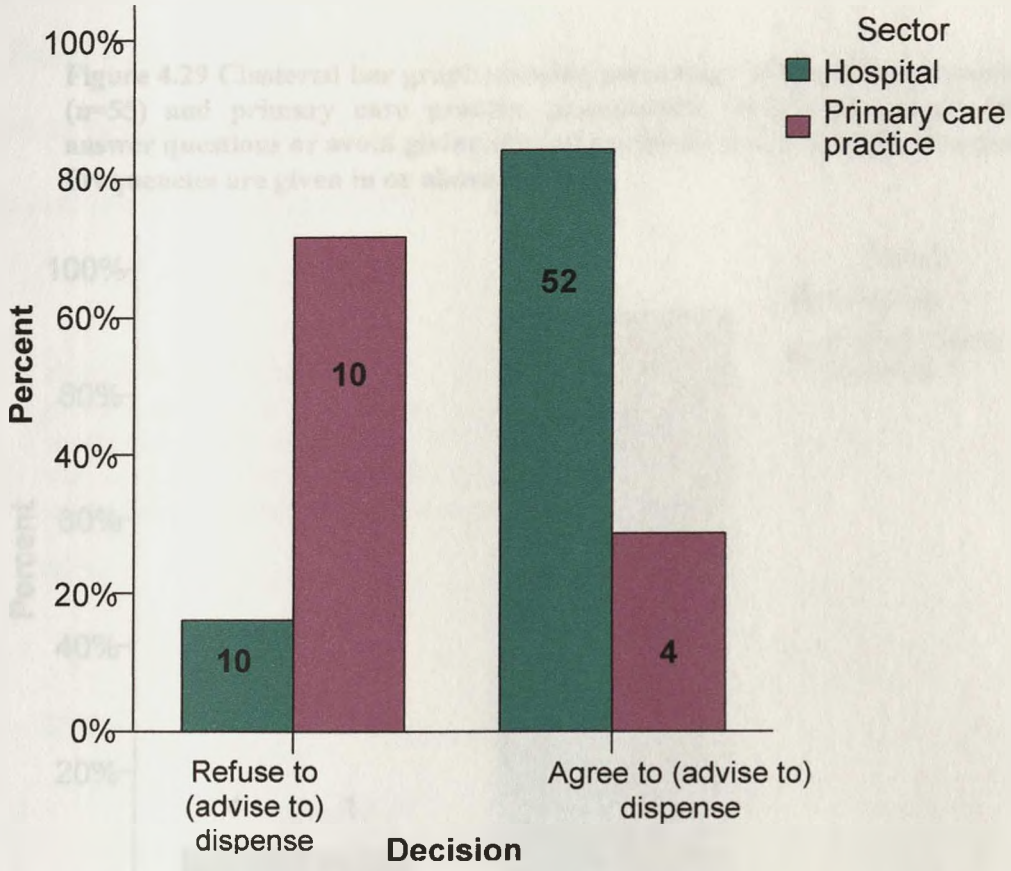


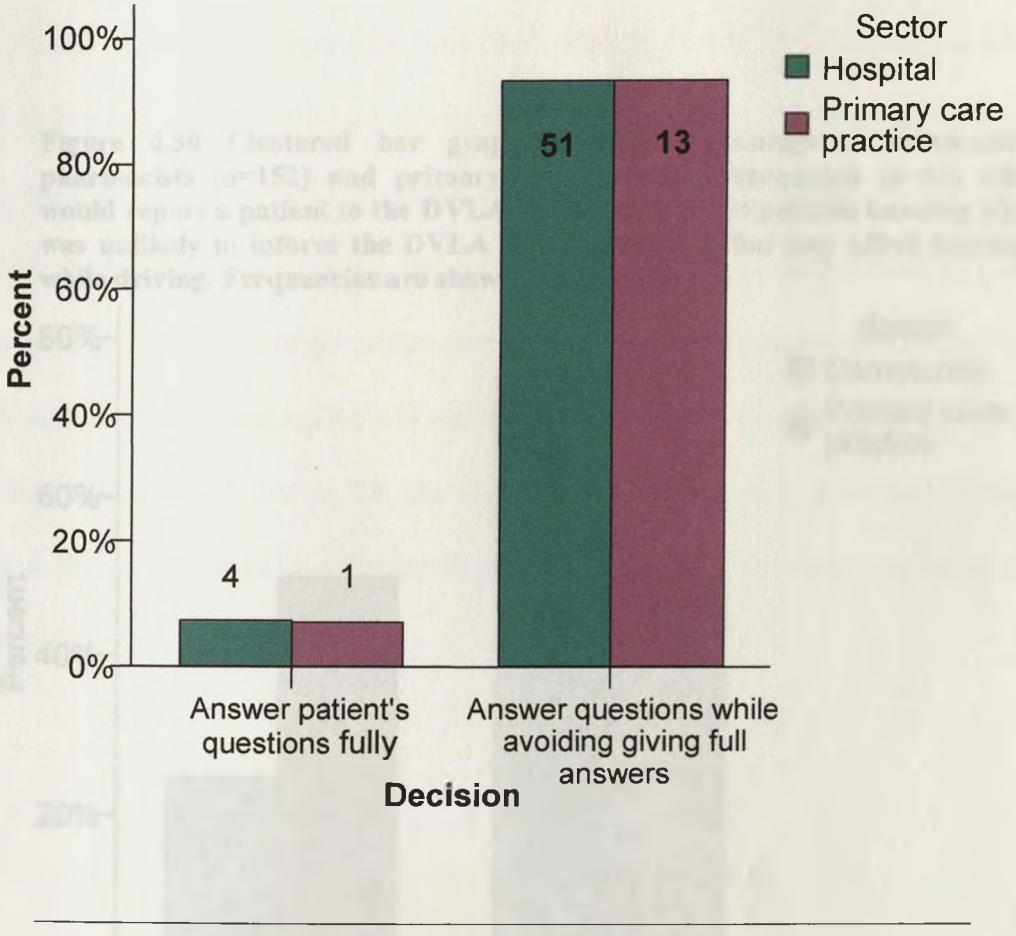
Figure 4.28 Clustered bar graph showing percentage of hospital pharmacists (n=62) and primary care practice pharmacists (n=14) who would refuse to dispense drug for unlicensed indication used in USA as asked for by consultant. Frequencies are shown in the bars.



It appears that more hospital pharmacists than primary care practice pharmacists would dispense/ advise to dispense a dug for an unlicensed indication if a consultant were to say it has been used with great effect in America (Figure 4.28). However, because the number of primary care practice pharmacist respondents was low, there is doubt as to how well they represent the wider population. This applies equally to the results regarding the scenario in which a terminally ill patient asks the pharmacist for details about her prognosis. In both the hospital and primary care practice sectors, 93% of pharmacists decided they would not answer all the patient's questions fully but would instead answer her questions in such a

way as to avoid giving full details, and would later talk to the doctor about the situation (see Figure 4.28).

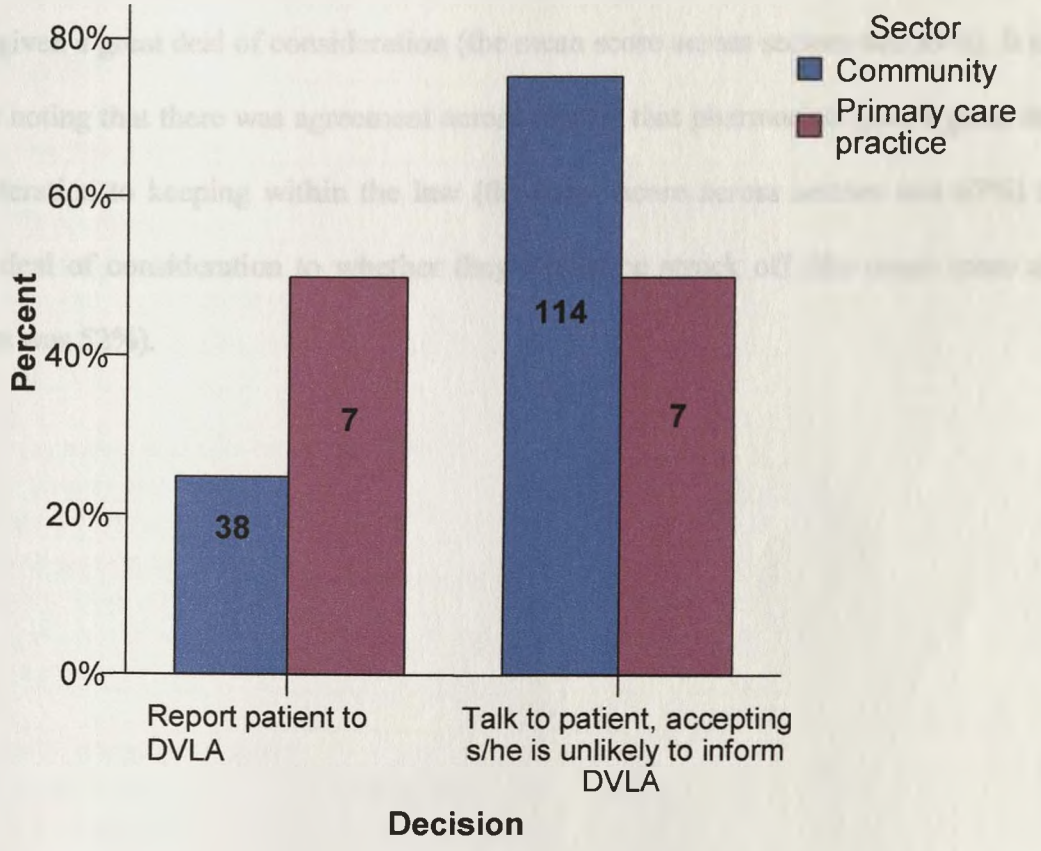
Figure 4.29 Clustered bar graph showing percentage of hospital pharmacists (n=55) and primary care practice pharmacists (n=14) who would fully answer questions or avoid giving the full prognosis to a terminally ill patient. Frequencies are given in or above the bars.



In regard to the scenario in which a patient has not informed the DVLA about her condition that might affect her while driving, most participants (86% community; 86% hospital and 73% primary care practice) reported that they had not come across this scenario in practice. In their questionnaire, hospital pharmacists had the option of answering that they would tell a medical consultant that a patient had not informed the DVLA about her condition. Community and primary care practice pharmacists were not

given this option, reflecting normal practice. This may account for the differences in proportions of community and hospital pharmacists answering that they would report the patient or would talk to the patient, knowing that doing so would not change the patient's mind. Figure 4.30 shows only the responses from community and primary care practice pharmacists because the discrepancy between the questions meant the responses from primary care practice pharmacists were not comparable.

Figure 4.30 Clustered bar graph showing percentage of community pharmacists (n=152) and primary care practice pharmacists (n=14) who would report a patient to the DVLA or just talk to the patients knowing s/he was unlikely to inform the DVLA of the condition that may affect him/her while driving. Frequencies are shown in the bars.



4.5 Results from questions relating to factors pharmacists consider when making ethical decisions

Pharmacists were asked how much importance they gave to certain factors when making decisions about situations such as those presented in the questionnaire. They were asked to use a 5-point adjectival rating scale to indicate how much consideration they gave to each factor. These results are presented in Table 4.31. The figures in the table suggest that there is little difference between the sectors in terms of how much consideration pharmacists give to each factor when making ethical decisions. The most marked of these was the consensus, both within each sector and across sectors, that the patient's health interests were given a great deal of consideration (the mean score across sectors was 89%). It is also worth noting that there was agreement across sectors that pharmacists gave a great deal of consideration to keeping within the law (the mean score across sectors was 67%) and a great deal of consideration to whether they would be struck off (the mean score across sectors was 52%).

Table 4.31 Table showing how much consideration pharmacists from each sector give to certain factors when making ethical decisions at work. The factor with the highest mean score across sectors is highlighted, with the mean score across sectors stated. Percentages have been rounded to the nearest 1% and exclude missing values and those who answered 'N/A'.

	Community		Hospital		Primary care practice	
Patient's interests: health						
1: No consideration	0	(0%)	0	(0%)	0	(0%)
2: Little consideration	0	(0%)	0	(0%)	0	(0%)
3: Some consideration	1	(1%)	0	(0%)	0	(0%)
4: Quite a lot of consideration	25	(15%)	11	(18%)	0	(0%)
5: A great deal of consideration (Mean 89%)	142	(85%)	50	(82%)	14	(100%)
Missing/ N/A	7		3		1	
Total	175		64		15	
Patient's interests: non-health (financial/ social/ personal)						
1: No consideration	3	(2%)	2	(3%)	0	(0%)
2: Little consideration	15	(9%)	9	(15%)	0	(0%)
3: Some consideration (Mean 46%)	69	(41%)	29	(47%)	7	(50%)
4: Quite a lot of consideration	61	(36%)	20	(33%)	6	(43%)
5: A great deal of consideration	21	(12%)	2	(3%)	1	(7%)
Missing/ N/A	5		2		1	
Total	175		64		15	
Keeping within the law						
1: No consideration	0	(0%)	0	(0%)	0	(0%)
2: Little consideration	1	(1%)	0	(0%)	0	(0%)
3: Some consideration	2	(1%)	3	(5%)	2	(15%)
4: Quite a lot of consideration	40	(24%)	15	(25%)	4	(29%)
5: A great deal of consideration (Mean 67%)	126	(75%)	43	(71%)	8	(57%)
Missing/ N/A	6		3		1	
Total	175		64		15	
Keeping within the guidelines of the RPSGB						
1: No consideration	0	(0%)	0	(0%)	0	(0%)
2: Little consideration	2	(1%)	2	(3%)	0	(0%)
3: Some consideration	9	(6%)	8	(13%)	5	(36%)
4: Quite a lot of consideration	57	(34%)	23	(37%)	3	(21%)
5: A great deal of consideration (Mean 50%)	101	(60%)	29	(47%)	6	(43%)
Missing/ N/A	6		2		1	
Total	175		64		15	
Financial interests of yourself						
1: No consideration (Mean 50%)	68	(42%)	40	(68%)	10	(71%)
2: Little consideration	48	(29%)	8	(14%)	4	(29%)
3: Some consideration	39	(24%)	9	(16%)	0	(0%)
4: Quite a lot of consideration	5	(3%)	1	(2%)	0	(0%)
5: A great deal of consideration	3	(2%)	1	(2%)	0	(0%)
Missing/ N/A	12		5		1	
Total	175		64		15	

	Community		Hospital		Primary care practice	
Financial interests of the company/ hospital/ trust/ practice you work for						
1: No consideration	24	(14%)	3	(5%)	5	(36%)
2: Little consideration	48	(28%)	10	(16%)	3	(21%)
3: Some consideration (Mean 47%)	80	(47%)	31	(51%)	6	(43%)
4: Quite a lot of consideration	13	(8%)	31	(25%)	0	(0%)
5: A great deal of consideration	4	(2%)	15	(3%)	0	(0%)
Missing/ N/A	6		3		1	
Total	175		64		15	
Your reputation						
1: No consideration	5	(3%)	2	(3%)	1	(7%)
2: Little consideration	5	(3%)	6	(10%)	1	(7%)
3: Some consideration	26	(16%)	10	(16%)	4	(29%)
4: Quite a lot of consideration	49	(30%)	25	(40%)	6	(43%)
5: A great deal of consideration (Mean 31%)	79	(48%)	19	(31%)	2	(14%)
Missing/ N/A	11		2		1	
Total	175		64		15	
Your relationship with the patient						
1: No consideration	1	(1%)	1	(2%)	0	(0%)
2: Little consideration	5	(3%)	2	(3%)	0	(0%)
3: Some consideration	33	(19%)	10	(16%)	6	(43%)
4: Quite a lot of consideration (Mean 41%)	70	(41%)	28	(45%)	5	(36%)
5: A great deal of consideration	61	(36%)	21	(34%)	3	(21%)
Missing/ N/A	5		2		1	
Total	175		64		15	
Your relationship with the relevant prescriber						
1: No consideration	2	(1%)	1	(2%)	0	(0%)
2: Little consideration	7	(4%)	5	(8%)	0	(0%)
3: Some consideration	57	(33)	19	(3%)	6	(43%)
4: Quite a lot of consideration (Mean 36%)	71	(42%)	28	(46%)	3	(21%)
5: A great deal of consideration	34	(20%)	8	(13%)	5	(36%)
Missing/ N/A	4		3		1	
Total	175		64		15	
Your relationship with pharmacy colleagues						
1: No consideration	3	(2%)	0	(0%)	0	(0%)
2: Little consideration	12	(7%)	5	(8%)	2	(15%)
3: Some consideration (Mean 40%)	61	(36%)	27	(44%)	5	(39%)
4: Quite a lot of consideration	56	(33%)	24	(39%)	3	(23%)
5: A great deal of consideration	39	(23%)	5	(8%)	3	(23%)
Missing/ N/A	4		3		2	
Total	175		64		15	
Patient's relationship with the prescriber						
1: No consideration	1	(1%)	2	(3%)	0	(0%)
2: Little consideration	22	(13%)	5	(8%)	0	(0%)
3: Some consideration	57	(33%)	11	(18%)	4	(29%)
4: Quite a lot of consideration (Mean 37%)	63	(37%)	23	(38%)	5	(36%)
5: A great deal of consideration	28	(16%)	20	(33%)	5	(36%)
Missing/ N/A	4		3		1	
Total	175		64		15	

	Community		Hospital		Primary care practice	
Whether you'll be struck off						
1: No consideration	7	(4%)	4	(7%)	1	(7%)
2: Little consideration	10	(6%)	7	(12%)	2	(14%)
3: Some consideration	21	(13%)	8	(14%)	2	(14%)
4: Quite a lot of consideration	21	(13%)	10	(17%)	3	(21%)
5: A great deal of consideration (Mean 52%)	103	(64%)	30	(51%)	6	(43%)
Missing/ N/A	13		5		1	
Total	175		64		15	
Other						
1: No consideration	0	(0%)	0	(0%)	0	(0%)
2: Little consideration	0	(0%)	1	(33%)	0	(0%)
3: Some consideration	1	(13%)	0	(0%)	0	(0%)
4: Quite a lot of consideration	1	(13%)	0	(0%)	0	(0%)
5: A great deal of consideration	167	(75%)	2	(67%)	3	(100%)
Missing/ N/A	4		61		12	
Total	175		64		15	

There was less agreement across sectors in regard to the financial interests of the pharmacist and the financial interests of the company, hospital, trust or practice. These results were tested for association between sectors. Due to the small number of primary care practice pharmacy respondents, the tests only included community and hospital pharmacists. See Table A2.2 in Appendix 2 for detail of the test results. Two associations were found between the sector and how much importance pharmacists considered certain factors when making ethical decisions. There was an association between the sector pharmacists worked in and how much consideration they gave to their own financial interests ($U=3634.5$; $n_1=175$; $n_2=64$; $p=.003$). Figure 4.32 shows the distribution of scores, illustrating that community pharmacists considered their own financial interests more than hospital pharmacists did.[77]

There was also an association between the sector pharmacists work in and how much consideration they give to the financial interests of the company, hospital or trust

[77] This figure shows a box plot. In such a plot, the box represents the interquartile range and the solid line within it represents the median. The lines above and below the box ('whiskers') denote the maximum and minimum values respectively, excluding any outliers or extreme values, which are shown as individual markers.

they work for (U=3609.5; n_1=175; n_2=64; p< .0005), with community pharmacists less concerned with this than hospital pharmacists are (see Figure 4.33). It should be noted that these results are derived from questions that varied slightly between the sectors. Community pharmacists were asked how much consideration they gave to the financial interests of the *company* they worked for, hospital pharmacists were asked how much consideration they gave to the financial/ resource interests of the *hospital* or *trust* they worked for.

Figure 4.32 Box plot of the distribution of scores of the level of consideration community (n=163) and hospital pharmacists (n=59) give to their own financial interests. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2=Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

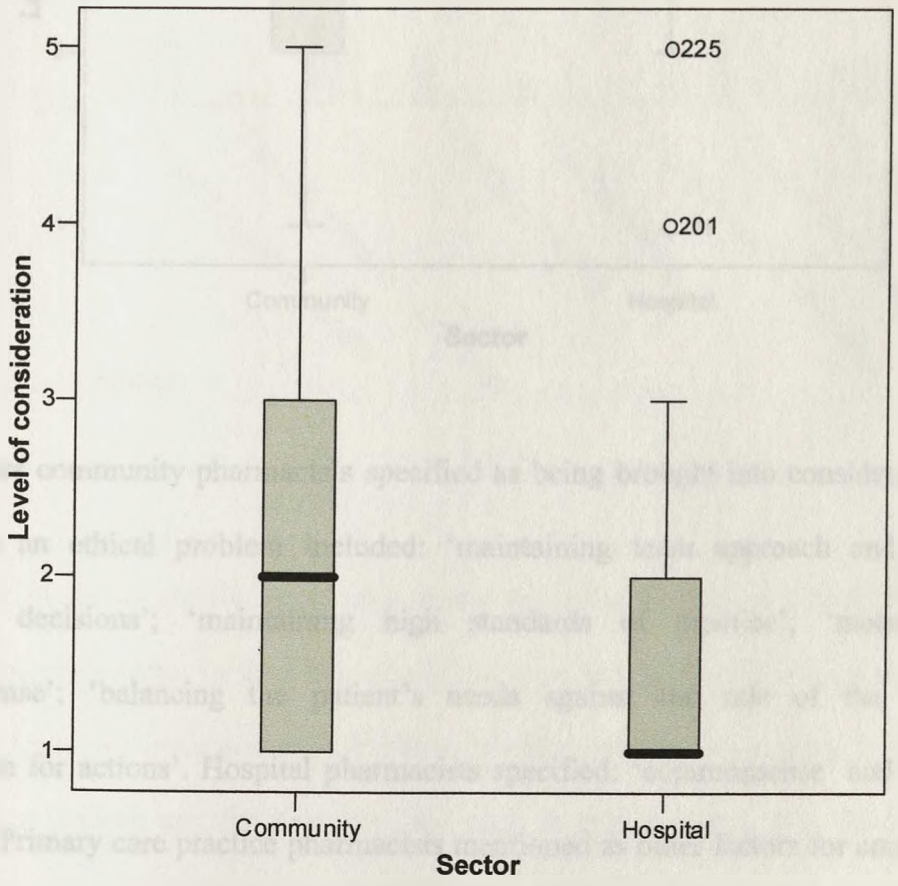
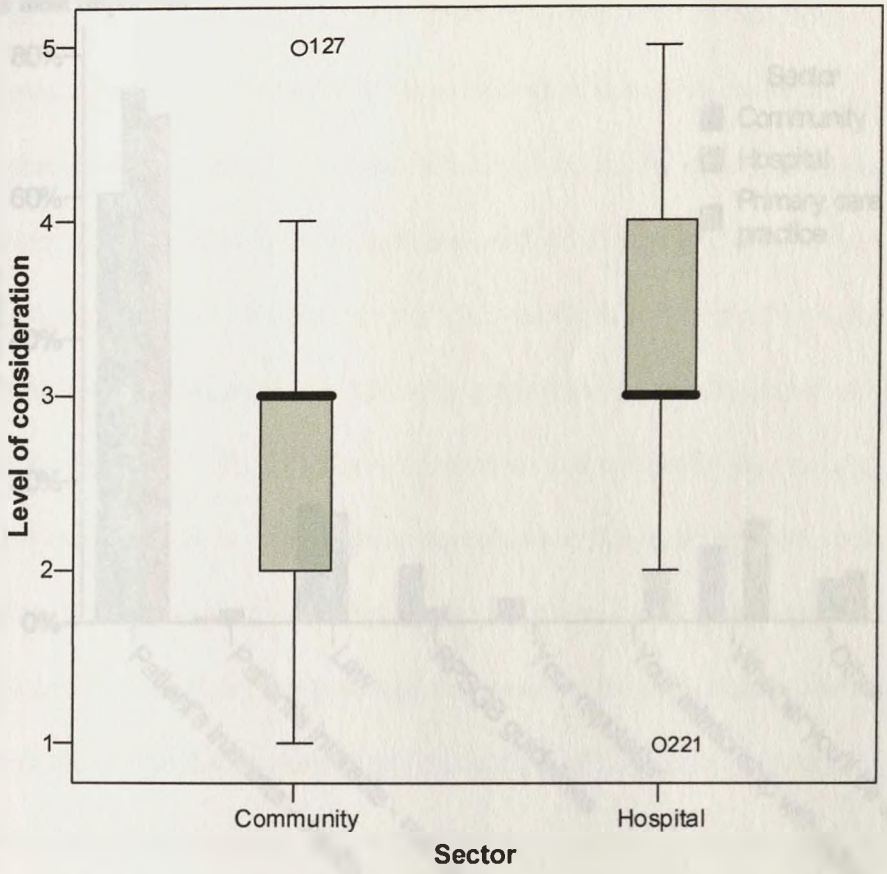
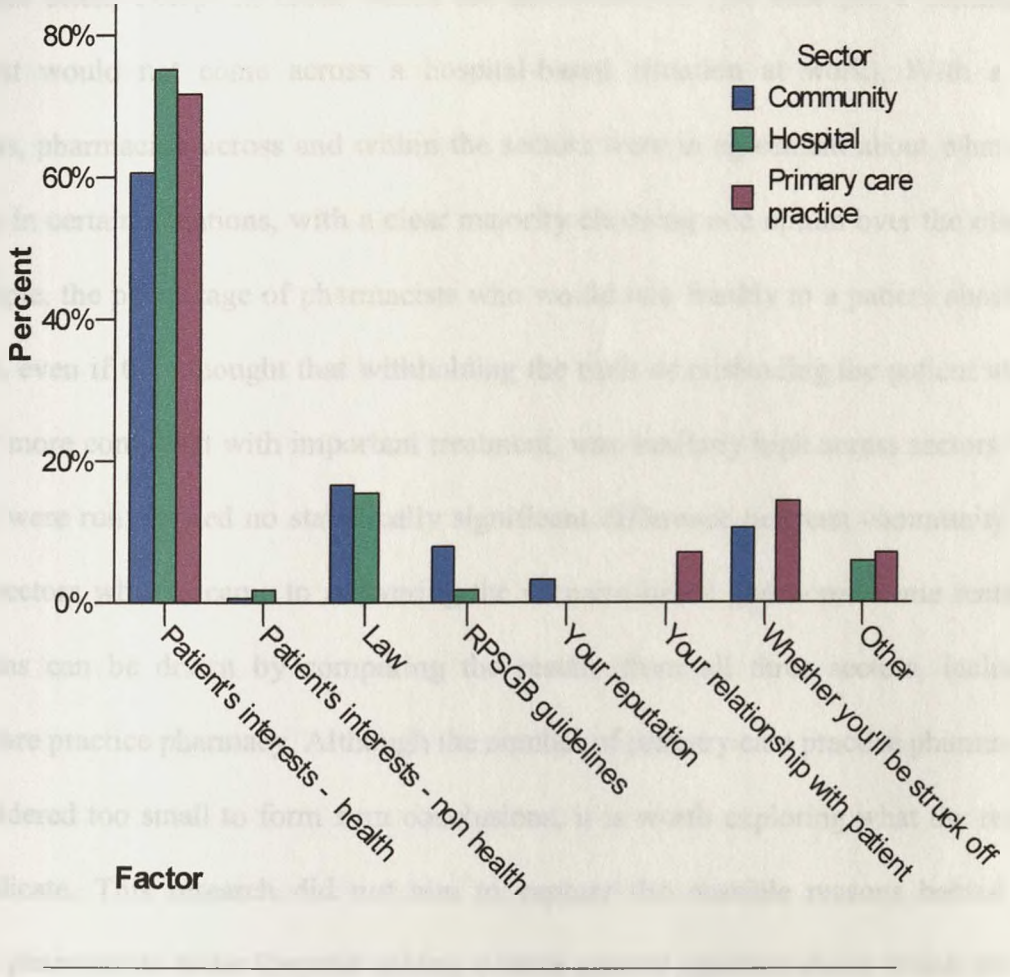


Figure 4.33 Box plot of the distribution of scores of the level of consideration community (n=169) and hospital pharmacists (n=61) give to the financial interests of the company, hospital or trust they work for. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2=Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.



Other factors community pharmacists specified as being brought into consideration when faced with an ethical problem included: 'maintaining team approach and policy in dispensing decisions'; 'maintaining high standards of practice'; 'moral values'; 'commonsense'; 'balancing the patient's needs against the rule of the law'; and 'justification for actions'. Hospital pharmacists specified: 'commonsense' and 'workload pressures'. Primary care practice pharmacists mentioned as other factors for consideration: 'doing least harm to the patient'; 'decision I can live with'; and 'if non-disclosure of something may cause harm to others'.

Figure 4.34 Clustered bar graph showing which factor community pharmacists (n=150), hospital pharmacists (n=51) and primary care practice pharmacists (n=14) considered the most important



As Figure 4.34 shows clearly, most respondents regarded the patient's health interests as the most important factor to take into consideration when faced with ethical dilemmas in their work. There was no association between whether pharmacists worked in the hospital or community sectors and the answers they gave to this question. See Table A2.14 in Appendix 2 for the full details of the statistical tests that were run.

4.6 Discussion

There is general agreement across community and hospital sectors about which situations occur most often, except in cases which are sector-limited (for example a community pharmacist would not come across a hospital-based situation at work). With a few exceptions, pharmacists across and within the sectors were in agreement about what they would do in certain situations, with a clear majority choosing one option over the other.[78] For example, the percentage of pharmacists who would talk frankly to a patient about her treatment, even if they thought that withholding the truth or misleading the patient would make her more compliant with important treatment, was similarly high across sectors. The tests that were run showed no statistically significant difference between community and hospital sectors when it came to answering the scenario-based questions. Some tentative conclusions can be drawn by comparing the results from all three sectors, including primary care practice pharmacy. Although the number of primary care practice pharmacists was considered too small to form firm conclusions, it is worth exploring what the results might indicate. This research did not aim to capture the possible reasons behind the decisions pharmacists make (beyond asking a more general question about which factors pharmacists considered important when making ethical decisions), and it was not something asked for in the scenario-based questions, but this discussion does suggest possible reasons for the results.

Pharmacists across the sectors reported the patient's health interests as the factor they considered most important when making ethical decisions. This would be consistent with the findings from the focus groups, which showed that one of the main concerns of community pharmacists was the patient's interests. It is notable that very few pharmacists

[78] For stylistic reasons, in this discussion pharmacists' decisions are said to relate to what they *would do* if faced with these problems, though of course for many of the participants they answered what they had *in fact* done when they encountered these problems.

rated patient's non-health interests as the highest factor for consideration. A division of health and non-health interests was reported in Benson's research into the values of the profession, which is possibly similar to the distinction seen by participants in the survey: "The provision of care and compassion is closely linked with a focus on a *patient as a person* as opposed to the more reductionist sense of the *patient as a body* associated with the *respect for medicines* strand. The extent to which this care for the patient as a person is considered possible reflects personal as well as contextual and institutional constraints and values."[79]

The concern for patient welfare is arguably reflected in the decisions pharmacists made (or would make) in a number of scenarios presented. For example, most (97%) community and most (98%) hospital pharmacists would contact the prescriber for further information or clarification about a prescription that was lacking the detail it would ideally contain. Such action would arguably be in the patient's best interests as it could reduce the possibility of the wrong medicine being dispensed, or at the wrong dose. There may of course be circumstances in which it would be in the patient's best interests to dispense the medication promptly, especially if the risk of harm was deemed low.

The focus groups showed that where pharmacists broke the rules it was mostly for the interests of the patient. In response to the scenario in which a GP asks for advice on whether to prescribe a low-cost, low-risk-of-harm medication that is not on the formulary, most (86%) primary care pharmacists would advise the GP to prescribe the medication. In this case, the pharmacist is willing to go against the formulary for the sake of the patient, at least when it will have no significant financial impact on the trust.

Most community pharmacists (79%) would be willing dispense from an unsigned prescription for a drug such as paracetamol if the prescriber could not be contacted.

[79] Benson, A.; Cribb, A. & Barber, N. (2007) *Respect for Medicines and Respect for People: Mapping pharmacist practitioners' perceptions and experiences of ethics and values* (London: Royal Pharmaceutical Society of Great Britain)

Pharmacists may be willing to make the supply without a prescription partly because paracetamol can be easily bought without a prescription, it is a relatively low-risk medicine, and regulation of its sale is limited. Results from the question asking participants which factor they considered most important when making ethical decisions suggest that pharmacists would make the decision to dispense paracetamol from an unsigned prescription because it would be in the interests of the patient, rather than for financial gain resulting from the transaction. This is compatible with the qualitative findings, in which financial interests of the pharmacist were hardly mentioned, though of this type of scenario, Pharm1 did comment, "We're pharmacists, but we're also businessmen".

Few of the answers given by community pharmacists to the scenario-based questions would indicate that community pharmacists are motivated by financial interests. Although a possible case could be made that the 80% who would dispense paracetamol from an unsigned prescription, the 58% who would sell EHC over the counter to a girl who appeared underage, and the 41% who would supply medication for use against guidelines were motivated by the financial gain associated with these sales, there are also arguments that the pharmacists making these decisions would do so in the interests of the patient and to respect the patient's autonomy. This would be fitting with the 81% who would refuse to dispense an opioid analgesic from an unsigned prescription, the 87% who would advise against the sale of an unnecessary product, the 71% who would not dispense a generically equivalent brand to that stated on the prescription, or the 86% who would not sell an over-the-counter product to a customer who seemed to be abusing it.

Despite this, it should be noted that many (24%) community pharmacists gave 'some consideration' to their own financial interests when making ethical decisions. The only association found between the sector in which community and hospital pharmacists worked was in the answers pharmacists gave to questions about how much consideration

they would give to the financial interests of themselves or the company, hospital or trust they worked for. Community pharmacists were more concerned about their own financial interests than hospital pharmacist were, but were less concerned about the financial interests of the company they worked for than hospital pharmacists were about the financial interests of the trust or hospital they worked for. In part this supports research by Hibbert, Rees and Smith, which showed that community pharmacists experienced a conflict between business or economic concerns and "professional responsibilities". [80] Given the fact that retail features much less in hospital pharmacy it is hardly surprising that hospital pharmacists do not feel the same conflict that community pharmacists do. Cooper reports that community pharmacists also feel this business pressure from the company they work for, one pharmacist feeling "forced to balance the independence of the patient with what she considered to be 'pressure' from her manager and her employer's strategy for generating further sales."[81]

If pharmacists are willing to break small rules for the interests of the patient, then there is another factor at play that means that most (79%) community pharmacists are willing to dispense from an unsigned prescription for a drug such as paracetamol, but that most (71%) would not dispense a generically clinically equivalent medicine when out of stock of the brand specified on the prescription. This is, strictly, in compliance with the rules and with the prescriber's wishes. It is worth noting, though, that the prescriber may only know the medication by one of its brand names and so writing a brand name is not necessarily an expression of the wish to only supply that brand. Dispensing a generically equivalent brand could have the same clinical effect on the patient, could be more convenient for the patient, and could mean a business transaction for the pharmacy.

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[80] Hibbert, D.; Rees. J. A. & Smith, I. (2000) 'Ethical awareness of community pharmacists' *The International Journal of Pharmacy Practice* 8: 82-87 p85

[81] Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham

There were responses that indicated that pharmacists preferred to abstain from involvement. This may be motivated by a respect for the patient's autonomy, or by a reluctance to interfere with decisions made at least in part by other professionals. Interfering in some decisions may, for example, be seen as damaging to inter-professional relationships, or as disrespectful of the decisions made by another professional. On one hand, it seemed that having respect for patient autonomy may arguably be the driving force behind the answers given to the question about a patient whose compliance with important medication may be increased if she was misled by the pharmacist. There was consensus among pharmacists from all sectors that they would not withhold the truth from or deliberately mislead a patient, even if doing so would mean the patient would be compliant with medication that was important to her.

Compare this with the case in which a terminally ill hospital patient asks for information about her prognosis when she felt the doctors were not telling him/her the truth. There appears to be a similarity between hospital and primary care practice pharmacists' responses concerning this case. Most hospital (93%) and primary care practice pharmacists (93%) would choose to answer the patient's questions, while avoiding giving full answers. Possibly, this is because a situation of this kind is potentially very awkward and emotionally difficult, and so full involvement in the case is unappealing. It is also possible that in this case pharmacists would act paternalistically, and would make decisions about what the patient ought to know for her own good. Arguably, the patient's autonomy would be restricted if she was not given full information upon which to base her decisions about treatment and care, and about her psychological preparedness and relationships with family members and friends, and so forth.

It is also possible that pharmacists would not want to interfere with the way the rest of the medical team was handling the case. Pharmacists' responses to the scenario in which

a patient had failed to inform the DVLA of her medical condition that may affect her while driving may illustrate pharmacists' tendency towards non-interference even when interference may arguably be in the patient's best interests, and in the interests of the public. Most community pharmacists (75%) answered that they would talk to the patient about the fact that she had not declared her condition to the DVLA, rather than report the patient, even though they knew the patient was unlikely to change her mind. This decision is one of non-interference, and is possibly driven by a respect for patient autonomy, or by a reluctance to interfere with decisions made by other healthcare professionals (for example the physician who probably already knows of the patient's epilepsy). Other arguments in favour of not informing the DVLA of the patient's condition may be that it would be in the patient's best interests, for example in order for her to maintain her independence.

There is a possible difference between community and primary care practice pharmacists when it comes to reporting a patient to the DVLA. Results suggests that, possibly, community pharmacists would be less likely to report the patient to the DVLA than primary care practice pharmacists would. The apparent difference is possibly due to the fact that primary care practice pharmacists work in a setting of general practice, whereas community pharmacists tend to work in more isolated conditions. The result may be that primary care practice pharmacists are exposed to these kinds of problems and are more familiar with them, and so do what is more commonly practised. In this case GPs are obliged to inform the DVLA of certain medical conditions of their patients. Community pharmacists, on the other hand, may be less familiar with this practice and the associated procedures.

Many hospital pharmacists (37%) would choose to talk to the patient and 55% would choose to inform a medical consultant (respondents from community and primary care practice were not given this option). It is interesting that the divide within hospital

pharmacists was between reporting the patient to the consultant and talking to the patient even though the pharmacist knew the patient was unlikely to change his/her mind. The actions of reporting the patient to the DVLA and informing the consultant of the problem are similar in terms of the possible outcome for the patient, and yet there seemed to be reluctance for the pharmacist to be the one to report the patient to the DVLA (only four hospital pharmacists answered that they would do so). Again, this may be accounted for by the fact that there is more than one professional involved in the patient's case and hospital pharmacists may not regard the decision as theirs to make.

Cooper suggests community pharmacists suffer subordination under doctors,[82] which may account for any reluctance of hospital and primary care practice pharmacists to tell a terminally ill patient her full prognosis when her doctor had so far avoided doing so, and the reluctance of community pharmacists to report a patient to the DVLA (possibly because the patient's doctor would be very likely to know about the condition).

The conflict between the directions of the prescriber, patient autonomy and rules is possibly also present in the scenario about the use of medication outside the product guidelines. Community pharmacists were divided on whether to supply medication (such as hydrocortisone cream) to a patient who has said she intends to use it against the guidelines. More community pharmacists answered that they would refuse to supply the medication, with 59% saying they would refuse the supply and 41% answering that they would make the supply. Making the supply would allow the patient to exercise autonomy, would generate income for the pharmacy, and would possibly have health benefits for the patient. Possible reasons pharmacists had for refusing the supply are that some guidelines are sound and reasonable. In the case of hydrocortisone cream, long term use can lead to damage of the skin, or the cream can worsen existing skin conditions, which is considered

[82] Ibid. p273-279

worse if it is on the face. It is also against the guidelines for pharmacists to knowingly supply it for such use. Even so, a community pharmacist is likely to know that a doctor may prescribe hydrocortisone cream for short-term use on the face, advising the patient to use it only sparingly and for a short time only. Cooper's work showed some concern among community pharmacists on the matter of supplying medication for use outside the product licence, with pressure coming from a combination of aggressive promotion of medicines and demanding customers.[83] The focus groups conducted for my research illustrated two attitudes towards the supply, or otherwise, of medicines for use outside the product licence. One participant thought the pharmacist should take responsibility for her own response to a request from a patient for medicine that would be used against the product licence, which in this case was hydrocortisone cream on the face. The view of the second participant was that the pharmacist could reasonably give diplomatic assent to the use of this particular medicine outside the product licence:

> *Hydrocortisone: I had this lady come in last week come in to get ... the cream, and I can see that she has got eczema round the eyes. ...I knew that she was using it on her face and I refused to sell it to her... but I'm sure that she would have gone to the next door pharmacy and say, 'I'm using it for my hands', and then she would be able to buy there.*
>
> *Pharm4*

> *Well, I've had somebody come in and say, 'Well, I've got eczema on my hands anyway but I've also got a bit on my face, but if you want me to,*

[83] Ibid. p154-156

I'm just using it on my hands.' [All participants laugh] And so I usually say, 'Well, that's fine, I can sell it to you for your hands but I do not recommend that you use it on your face because it is not recommended.' [General agreement from others] ... But then the guy came back and says, 'Would you use it if you had eczema on your face?', and I said, 'Well, that's a different matter'.

Pharm1

There were interesting data on responses to scenarios relating to confidentiality. Most pharmacists in each sector (92% community; 95% hospital) answered that they would not disclose information about a patient's treatment to a spouse or close family member of that patient. This is in keeping with the RPSGB's Code of Ethics, and respects the principle of confidentiality. There may be some situations in which unique circumstances justify disclosure, which may account for those who answered that they did disclose the information.[84] There was less agreement over whether confidential information about a patient aged fifteen years should be disclosed to that patient's parent. In this case, 63% of community pharmacists and 59% of hospital pharmacists answered that they would protect the confidentiality of the patient. Perhaps in this case some pharmacists regard the parents as having a right to know about their child's treatment, or perhaps some pharmacists believe it would be in the patient's best interests if the parents were involved. The RPSGB's guidelines in the Code of Ethics at the time of the survey stated that adolescents should usually have the same rights to confidentiality as adults:

[84] See discussion of the quantitative data in Chapter Three; pharmacists may break confidentiality unknowingly, and so those who answered this question by claiming that they would not disclose confidential information to a family member of a patient might not actually protect confidentiality in reality.

"Pharmacists should be aware that information about services provided to adolescents should not normally be disclosed to their parents."[85]

Opinion about confidentiality divides further with the scenario in which a member of the public asks the pharmacist to identify a tablet that does not belong to him/her. Results suggest (but have not been confirmed with statistical tests) that pharmacists in primary care practice would be more reluctant to identify the tablet than community and hospital pharmacists would. Although the question in the survey indicated that the pharmacists would be able to identify the tablet, primary care pharmacists' answers may have been affected by the fact that they are not as likely to be as familiar with the appearance of medication as community and hospital pharmacists are, and in general practice there is not a stock of medicine to compare the tablet to. Community pharmacists were almost equally divided between disclosing the identity of the tablet (51%) and not disclosing its identity (49%); hospital pharmacists were similarly divided, with 51% identifying the tablet and 49% not doing so. The division here may be because of the uncertainty of the case. As with all the scenarios presented, very little information was given to participants. In this case, factors that might affect what the pharmacist decides to do include what the tablet is, whether it is legal, what it is usually used for, where the person asking about it got it from, and so on. This is a complex scenario for other reasons too. There are strong arguments for disclosing the identity of the tablet, and strong arguments for refusing to do so. A pharmacist may be obliged not to tell the enquirer what the tablet is if in doing so this would breach the confidentiality of one of her patients. On the other hand, to not tell the enquirer what the tablet is could be dangerous. She may assume it is harmless when it is not, and may take the tablet, causing harm to herself, or she may not have realised the tablet was hers, and may miss vital medication as a result.

[85] RPSGB *Medicines, Ethics and Practice: A Guide For Pharmacists* 2005 (Royal Pharmaceutical Society of Great Britain: London) p85. The current Code of Ethics for Pharmacists and Pharmacy Technicians does not make specific reference to the disclosure of confidential information about adolescents to their parents.

Further, it is arguable that the enquirer has a right to know what the tablet is, since its identity is a publicly knowable fact. This case is discussed in greater depth in Chapter Five.

There was a consensus among community and hospital pharmacists alike that if a patient were to return unused, unopened, in-date medication for disposal they would not re-shelve it but would dispose of it. Possible explanations are that the pharmacist would be breaking the rules by re-shelving the medicine; that it would be of no great advantage to the public in doing so; and that the medication could possibly be used as a donation to developing countries. Pharmacists might be hesitant to pass the medication to developing countries or to other patients after re-shelving because they cannot be sure how the medication has been stored, or whether it has been altered deliberately. The risk may be low, but pharmacists may be reluctant even on principle to dispense medication that is potentially harmful or ineffective.

There were apparent differences between the decisions hospital pharmacists and primary care practice pharmacists would make in regard to a couple of scenarios. This could perhaps be explained by the different work settings of the two sectors in terms of their exposure to certain problems and to the makeup of the professional team they work in. In the sample surveyed, hospital and primary care practice pharmacists would respond differently when asked to dispense a drug for an unlicensed indication that is used in the USA to good effect. The results from the questionnaire suggest the possibility that hospital pharmacists would be more likely to agree to dispense the medication than primary care practice pharmacists would advise the prescription. This difference may be accounted for by the relationship between the consultant and the pharmacist. The hospital pharmacist is more likely than the primary care practice pharmacist to know the consultant, her way of

working and the principles under which she prescribes, and thus us more likely to have a relationship of mutual trust.

Similarly, in regard to the case of suspected child abuse of a patient, results may indicate that primary care practice pharmacists may know what to do and would go through the appropriate channels to report the problem, while more community and hospital pharmacists would be unsure what to do. Possibly, primary care practice pharmacists would be more exposed to and aware of this problem through discussions with doctors and nurses, and may have had training specifically on this matter, or through discussions with colleagues may know how the relevant procedures operate and as a result may be more likely to know what to do. Again, these suggestions are made tentatively because no statistical test was run on these data.

4.7 Conclusions regarding quantitative data results

These results show general agreement across pharmacy sectors about which ethical problems occur most often, and how pharmacists deal with, or would deal with them if they arose. The possible discrepancies that exist between sectors may be explainable by the different settings pharmacists work in, the resulting exposure to certain problems, as well as the associated inter-professional relationships in each setting. Although the focus groups and relevant literature have provided some insight into possible reasons behind the decisions made, there is scope for further investigation into pharmacists' reasoning behind these particular decisions. The results indicate where our attentions should lie both in terms of the kinds of ethical problems pharmacists have to deal with most often, and the areas of practice that might be worth further investigation with supplementary qualitative research.

Conclusions that could be drawn from the primary care practice questionnaire were limited, and a wider-scale investigation into this sector would yield data comparable to those of the other sectors.

4.8 Limitations of the empirical research

The purpose of this section is to reflect on the empirical research methods used. First, I will make some comments on the questionnaire and then will turn to the focus groups. The method of focus groups is discussed here (as opposed to Chapter Three) to avoid interruption in the presentation of the data.

The chosen methods were suitable for the aims in principle, and also largely in practice, but the main concern I have for the research methods is in whether the detail of their design fully matched their purposes.

4.8.1 Questionnaire

Researching ethics using quantitative methods is unusual, but in this case a quantitative questionnaire was the appropriate choice of method to meet the particular research aims of discovering the frequency of occurrence of certain problems and the decisions pharmacists make when faced with these problems.

There were necessary limitations in the design of the questionnaire itself. The scenario-based questions asked pharmacists to first indicate how often, if at all, they had encountered a particular situation and to then indicate what action they took, or *would* take, all things being equal. This is a difficult question to answer (as is discussed below) but there is an additional problem, which is that effectively participants are being asked different questions. Suppose a pharmacist had come across a particular situation once in her career, and the particular circumstances relating to that situation were such that she made a decision that, under slightly different circumstances, she would not have made. For example, the questionnaire asked community pharmacists what they would do if, all things being equal, a patient came to the pharmacy for her methadone one day after the date specified on the prescription. Pharmacists who had not encountered that situation already may answer that they would not make the supply. But there may be pharmacists who had been in that situation and, for reasons not covered by the phrase 'all things being equal', had made the supply (maybe, to borrow an example from one of the focus group participants, because the patient was pregnant). Effectively, the pharmacist who has

encountered this broad scenario before is answering a different question to those who are asked to consider the situation with 'all things being equal'.

The questionnaire was complex, which was mostly unavoidable given the nature of the research, but some of the demographic questions were unnecessary for meeting the aims, and their exclusion could have simplified the questionnaire.

In fact, in an effort to achieve simplicity and clarity, the questionnaires asked narrow questions about very complex situations. There was also some resistance to the questionnaire, and this was expressed in some of the responses. The information given to questionnaire participants was very limited, and they were restricted in the choices they were given, when in real life there may be many more choices available.

Keeping details in the questions to a minimum has its advantages, as it means respondents are forced to make decisions on limited information, which may resemble practice.[86] However, it also means there is scope for interpretation and respondents may understand the questions differently, leading to inconsistent answers. I attempted to overcome this problem by asking respondents to consider 'all other things as being equal' when thinking about the situations they were presented with. However, as Hasman points out, this is perhaps an unrealistic request, and would only work if ethics was something that could be abstracted from context in this way. "Studies offering only single dimensional information to the decision-maker appear to be based on the assumption that the phrase "every thing else being equal" is in fact meaningful to respondents. We might question how reasonable such an assumption is, however, especially in a context such as health care prioritisation where emotions and personal experiences could have a significant impact on judgements. It could be argued that there is a significant risk of respondents

[86] Mossialos, E. & King, D. (1999) Citizens and Rationing: Analysis of a European Survey. *Health Policy* 49, 75–135.

assuming additional information which correspond to their personal experience and that this implicit background is not held generally and consistently by all respondents."[87]

The following remark is typical of some of the comments that appeared on the returned questionnaires: "I almost didn't fill in the questionnaire because I felt I *couldn't* without further information. The questionnaire 'pushes' pharmacists to pick choices that are legal and ethical and not necessarily realistic. In almost all cases I would have chosen a *greyer* alternative that I feel would not have put the patient's health/ welfare at risk and not had me struck off!"

Despite these reactions from some respondents (and no doubt more non-respondents), the questionnaire was successful in that most of the answers to the questions were comprehensible and the response rate (54%) was good, especially for a questionnaire of this type, length and complexity.[88]

4.8.2. Focus groups

The focus groups were largely successful, but did suffer from low numbers of participants. The strategy of recruiting on the back of courses run by Keele University was useful for identifying and contacting potential participants, and possibly for increasing the number of participants. However, this system of recruitment was restrictive in the choice of pharmacy sectors for the focus groups, partly because primary care practice pharmacists did not attend the courses run at Keele University at that time, and because the timing of the focus

[87] Hasman, A. (2003) 'Eliciting Reasons: Empirical Methods in Priority Setting' *Health Care Analysis* 11; 1; 41-58, p52

[88] "Response rates of less that 50 per cent with samples are common;" "I once managed an 86 per cent response rate from a population, using a mailed questionnaire, a method prone to low response rates....I have never managed such a high response in studies involving the use of samples. As a general rule, neither do most social researchers." Blaikie, N. (2003) *Analysing Quantitative Data: from description to explanation* (London, Thousand Oaks, New Delhi: Sage) p158 & p212, respectively.

groups was dependent on the timetable the courses ran to. The alternative would have been to recruit across a wider geographical area independently of the courses at Keele University, but this would have been at some financial cost in terms of postage and reimbursement of travel expenses and time out of work. My attempts to recruit pharmacists who were not already studying at Keele University (i.e. contacting locums through an agency) were unsuccessful. The results of recruitment through Keele University courses were that the number of focus groups was small, the numbers in the focus groups were also small, saturation of data was not achieved, and there was no focus group for hospital or primary care practice pharmacists. As a result it is possible that not all ethical problems that arise in pharmacy practice were identified by the focus groups. This last shortcoming was addressed by consulting pharmacists known to members of the project steering group in order to develop scenario-based questions that would be appropriate for inclusion in the questionnaire.

4.8.3 Closing remarks

In some ways, this project was an ambitious one given the broad aims of the research and the number of methods required to address them. However, the advantage of using a combination of types of methods was that the research could genuinely cross disciplines and was not restricted in the questions that could be explored.

Chapter Five: The use of empirical data in applied ethics

5.1 Overview

The primary aim of this chapter is to come to an understanding about the respective roles of empirical research and philosophy in applied ethics. The work displayed in the thesis up until this point has been empirical. The findings from the focus groups and the questionnaire have shed light on pharmacists' perceptions of ethics in general, and on the way they understand particular ethical notions, including their role as ethical decision-makers. The questionnaire has gone some way to answer how common certain problems are and how pharmacists tend to deal with these ethical problems in their work. This increased understanding is good in and of itself, and also has important implications for further research.

Where findings of this type might also be considered to have impact is in policy, with the profession making decisions about what is ethically acceptable, and giving guidance about ethical conduct at least partially on the basis of findings like these. It is this use that this chapter sets out to question. Ethics is a branch of philosophy, and philosophy is not usually concerned with empirical research. Although philosophical thought does require empirical facts of some kind (after all, philosophy has to be is *about something*) empirical research is not normally the business of philosophers. Even so, it is fairly clear that *applied* or *practical* ethics will require consideration of the way the world is constructed, the relationships between people, people's understanding of morality and so on. What is questionable is exactly what the relationship should be between the social sciences and philosophy in applied ethics.

This chapter examines three approaches commonly taken towards the use of empirical investigation in applied ethics, though there are subtle variations between them. First, there will be a description and critique of relativism, a metaethical theory that uses empirical data as the basis for making moral claims. The section looks briefly at what relativism is, and discusses the problems with it, which, it is argued, make relativism an ultimately untenable position.

The second approach considered in this chapter is one that is sometimes used in applied ethics, which is an unstructured mixture of relativism, personal opinion, popular opinion and philosophy. Such an ad hoc approach seems to appeal to a combination of the idea that popular opinion about an ethical matter can have bearing on moral facts and the notion that some ethical theory is still needed. The discussion starts with a brief mention of a couple of examples of sound empirical research literature in pharmacy ethics to show, in contrast, some of the other work that seems to adopt less rigorous methods. It is concluded that, at least sometimes, ethics in pharmacy has been taken to be something that can be understood through a combination of empirical investigation, occasional philosophical reference and personal opinion about what ought to be the case. I hope to show that such a method is inadequate in answering questions about ethics.

Following this will be a discussion of another use of empirical data in ethics, namely the 'informed philosophical approach', which takes an objective view of ethics with an appreciation of the role empirical data plays in telling us about the world, and informing workable policy. This is the approach I recommend is adopted in pharmacy ethics research and policy-making to bring them forward in a robust and workable form.

Finally, the chapter uses a case study to demonstrate the way philosophical analysis works well with the input of empirical research. The case study involves taking a situation discussed in the focus groups and using it to ask questions about the concept of

confidentiality as it is usually understood in applied ethics. This example illustrates one direction in the relationship between empirical research and philosophical analysis, leaving the following chapter to demonstrate how this multi-disciplinary approach works in the other direction too.

5.2 Moral relativism

Whether we think empirical findings have any bearing on applied ethics depends in part on our metaethical standpoint. We might, for example, rely very heavily on empirical findings in applied ethics if we decide that popular moral belief represents moral truth and that discovering moral facts involves asking people what their moral values are. With all the different cultures and societies that exist, there is at least as much diversity in moral practice and values. Many people are sympathetic to the view that each variation in moral custom is not a deviation from a single objective truth, but rather is one of a plurality of truths. That is, each culture and society has a set of moral values that is right for them. It is quite common for us to look upon the practices of other cultures and societies and decide that while their customs would be unacceptable in our own society, those customs are right for them. There is a tendency to want to accept the moral codes of other societies and cultures and refrain from imposing our own moral values on them. Moral relativism is the metaethical theory that captures the intuition that differing moral beliefs represent a real difference, rather than a variation in interpretation of a single truth. A moral relativist holds not only that moral opinions or moral understanding vary between cultures but that, correspondingly, moral *truths* differ between cultures or societies. In other words, the variety of moral values between societies can be accounted for by things being 'right for

them' and 'right for us', rather than by holding that only one of these sets of values, if any, can be right.

So according to moral relativism there are no universal moral truths, but moral claims exist in relation to societies or cultures.[89] For moral relativism, moral claims are a matter of belief. Whether an action or principle is right or wrong is wholly dependent on whether the particular society or culture believes it to be right or wrong, or whether it is fitting to a culture that it is right or wrong. So a moral relativist will hold that burning the dead body of one's father is simultaneously right for the Greeks and wrong for the Callatiae tribe, and, equally, that eating the dead body of one's father is right for the Callatiae tribe, while at the same time wrong for the Greeks. As long as at least one society has the opinion that something is right, it is right *for them*, and so long as at least one society has the opinion it is wrong, it is also wrong *for them*. Thus, to discover what is right for a particular society, one must ask members of that society. In the case of pharmacy, relativists would insist that to make any assertions about ethics in pharmacy practice, we must survey the moral values, principles or actions of the relevant community, which in this case might be the pharmacists and their patients and/or the wider public.

In contrast, non-relativists, or objectivists as I shall refer to them, hold that there is a single truth about morality, that there is one answer to each moral question. When the Callatiae tribesmen say, 'It is right to eat the body of one's dead father', they are either right or wrong, simpliciter.

Key to relativism is the doctrine that morality is a social construct. According to relativism, there is an ontological difference between claims about morality and claims

[89] In the focus groups, pharmacists spoke of morality as something whose truth was dependent on the opinion of society or the relevant community, an understanding of morality that is consistent with relativism (see Chapter Three, section 3.2.3). Pharmacists also spoke of morality being based on personal opinion, which could be recognised as subjectivism. Subjectivism is the idea that the truth of moral statements is dependent on what the individual who states them feels. Moral relativism differs from subjectivism in that relativism holds that moral claims are true or false in relation to the beliefs of a society or culture, not individuals.

about science (as science is typically understood).[90] Unlike scientific facts, claims about morality are dependent on human thought. On this view, morality would not be unique in its ontological make up. For example, aesthetic qualities are not objective but require a creator and an onlooker.

That morality is socially constructed is a compelling claim; societies function well within structures of morality, and where societies differ in their situations the moral frameworks are different to accommodate this. One of the arguments for moral relativism is that societies actually need certain customs in order to function, and would cease to be the societies they were without certain moral practices in place. But as Wong, a moral relativist himself, points out, this is no argument for relativism. "To show that certain beliefs are necessary for maintaining a fascist society, for instance, is not to justify those beliefs."[91] I shall return to this point later.

Wong gives a plausible explanation for the origin of morality as a social construct. He explains, "morality serves two universal human needs. It regulates conflicts of interest between people, and it regulates conflicts of interest within the individual."[92] This need, Wong claims, is what morality is born from; "Ways of dealing with those two kinds of conflict develop in anything recognizable as human society...[G]iven this picture of the origin and functions of morality, it would not be surprising if significantly different moralities were to perform the practical functions equally well....Moralities, on this picture, are social creations that evolve to meet certain needs."[93]

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[90] Some hold that scientific facts are relative. Since scientific facts are only being used here to illustrate a point, let us assume for the sake of argument that scientific facts are objective, as is typically thought.
[91] Wong, D. (1993) 'Relativism' in Singer, P. (ed.) (1993) *A Companion to Ethics* Blackwell: Oxford pp.442-450 p443
[92] Ibid. p446
[93] Ibid. p446

5.2.1. Diversity of moral opinion

For some, the very fact that our world holds such diversity of cultures and moral practices geographically is enough to convince them that there is not one universal set of moral truths, but many truths relative to each society in turn. After all, if moral truths were universal, why would there be so much discrepancy between cultures? Might diversity of belief indicate diversity of truth? It is worth making the point that although the world is diverse in moral opinion, this is not itself evidence of plurality of moral truth. The planet Earth has always been spherical; it is not the case that the world was flat up until the majority was convinced by Columbus it was round. By the same token, the fact that there are differences in moral opinion between cultures is no indication of morality being relative to culture. Even so, we are still able to agree to a much greater extent about scientific facts than we are about moral facts. Perhaps this is because moral facts are more difficult to understand than scientific facts, making it harder to reach a consensus. Even if we did manage to reach a consensus this would not necessarily help since consensus alone is not an indication of truth.

In his moderate form of relativism, Wong points to an example of moral difference between societies which he hopes will illustrate that two otherwise contradictory moral principles are equally justifiable. To choose between them would be impossible, Wong says, and their co-existence indicates that moral claims are relative. The example Wong gives is the differences between the "emphasis on individual human rights in the ethical culture of the modern West and ... the central value of a common good that consists in a certain sort of ideal community life" in Africa, China, Japan and India.[94] Each value is very different, Wong argues, and equally justifiable. "It would be surprising, the argument goes, if there were just one justifiable way of setting a priority with respect to the two values. It

[94] Ibid. p445

should not be surprising, after all, if the range of human good is simply too rich and diverse to be reconciled in just a single moral ideal."[95] Wong has chosen an example less easily dismissed by an objectivist, because neither cultural norm is immediately repelling. But the example fails to prove anything. At best, the objectivist will agree that it would be hard to decide which of the two cultural values was more worthy than the other, but the difficulty, or even impossibility in face of epistemic obstacles, does not indicate there actually is no difference in value.

Bear in mind also that Wong's argument rests on choosing an example of two apparently contradictory values that are of equal appeal. Of equal appeal to whom? For Wong to be right, his example must be of two cultural values, one of which is appealing to the first culture and unattractive to the second, and the other must be appealing to the second culture and unattractive to the first. But for Wong to be *persuasive* his example must be of equal appeal to one and the same person, or to one and the same culture he is aiming to convince. Effectively, all Wong is doing with this example is to point to two contradictory values within one culture or individual, and this does nothing to support his claim that diversity *between* cultures can yield contradictory moral qualities of equal value.

5.2.2 Tolerance

Relativism is, theoretically, void of moral imperialism and its slogan, 'Who are we to judge?', is very attractive to liberals. This aspect of relativism can be characterised as tolerance. It allows us to look upon other cultures without criticism, but instead with acceptance. Given this is relativism's greatest appeal, if it can be shown that tolerance is mistakenly attributed to relativism, or if it can be shown that it exists only to the same

[95] Ibid. p445

extent that tolerance exists in objectivist accounts of morality, then relativism will lose its attraction. The following three sections give details of three objections I want to make against the relativist's claim that tolerance is a valuable feature of relativism.

5.2.2.1 Tolerance is itself a universal value

Contrary to first impressions, moral relativism cannot straightforwardly claim that it leads to a lack of criticism of other societies' and cultures' moral practices. A strong claim that tolerance is a virtue of relativism is inherently incoherent. To make such an assertion is to make a universal moral claim. Since relativists hold that moral claims are relative, the virtue of tolerance must itself be relative, and cannot be applied universally as a feature of the theory itself. As Sheehan puts it, "it is natural to think that we ought always be tolerant of others. But this looks to involve the relativist in a contradiction. Understood in this strong way, the relativist seems to be making an absolute moral claim of precisely the kind that is not supposed to exist. The moral relativist cannot both require that we are always tolerant and claim that there are no absolute moral truths."[96]

The claim need not be this strong, though, and moderate versions of relativism steer clear of any charges of inconsistency. In doing so, though, they may lose their appeal. The defence against the inconsistency accusation is that tolerance is not a universal moral claim, but rather it is a principle attached to western society. So while it is *right for us* to be tolerant of the moral practices of other cultures and societies, this does not mean we should regard other cultures and societies as having a moral obligation to be tolerant. This seems to work, and moral relativism has escaped the criticism of inconsistency, but at a high price, namely the loss of one of its greatest appeals.

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[96] Sheehan, M. (2007) 'Moral Relativism' pp 93-98 in Ashcroft, R.; Dawson, A.; Draper, H. & McMillan, J. (eds.) *Principles of Healthcare Ethics* (UK, John Wiley & Sons Ltd.) p94

5.2.2.2 Tolerance of different cultures' moral belief does not need relativism

But what special appeal does moral relativism now have? Does this apparent revelation that we in the west believe in tolerance warrant a belief that moral truth is relative? Being tolerant is, after all, entirely consistent with holding that morality is objective. For example, a consequentialist would argue that it would be morally far better to tolerate some smaller acts that we would otherwise object to in order to safe-guard a world that is generally good (or better than it would otherwise be). For example, it might be that tolerance and freedom generally bring about more contentment than restriction, criticism and regulation do, and so it may not be worth criticising a society for a matter such as favouring eating dogs over eating pigs, but it may well be worth campaigning against a cultural and religious practice such as female genital mutilation, since the negatives of restriction and criticism might be out-weighed by the negative effects of female genital mutilation.

5.2.2.3 Tolerance is not necessarily a good thing

Given relativism's appeal of tolerance, we must be sure that tolerance is a good thing, but it is far from clear that we should tolerate all practices of other cultures and societies. To borrow Blackburn's example, according to relativism, depriving women of education is, in the Taliban group, morally right. That is, it is true for the Taliban that women ought not to be educated. "[But] what can that mean? Surely it is just a bad way of saying that the Taliban *hold* that women should not be educated, which we already knew."[97] To fail to reject another culture's practices just because they belong to another culture is, to

[97] Blackburn, S. (2001) 'Relativism' in La Follette, H. (ed.) (2001) *The Blackwell Guide to Ethical Theory* (Oxford: Blackwell) pp.38-52 p40

Blackburn, beyond reason. "I am unsympathetic to this degree of toleration – the kind of open mindedness that comes when all one's brains have fallen out."[98]

The relativist can give two answers to this. The first is to claim that although moral truths are relative, this does not mean that 'anything goes'. As Wong explains it, a moral system sets out to resolve conflict within individuals (intra-personal) and between people (inter-personal), and it is possible that a moral system could fail in this purpose. [99] It might be, for example, that the moral axioms of the Taliban are contradictory, and that upon examination of their own belief system the Taliban would come to realise that in fact they ought to grant equal rights to women and men. In this way, relativism may enjoy a plurality of truths, and grant that some cultures and societies are mistaken in their moral claims.

Second, relativists can answer the problem about seemingly intolerable practices by claiming that although in western society we tolerate most acts, some acts are just intolerable. Sheehan explains how there could be exceptions to the tolerance rule. "Being tolerant is an important value but there are some things that are sometimes more important. When these more important things are under threat, our obligation to be tolerant is overridden. Genocide and slavery are good examples of this. In both cases our obligation to be tolerant is outweighed by the violations to individual freedoms and liberties that genocide and slavery involve."[100] In this way moral relativism regains some of its attraction; under it we can be tolerant of the practices of other cultures and societies, but at the same time we can object to any heinous acts they commit. This does, however, strike me as a peculiar position to be in. Suppose you are a relativist, and so you sincerely believe that there are multiple truths about morality. Suppose you belonged to a society in which murder of the innocent was wrong, and you discovered that there was another society for

[98] Ibid. p50
[99] Wong, D. (1984) *Moral Relativity* Berkley CA: University of California Press p446
[100] Sheehan, M. op. cit. p94

whom it was morally praiseworthy to kill disabled newborns. Suppose also that in that society the vast majority of its members, including parents, approved of this practice. Suppose that killing disabled newborns fitted exactly with the society's value system (this is to eradicate the possibility, within the relativist model, that this society could have false beliefs about the morality of killing newborns). Following on from Sheehan's point, it would be entirely possible for you to simultaneously hold that killing disabled newborns was *wrong for your society*, that killing disabled newborns was *right for the other society*, and that it was *right for your own society* to interfere with the other society to prevent the practice. That is, the sincere relativist would be morally obliged to act to prevent something that was morally abhorrent for her society while at the same time declaring that she honestly believed the practice was right for the society in which the act was occurring.

Under this moderate model of relativism, it does not seem any more attractive than an objectivist account and looks considerably more complex. The objectivist would deal with the above moral problem in a much simpler way by holding that there was one single answer to whether killing disabled newborns was right or wrong. This would allow for the possibility that the baby-killing society was simply wrong, and that the practice ought to be stopped. Not only is the simplicity of this theory a virtue, but the types of claims objectivists make appeal to very strong intuitions. As Blackburn writes, "Many people, and many ethical theorists, believe that without some 'robust' or 'objective' conception of moral truth, our *right* to hold judgements with a sufficient degree of conviction evaporates. If we want to oppose cruelty, or defend free speech, or outlaw child sex, we need the conviction that it is not 'just us', voicing a contingent or accidental aspect of how we feel. We want to hold that truth is on our side: absolute truth."[101]

[101] Blackburn, S. op. cit. p38

5.2.3 Cultural and societal boundaries; paralysis of moral debate

In the next section I will discuss a logical problem with relativism, but before that it is worth briefly discussing a few other significant problems with moral relativism. The first I want to raise is do with the boundaries of societies and cultures. It is fairly obvious that societies are fluid entities with sub-groups, overlaps and a mixture of categorisation. For example, a Chinese man and an English woman may share the same social group, but be in different ethnic, cultural or religious groups. Where exactly are we to set the boundaries for moral agreement? Agreement of moral values may itself be one of the defining characteristics of a culture, which would lead the relativist in the flawed position of *petitio principii*, or making a circular argument; it would be circular to claim that one's cultural groups is defined by one's values, and that one's values are true in virtue of the culture one is part of.

Relativists are also forced to admit to a lack of progressive moral debate between societies. A denial of universal moral principles means moral arguments can only be had within one's own society about one's own society. To argue with another society about morality is to the relativist equivalent to arguing with someone about whether vanilla ice cream or chocolate ice cream is better. Lack of debate about normative ethics also hinders any development *within* a society. If what is morally right is what society as a whole believes and practices, then acting to the contrary is to act immorally. Hence, arguably, any change is not progressive, but morally wrong. Of course, societies *do* change their values over time. For example, suppose homosexuality was regarded by the majority in Elizabethan society as morally wrong. If we assume that the majority of British society now regards homosexuality as morally sound, then how can moral relativism account for this change? Are we now wrong because we are contradicting the moral beliefs of

Elizabethan society? If so, then how does the moral relativist account for the fact that the majority now believes in something morally wrong? That would be contrary to the most basic principle of moral relativism.

There is a debate to be had about what constitutes a moral claim in relativism. It is not obvious that surveying the population would be sufficient to determine what was relatively right and wrong. Unless practising relativists have been misapplying their theory, it cannot be that relative moral truths are determined solely by the majority opinion of a population, since rarely are surveys taken to establish what is considered right or wrong. It seems that somehow a sense of what is right for a culture, independently of what the majority thinks, has a part to play in determining relative moral truths. For example, although the majority of the population in Britain thinks capital punishment should be re-instated, this has not been made law. We can imagine that this is because Members of Parliament have had a debate in non-relativist terms about the issue, and have decided capital punishment is wrong. We can also imagine a relativist debate drawing the same conclusion on the grounds that although the majority of British people thought capital punishment ought to be re-introduced, to do so would not be in keeping with the general picture of British morality, or its cultural moral principles. I make this point because even if relativism were correct, it is not obvious that the simple answer to what is right and wrong in pharmacy practice can be reached by surveying the population of pharmacists, patients and/or the public.

5.2.4. Relativism falls foul of the is/ ought gap

There is one final, more technical, point to be made against the argument that different societies have different moral frameworks and should therefore be tolerated. To say

differences exist is to make an empirical observation. To go straight on from that to say these differences are indicative of actual moral differences is to commit a logical fallacy by deriving an *ought* from an *is*. Anthropologist Fluehr-Lobban, who is a critic of the traditionally tolerant position of anthropology, observes, "Cultural relativism, long a key concept in anthropology, asserts that since each culture has its own values and practices, anthropologists should not make value judgements about cultural differences".[102] Just because there are factual differences to observe, it does not necessarily mean there are differences on a normative level.

The essence of this objection to relativism is the violation of a simple logical rule, known as Hume's law, or the is/ought principle. Hume identified the logical fallacy that occurs when value statements are made on the basis of fact alone, a logical leap from 'is' to 'ought'. Hume puts it this way:

> I have always remarked, that the author proceeds for some time in the ordinary ways of reasoning... when of a sudden I am surprised to find, that instead of the usual copulations of propositions, *is* and *is not*, I meet with no proposition that is not connected with and *ought* or an *ought not*. This change is imperceptible; but is however, of the last consequence. For as observed and explained; and at the same time that a reason should be given; for what seems altogether inconceivable, how this new relation can be a deduction from others, which are entirely different from it.[103]

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[102] Fluehr-Lobban, C. (2004) 'Cultural Relativism and Universal Rights' in Sommers & Sommers (eds.) (2004) *Vice and Virtue in Everyday Life* 6th edition (USA: Wadsworth)

[103] Hume, D. (1974) *Treatise of Human Nature* Volume Two Book III, part I, section I (New York: Everyman) p177-178

Hume points to arguments that state only fact in the premises and values or 'ought' statements in the conclusion. An example of a logically fallacious argument of this form is:

1. Speeding on the roads is responsible for 3,000 deaths on the road per year.
2. Speed cameras are proven to help slow traffic.

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3. So there ought to be more speed cameras in operation.

For this argument to be logically valid, either the conclusion must be void of the word 'ought' (or anything of the same meaning), or at least one of the premises must contain a relevant value statement. The following premise could be added, for example: 'If speed cameras can help slow traffic, there ought to be more cameras in operation', and premise 1 would be redundant.

The is/ought mistake commonly occurs in arguments such as that above. The argument with such a conclusion lacks validity without an 'ought' premise, and yet it is not obvious that the premise 'If speed cameras can help slow traffic, there ought to be more cameras in operation' is true. A moral case could be made for the government spending its money on schools or hospitals instead, or there might be a valid argument that it would be immoral to violate the public's right to privacy and liberty with speed cameras, or that individuals ought to be encouraged to rely on their own conscience to drive responsibly. The 'is/ ought' leap can occur in the other direction too, for example:

1. A pharmacy manager ought to set a good example for her employees.
2. Mrs Donovan is a pharmacy manager of four employees.

3. So Mrs Donovan is a pharmacy manager who sets a good example for her employees.

Here, an 'is' has been derived from an 'ought' with no empirical or logical reason for supporting the conclusion from the premises. One way to make the argument valid would be to add the premise: 'Every pharmacy manager stands as a good example to her employees', with premise 1 being redundant.

This is/ ought problem has in many ways blocked the use of empirical data in applied philosophy. "It is traditionally held in moral philosophy that it is impossible to derive an ought from an is, that how the world is tells us nothing about how it should be. The idea of empirical studies playing a major role (or any role) in bioethics is therefore seen as problematic by some bioethicists. ...[M]ethodological problems are exacerbated because the field of empirical studies in bioethics attracts both bioethicists who often have limited knowledge about research methodology, and social scientists who often have limited knowledge about ethics. Many studies in the field are therefore either methodologically or philosophically naïve. This obviously has implications for the validity of research results, and for the use which can be made of them."[104] However, better understanding of the relationship between empirical data and philosophy in applied ethics means that sociologists and philosophers respectively can avoid this methodological and philosophical naïveté.

[104] Holm, S. (2003) 'Putting Empirical Studies in their Place' in Holm, S. & Jonas, M. (eds.) (2003) *Engaging the World: The Use of Empirical Research in Bioethics and the Regulation of Biotechnology*, 2003 (Netherlands: IOS Press) pp18-27 p131

5.2.5 Conclusions of discussion on relativism

This brief examination of relativism set out to address one set of questions concerning the role of empirical data in applied ethics. For those who think morality is relative to society or culture, surveys of opinion of morality are essential to uncovering moral truths. Upon closer inspection, we see that the claims that must be made to support such a position are not entirely stable. The greatest appeal of relativism are its tolerance and lack of imperialism, but to take this too far results in a contradiction, and in its moderated form it serves exactly the same function as tolerance within an objective frame of morality, only more complicated. Other weaknesses of the theory include a problem of defining social or cultural boundaries, falling foul of a logical fallacy and, importantly for this thesis, knowing whose opinion to ask in order to arrive at the truth.

In the section that follows, it is assumed that moral truth is objective, that there is a single truth about right and wrong, and that it is the role of the ethicist to uncover what that truth is.[105] Taking an objective approach does not necessarily mean the abandonment of empirical investigation. The following sections ask what the respective roles of empirical research and philosophical analysis might be in applied ethics, and the discussion starts by taking a brief look at some studies in pharmacy ethics that sit in the social science discipline and *could* be used by relativists to draw normative conclusions in the way I have

[105] I will not argue for this view, as it would be beyond the scope of the thesis to do so. The main features of the objective account of ethics are: 1) there are moral facts about whether something can justifiably be called 'good', 'bad', 'right' or 'wrong' independently of people's beliefs; 2) moral statements are meaningful propositions that can be true or false (as opposed to a non-cognitivist account that propositions relate to the speaker's attitudes or desires and are neither true nor false); 3) moral facts are knowable. The epistemic basis of moral objectivism is commonly either intuitionism (that moral facts are knowable by intuitions and are not further reducible) or naturalism (that moral facts can be known through consistency with other non-moral facts). Accounts that oppose moral realism include error theory and non-cognitivism.
For a clear exposition of these theories see McNaughton, D. (1988) *Moral Vision: an introduction to ethics* (Oxford: Oxford's Blackwell Book Service) See also Ayer, A. J. 1949 *Language, Truth and Logic* (London: Victor Gollancz Ltd); Hare, R. M. (1952) *The Language of Morals* (Oxford: Oxford Clarendon Press) and Sayre-McCord, G. (ed.) (1991) *Essays on Moral Realism* (Ithaca & London: Cornell University Press)

described in this section, or could be used by objectivists to inform normative conclusions without committing the mistake of jumping from and is to an ought.

5.3 Sociological studies in pharmacy practice about subjects with an ethical dimension

The purpose of this section is to give a brief account of well-conducted descriptive ethics in order to recognise sound research in the social science discipline before going on to explain in the next section how descriptive ethics can be misused to draw unjustified normative conclusions in ethics. The section to follow that will return to sound empirical studies to show how the 'informed philosophical' approach works in applied ethics.

Sociological studies can make an important contribution to applied ethics, but are not themselves ethics. In what follows, I draw on three examples of sound empirical studies about subjects in pharmacy practice that have obvious ethical dimensions that the researchers do not explore philosophically, because to do so would be to step outside the discipline of social science. Hibbert, Rees and Smith's paper 'Ethical awareness of community pharmacists' reports their findings in interviews whose aims included discovering whether pharmacists gave examples that would reveal something about the underlying ethical principles pharmacists work to. The research was entirely empirical, and the paper makes sensible connections to relevant ethical concepts, but does not use the data to draw any normative conclusions.

Bissell and Anderson's paper 'Supplying emergency contraception via community pharmacies in the UK: reflections on the experiences of users and providers'[106] is a good example of sociological research that examines people's views on ethical issues but does not attempt to draw normative conclusions from them. For example, the article discusses the fact that users of emergency hormonal contraception (EHC) "welcome an absence of judgemental attitudes when accessing the service"[107] but does not attempt to translate this into any claims about whether pharmacists ought to be judgemental, or what these judgements ought to be. Also writing about attitudes towards the supply of EHC, Harper and Barrett discuss the findings of their study, reporting pharmacists' and GP's attitudes towards the deregulation of EHC,[108] and putting this into the context of the views of the RPSGB and its members. Although not made explicit in the paper, the reported attitudes of the pharmacists and GPs and the RPSGB and its members were laden with ethical values, and Harper and Barrett are clear about the fact that some members of the Society had formed the organisation 'Christians in Pharmacy', motivated by their moral objections to the deregulation of EHC. Harper and Barrett do not take the discussion further than this, and do not go on to make any presumptions about whether EHC ought to be deregulated or not. Instead, we are presented with interesting research that is in itself informative, could also lead to further research, and could help form the empirical basis for philosophical discussion about the ethics of deregulation of EHC.

[106] Bissell, P. and Anderson, C. (2003) 'Supplying emergency contraception via community pharmacies in the UK: reflections on the experiences of users and providers' *Social Science and Medicine* 57: 2367-2378
[107] Ibid. p2367
[108] Harper, R. and Barrett, G. (1998) 'Community pharmacists and General Practitioner Attitudes to the Deregulation of Emergency Contraception' *Journal of Social and Administrative Pharmacy* 15; 2: 83-91

5.3.1 Misapplied ethics

When applied ethics is done well, the result is a set of evidence-based, rational conclusions. Not all research into pharmacy practice is as disciplined as the purely sociological studies that exist in pharmacy practice, and some research has stepped outside the boundaries of descriptive ethics by making normative or 'ought' judgements. When a descriptive ethicist draws an 'ought' conclusion the researcher has made a category mistake, with the attempt to yield the conclusions of philosophy by applying empirical methods, rather like attempting to use mathematics to criticise the artistic merit of a musical masterpiece. When research fails to keep to its social science remit, and fails to obey the rules of logic in philosophy, the result can be ill-conceived and presumptuous conclusions. Such research is neither social science, philosophy nor applied ethics.

Applied pharmacy ethics seems at times to have been misinterpreted as a mixture of personal opinion, philosophical theory and widely held beliefs, a combination that falls into the trap of the first of the two versions of the is/ought fallacy. At a push, we might call this empirical research carried out under a relativist rationale, but even then it can be done badly. As Sheehan remarks, "[The] kinds of relativistic claims that are made on the margins of moral philosophy and in the broad sweeping statements of the more popular press are often the best examples of crude, unthinking relativism at its worst."[109]

A critical literature review by Cooper, Bissell and Wingfield[110] shows similar concerns over lack of philosophical engagement in work that claims normative conclusions. Although researchers cannot be expected to revisit the fundamental questions of philosophy for each piece of research, they should refrain from drawing unsupported normative conclusions. Research we might be particularly wary of are psychological

[109] Sheehan, M. op. cit. p98

[110] Cooper, R. J.; Bissell, P. & Wingfield, J. (2007) 'A new prescription for empirical ethics research in pharmacy: a critical review of the literature' *Journal of Medical Ethics* 33: 82-86

studies of moral development. Kohlberg's work on moral development defines six stages of moral development[111] and relies on some assumptions about morality, which Kohlberg himself is very conscious of. Kohlberg even includes in one of his books a chapter entitled 'From an *is* to and *ought:* How to commit the naturalistic fallacy and get away with it in the study of moral development.'[112] Kohlberg's normative assumptions were perhaps most famously challenged by Gilligan, who criticised his work for having a masculine bias. Whether Gilligan was correct or not, her objections, which were the foundation of her ethics of care theory, demonstrated that Kohlberg's normative assumptions were not infallible. Objections come also from Alston:

> Unless Kholberg can do more than he has done to show that his choice of a definition of 'moral' is based on something more than a personal preference among the variety of definitions that have been proposed, the fact that his later stages conform more exactly to his conception of moral judgement has no objective significance.[113]

Peters is similarly anxious to see that the Kohlberg's work is kept within certain disciplinary boundaries:

> [Kohlberg's] findings are of unquestionable importance, but there is a grave danger that they may become exalted into a general theory of

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[111] The six stages are: Stage 1 Punishment and obedience; Stage 2 Individual instrumental purpose and Exchange; Stage 3. Mutual interpersonal expectations, relationships and conformity; Stage 4 Social system and conscience maintenance; Stage 5 Prior rights and social contract or utility; Stage 6 Universal ethical principles. Kohlberg, L. (1981) *The Philosophy of Moral Development* (USA: Harper & Row)
[112] Kohlberg, L. (1981) *The Philosophy of Moral Development* (USA: Harper & Row)
[113] Alston, W. P. (1971) 'Comments on Kohlberg's 'From *Is* to *Ought'* in Michael, T. (ed.) (1971) *Cognitive Development and Epistemology* (New York: Academic Press)

> moral development. Any such general theory presupposes a general ethical theory, and Kohlberg himself surely would be the first to admit that he has done little to develop the details of such a general ethical theory.[114]

Latif[115] has conducted research into the moral development of pharmacists and follows Kohlberg's basic principles. Unfortunately Latif fails to engage with the philosophical arguments necessary for justifying the claims he makes. Latif has carried out psychological experiments to measure what he calls the "level of moral development" of individuals.[116] Latif uses Rest's Defining Issues Test,[117] which is based on Kohlberg's six stages of moral development,[118] progressing from simple obedience of what is asked, through appreciating and respecting the status of social or legal rules, to understanding morality as if from a veil of ignorance, Rawls-style. I reserve any judgement on whether individuals do pass through these stages of thoughts and attitudes as Latif describes; this is of no matter here. What I would like to draw attention to, though, is the assumption that the cognitive scale runs parallel with a scale of what is morally right. Latif assumes, and so gives no argument, that high levels of 'moral reasoning' (this can be substituted by 'certain cognitive states') correspond with "further[ing] human welfare" and "help[ing] people first

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[114] Peters, R. S. (1971) 'Moral Development: A Plea for Pluralism' in Michael, T. (ed.) (1971) *Cognitive Development and Epistemology* (New York: Academic Press) p 264

[115] Latif, D. A. & Berger, B. A. (1997) 'Moral reasoning in pharmacy students and community practitioners' *Journal of Social and Administrative Pharmacy* 14; 3: 166-179; Latif, D. A. (2002) 'An Assessment of the Level of Moral Development of American and Canadian Pharmacy Students' *International Journal of Pharmacy Practice* 10: 153-160

[116] Latif, D. A. (2002) 'An assessment of the level of moral development of American and Canadian pharmacy students' *International Journal of Pharmacy Practice* 10: 153-200 p153

[117] Rest, J. R. (1986) *Moral Development: Advances in research and theory* (New York: Praeger)

[118] Kohlberg, L. (1969) 'Stage and sequence: The cognitive-developmental approach to socialization' in Goslin, D. D. (ed.) (1969) *Handbook of socialization theory and research* (Chicago: Rand McNally) pp347-480

and foremost"[119] and that this is morally good. This may well be morally good, and certainly the statement is intuitively satisfying, but this alone will not do.

In his work, Latif assumes that lying, cheating and misrepresenting one's task performance is 'dysfunctional'. It is not clear what Latif means by this, and 'dysfunctional' may refer to psychological states, but certainly there are no grounds for using it in any ethical sense without a defence. Another assumption:

> A ...speculative explanation [of a 'lower level of moral reasoning'] revolves around the notion that a pharmacy career may be preferentially selected by students who possess lower moral reasoning abilities. If the perception of pharmacists' job descriptions by potential pharmacy students is that of primarily dispensers of medication, and not of health professionals that practice patient-focused care and desire to further human welfare and are required to make professional judgements that are difficult and challenging, then, perhaps, lower moral reasoners are the result.[120]

This statement reveals an assumption that a motivation towards providing patient-focused care and a desire to further human welfare are morally more worthy than the desire to dispense medicine. This is strongly intuitive, and the act of dispensing medicine is not *itself* in the moral realm, whereas human welfare is an ethical issue. Further, Latif's understanding of what it is to dispense medicine is rather simplistic. Pharmacists might argue, for example, with Latif's assumption that dispensing is incompatible with being

[119] Latif, D. A. (2002) 'An assessment of the level of moral development of American and Canadian pharmacy students' *International Journal of Pharmacy Practice* 10: 153-200 p156
[120] Ibid. p158

patient-centred, since good dispensing and therefore ethical dispensing, may require a patient-centred approach; good dispensing is dependent on *how* it is done, and Latif seems to overlook this.

Latif's work draws our attention to ethical awareness of individuals, and there is a very serious discussion to be had about the level of ethical sensitivity a professional ought to have, but Latif is also making a point about what pharmacists *should* be sensitive about. Why does Latif assume that being patient-focused is better than being self-focused, or community-focused, for example? Simply put, Latif's discoveries have no bearing on what ought to be done; he is drawing conclusions that are disjointed from his premises. This is the result of a misuse of methods. Work in ethics that uses either or both psychological and sociological research is purely descriptive, and it is unsound to then draw normative ethical conclusions without philosophical engagement. Philosophy is necessary for making normative claims.

5.4. Informed philosophy

From the previous discussion we have seen that applied ethics is a discipline that requires more than just an assortment of personal opinion, empirical investigation, ethical theory and commonsense. We have also seen that there is good reason to suppose ethics is not something that is relative to society or culture, and therefore questions about morality cannot be fully satisfied by surveying opinion and practice. Within the school of thought that morality is objective rather than relative, there still exists an argument among social scientists and philosophers about the role of empirical data in bioethics, and it is to this debate I now turn. The subject of the debate in the literature is bioethics rather than applied philosophy in general, but the principles are in most part universal, and I shall only discuss here the points relevant to pharmacy ethics. I suggest full inclusion of empirical data in applied ethics on the objective side of the relativism/ objectivism divide and use the term 'informed philosophy' to mean using empirical data to inform applied philosophy. I argue that empirical data are both useful in formulating practical ethical doctrines, to the point of being practically necessary, and are logically necessary on a normative and metaethical level.

In the academic world, the relationship between applied philosophy and sociology has been sour in places. Pharmacy ethics is sufficiently neglected as a field of research that this sourness has not manifested itself here specifically, but pharmacy ethics is close enough to bioethics that the debate between sociologists and applied philosophers in bioethics is fully applicable. Pharmacy ethics has probably not come far enough to bear all the criticisms made of bioethics, but we should be aware of the potential pitfalls bioethicists have fallen into. Each discipline has fired insults at the other, with accusations of arrogance and unsubstantiated claims. As De Vries puts it, this is "Not exactly scholarly

discourse."[121] This aside, each discipline has given some legitimate criticisms of the other. For example, sociologists "have brought the unwelcome news that bioethicists are paying insufficient attention to the way the organization of their profession affects their ability to influence medicine and the biological sciences."[122] "Moral philosophers ... are regarded as people of good faith, and are already interested in questions of the right and the good and of how we might live well and justly, and hence, they have come to predominate in the field of bioethics. However, whilst moral philosophers may appear to have the requisite skills for tackling these issues, they have also been heavily criticised for what many commentators see as their ahistorical, asocial and acultural approach to bioethical problems."[123] Meanwhile, John Harris recognises a disregard for philosophy when trying to address ethical questions and names it the 'Empiricalist Fallacy', writing, "facts are fascinating and some facts are even essential, but gathering them is not the business of ethics. Empirical research of any sort is not ethical research. It might be essential to ethics, it may be the result of ethics, but ethics it ain't. Empiricalists believe they can do something which may legitimately be described as ethics without resort to oughts at all, and this belief is simply erroneous."[124]

Applied ethics as a discipline involves six distinct features. The list comprises: philosophy; practical application; metaethics; consideration that ethical problems are socially constructed to some extent; completeness of conceptual analysis; and sociology of bioethics. In this section, each element of applied ethics is explained in turn.

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[121] De Vries, (2004) 'How can we help? from "sociology in" to "sociology of" bioethics' *Journal of Law, Medicine and Ethics*, 32, 2: 279-292 p280

[122] Ibid. p279

[123] Holm, S. (2003) 'Putting empirical studies in their place' in Holm, S. & Jonas, M. (eds.) (2003) *Engaging the World: The Use of Empirical Research in Bioethics and the Regulation of Biotechnology* (Netherlands: IOS Press) p136

[124] Harris, J. (2003) 'Putting empirical studies in their place' in Holm, S. & Jonas, M. (eds.) (2003) *Engaging the World: The Use of Empirical Research in Bioethics and the Regulation of Biotechnology* (Netherlands: IOS Press) p18

5.4.1 Philosophy

Ethics is recognisable as a branch of philosophy through the types of questions it asks, its normative and metaethical theories and its analytic approach. In terms of analysis, no other discipline offers a greater degree of logical analysis or puts every detail of a subject under more scrutiny, from examining concepts and definitions, placing things in the abstract for clear analysis, to imposing strict rules of consistency and clarity. To the frustration of some, philosophy leaves no aspect of a subject unexamined. As Hedgecoe writes, philosophy "is a crucial discipline in [bioethics]...Bioethics without philosophical input would lack much of the rigour and 'bite' that modern medical ethics has."[125]

Normative and metaethical theory are essential to applied ethics as they answer the fundamental and natural question about the nature of morality, and about moral values, duties, rights, goodness. Applied ethics simply would not be ethics without this kind of thought behind it. Those in opposition to the use of ethical theory in applied ethics, explain Garrard and Wilkinson,[126] claim that normative theories are insufficient and non action-guiding without empirical data. For example, a consequentialist theory will tell us to maximise the good, but will not tell us in detail how to identify the good, or how to go about promoting good. Of course, consequentialism will have to be teamed with empirical information before it can be put into practice, and any ethical theorist will readily admit to this. Ethical theory plus empirical information will yield a workable claim such as this simplified one: 'The pharmacy profession ought to ensure minimum errors through dispensing incorrect medication. It has been shown that distinctive product packaging plays a significant role in reducing dispensing errors. In order to achieve as low a level of

[125] Hedgecoe, A. M. (2004) 'Critical bioethics: beyond the social science critique of applied ethics' *Bioethics* 18; 2:120-143 p134

[126] Garrard, E. and Wilkinson, S. (2003) 'Does bioethics need ethical theory?' in Häyry, M. & Takala, T. (eds.) (2003) *Scratching the Surface of Bioethics* (New York/ Amsterdam: Rodopi Publishers) pp35-45 p36-7

dispensing errors as possible, the pharmacy profession should ensure that product packaging is distinctive.' In short, normative ethical theory is necessary but not sufficient for applied ethics.

Those opposing normative theory in applied ethics might also claim that all normative theories are useless because they collapse into one when they try to satisfy our moral intuitions. As Garrard and Wilkinson demonstrate, one example is sufficient to refute this claim.[127] Deontology can be said to effectively collapse into act consequentialism, and in many practical instances the policies a deontologist would adopt are indeed the same as the policies a consequentialist would adopt. However, their reasons for these policies would be quite different, and these differences come into effect in other instances. For example, an essential part of a deontological theory is that it is agent-relative, while an essential part of a consequentialist theory is that it is agent-neutral. Garrard and Wilkinson's example is the moral claim 'doctors should look after their patients'. Being agent-relative, the deontologist doctor must look after her own patients, no matter what her colleagues are doing. Being agent-neutral, the consequentialist doctor might neglect her own patients in order to spend time training a group of other doctors on how best to look after their patients. In this way, a principle consequentialists might share with deontologists, which at first sight looks identical in each instance, turns out to have quite different applications depending on the normative theory.

Two further arguments can be put forward against the claim that normative theories collapse into one another. One is simply that the normative theories that have been developed so far are not necessarily comprehensive, and since there is no argument to say that normative theories necessarily collapse into each other it may be there is a yet undiscovered normative theory that does not collapse into the others.

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[127] Ibid. p36-7

The second defence against the criticism that normative theories collapse into one another and are therefore of no use in applied ethics is to point out that similarity between two theories does not render them both false. The fact that two different theories might come to the same conclusions does not indicate that neither of those theories was correct in arriving at that conclusion. Withdrawing all theory from the process of deciding what the right action is would be a serious mistake. We would be left with a riot of intuitions. Just because the same conclusion is reached by the process of following two different theories, does not mean that a second conclusion, based on no normative theory, is more justifiable.

Similarly, metaethical theory is essential in applied ethics for two reasons: first, to answer the fundamental questions about morality and, second, for practical reasons. Metaethical theory has a direct impact on how we go about using empirical research, as we saw in the previous section of this chapter. For example, the question whether to rely wholeheartedly on public opinion in deciding policy, or to draw conclusions based on reasoned arguments and consideration of empirical data and public opinion is a metaethical one. Not engaging in metaethics at this point would be to be paralysed altogether, or else to go forward blindly.

5.4.2 Practical application

Philosophy alone will not do in applied ethics. It is fairly obvious that armchair philosophy alone is unlikely to yield an applicable normative theory of ethics. If it were applicable, this would be coincidental. It would be extremely difficult to have the imagination for a normative ethical theory without some empirical input but even if it were possible to construct a normative theory in this isolated way, which was logically consistent and elegant in its structure, it would very probably be inapplicable. Siegler *et al* and Holm together give a list of pragmatic reasons for using empirical research in applied ethics. Empirical research can "help identify key issues, frame research questions, structure ethical analyses, and contribute to a better understanding of the normative issues that lie at the heart of clinical medical ethics,"[128] and also test the effects of regulations, test the effects of teaching, bring realism to ethical analysis and find out whether a moral theory is applicable given human psychology.[129]

Siegler *et al* correctly claim that empirical research helps structure our thoughts and analysis, mostly by identifying the main issues, and Holm adds that this can be used to test the effects of the regulations and teachings of bioethics. For example, one of the main objectives of this research project has been to gather data on the types of moral dilemmas pharmacists face in their work. The result of this empirical research means we can direct philosophical analysis and thought to the relevant areas, and to prioritise research in the most commonly occurring, most problematic, or most important areas. Empirical research has shown, for example, that pharmacists are often confronted with problems to do with confidentiality, and so it would be sensible to concentrate on this as opposed to, say, fraud

[128] Siegler, M.; Pellegrino, E. D. & Singer, P. A. (1991) 'Clinical medical ethics' *The Journal of Clinical Ethics*; 1: 5-9 p7

[129] Holm, S. (1997) *Ethical Problems in clinical practice: The ethical reasoning of health care professionals* (Manchester University Press: GB) p25

in the profession, which was not a subject raised in the focus groups. Holm classes a problem as "practically important" if it falls into one of the following categories:

1. It is frequent
2. It has serious consequences
3. It bothers practitioners (e.g. by being a 'hard problem')[130]

In her article about the role of philosophy, sociology and law in institutionalised bioethics, Tuija Takala[131] asks whether philosophy is sufficient for answering ethical questions about situations that have legal, social and scientific dimensions, and concludes that bioethics is a multidisciplinary field and the expertise of the philosopher is not the only type of expertise required to get the job done properly, that the experience of lawyers and theologians is also needed. Sociologists should be added to this list. Holm points to three types of empirical data used in applied ethics: biological data (this is most relevant in bioethics), psychological data and sociological data.[132]

[130] Holm, S. (2003) 'A defence of empirical bioethics' in Holm, S. & Jonas, M .F. (eds.) (2003) *Engaging the World: The Use of Empirical Research in Bioethics and the Regulation of Biotechnology* (Netherlands: IOS Press) pp3-7 p5

[131] Takala, T. (2003) 'Who should decide and why? The futility of philosophy, sociology and law in institutionalised bioethics and the unwarrantability of ethics committees' in Holm, S. & Jonas, M .F. (eds.) (2003) *Engaging the World: The Use of Empirical Research in Bioethics and the Regulation of Biotechnology* (Netherlands: IOS Press) pp69-75

[132] Holm, S. (2003) 'A defence of empirical bioethics' in Holm, S. & Jonas, M .F. (eds.) (2003) *Engaging the World: The Use of Empirical Research in Bioethics and the Regulation of Biotechnology* (Netherlands: IOS Press) pp3-7 p3

5.4.3 Metaethical

The reasons for using empirical data in applied ethics are not just practical but also normative and metaethical because ethics necessarily involves human psychology. [133] If 'ought' implies 'can', and if psychological restrictions can exist, the ethicist needs to be aware of the psychological capacities of the moral agent in order to determine what ought to be done. For example, the consequentialist seeks the best possible outcome (that is practically possible, rather than logically coherent). Where possibilities are shaped by psychological capacity, the consequentialist will need information about psychological limitations. This might, for example, include the willingness to follow certain rules or policies laid out by a professional organisation. The same is true for the Aristotelian ethicist, whose image of the virtuous person will be shaped by the psychological makeup of human beings, and also for the deontologist, whose universal principles must at least be possible. Sociologists are essential for informing us of whether a policy works in practice, or is unrealistic, or inefficient. "An oft-made criticism of bioethicists is that they are full of good ideas and policy suggestions, but that they never stop to consider how these ideas and suggestions are actually working."[134] Sociology in bioethics "measures the things bioethicists need measured: Are research subjects *really* informed after they sign an informed consent? How does culture get in the way of communication between ethicists, doctors and clients? What does (some selection of) the public think about genetic testing?"[135]

[133] Holm, S. (1997) *Ethical Problems in Clinical Practice: The ethical reasoning of health care professionals* (Manchester and New York: Manchester University Press) p. 25
[134] De Vries op. cit. p284
[135] Ibid. p283

5.3.4 Consideration that ethical problems are socially constructed to some extent

Empirical data cannot be ignored, because they are central to ethical problems. By their very nature, ethical problems are socially constructed. It is important to note that this is not the same as asserting that ethics per se is socially constructed, or that moral claims are relative. Rather, moral problems reside in social situations. A set of circumstances can be a problem because society perceives it to be a problem. "Considerable moral work gets done in deciding how a situation is to be characterized, and that moral work can determine how issues are resolved."[136] This does not alter the objective truths of a situation, just the way in which these truths are treated. For example, a moral problem arises when a patient who is buying hydrocortisone cream makes it known to the pharmacist that she intends to use it on her face. The situation is made problematic because of a number of social factors, where 'social' is interpreted broadly: supplying hydrocortisone cream for use on the face is against guidelines and unlawful for this use without prescription; as a pharmacist, supplying medication under these circumstances could lead to disciplinary action; (possibly) denying the patient the hydrocortisone cream violates the patient's autonomy; (possibly) supplying the hydrocortisone cream is harmful for the patient; (possibly) not supplying the hydrocortisone cream is an omission of an act; similarly, supplying the hydrocortisone cream is an act, and so on.[137] The parameters of the problem are socially set. When the philosopher considers the place of autonomy, it is because society has generated the idea of autonomy. While the moral truths pertaining to autonomy are not relative to society, the concept itself has been constructed by society, and recognising that there is an ethical problem in the first place is dependent on society.

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[136] Hoffmaster, B. (1994) 'The forms and limits of medical ethics' *Social Science and Medicine* 39: 115-1164 p1157

[137] I use 'possibly' because I have generated these unsubstantiated statements purely for this hypothetical case as an example.

What is more, the concepts used in moral theory must be at least very similar to those used in practice. While philosophy plays the role of challenging set practices and ideas, it must be in synchrony with those making ethical decisions. It is no good philosophers debating one idea of informed consent, for example, unless this matches clinicians' ideas of informed consent. This relates to the earlier point about the pragmatic need for ethics to be applicable. Hedgecoe points out that assessments that are made of any situation are based on empirical facts and come before philosophical theory. "The simple act of deciding how to apply a particular theory relies on ideas and concepts external to that theory, and thus beyond its consideration."[138]

5.4.5 Completeness of conceptual analysis

Conceptual analysis is one of philosophy's fortes. The quality of bringing understanding about exactly what a concept means, pointing to the differences in applications of certain terms and clarifying exact meaning brings clarity to discussion and debate, and enhances one's understanding of what exactly one is dealing with. Hedgecoe highlights an inadequacy in bioethics' ability to do this in applied ethics. Pointing to the concept autonomy as an example, Hedgecoe argues that providing definitions gets us nowhere in deciding what is the right definition of autonomy to follow. To do this we would need to carry out empirical work, comparing "how autonomy occurs in clinical settings... [with] how patients view their autonomy (and that of their doctors and other staff) and how difficult decisions are made. None of this can be provided by bioethics as it is

[138] Hedgecoe, A. M. (2004) 'Critical bioethics: beyond the social science critique of applied ethics' *Bioethics* 18; 2: 120- 143 p.126

conventionally conceived."[139] He continues by saying there is a mismatch between the concepts bioethicists use and those used in practice; "taking medical ethics to be 'applied' moral philosophy simply does not fit the experience of those who have spent time in clinical settings."[140] Hedgecoe's model of empirically led bioethics is akin to, but not identical with, relativism, which has already been shown to be problematic. Even so, Hedgecoe makes a valuable point about communication between practising healthcare workers and applied ethicists. Bioethicists would surely benefit from listening to the language used in practical settings, and should pay very close attention to what actually occurs in practice.

5.4.6 Sociology of bioethics

It is important to distinguish between sociology *of* and sociology *in* bioethics.[141] Sociological studies *in* ethics take a view from inside an institution and answer questions about what is going on within it (for example, 'How informed are patients about their treatments?'). Sociological studies *of* institutions answer questions from outside the organisation (for example, 'Where is pharmacy ethics placed in the wider medical scene?'). Most of the sociological questions that are relevant to this doctoral thesis are from sociology *in* pharmacy ethics. However, there is a point of overlap at which ethical concepts might be influenced by sociological theory. Although bioethics can function as an independent discipline, with 'sociology *of*' being just an onlooker, ethical theory could learn a lot from analysis of itself in society. Sociology *of* has effects on ethical theory and

[139] Ibid. p128
[140] Hoffmaster, B (1992) 'Can ethnography save the life of medical ethics?' *Social Science and Medicine* 53: 1421-1431 p22-1423
[141] See De Vries (2004) 'How can we help? from "sociology in" to "sociology of" bioethics' *Journal of Law, Medicine and Ethics* 32; 2: 279-292 for a full discussion of this.

on the position of the bioethicist herself. For example, as Bennet points out, feminist sociological theories could alter ethical theory. "Feminist theory provides an alternative theoretical framework for bioethical decision-making by providing an analysis that is based on interpersonal relations and connections rather than individualised rights. Feminists have argued the need for greater acknowledgement and valuing of the role of caring and nurturing relationships in our lives and our decision-making."[142] Such outside analyses challenge traditional ethical theories and prevent bioethics from being insular, pointlessly conservative and beyond questioning. Only empirical data and sociological analyses are able to advance ethical theory in this unique way, providing resources beyond reason alone.

On the level of the individual bioethicist, Hedgecoe cites reflexivity as crucial to the success of bioethics.[143] The bioethicist should be aware of where she is situated in society and bioethics, and should be aware of the special limitations and strengths this situation brings to her insight into ethical thinking.

Even without stepping over the line into moral relativism, this six-piece description of applied ethics is not as extreme as it could be. In his paper 'Critical Bioethics: Beyond the Social Science Critique of Applied Ethics', Hedgecoe promotes a critical bioethics that is based on descriptive ethics but boasts the crucial qualities of philosophy. The starting point of Hedgecoe's critical bioethics is empirical data and effectively it is very similar to the six-piece account given above. The differences are not just a matter of whether we call it 'descriptive ethics with philosophy' or 'philosophy with descriptive ethics'. By using empirical data as a starting point, Hedgecoe appeals to characteristics of moral relativism, as the following two extracts demonstrate:

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[142] Bennet, B. (1999) 'Posthumous reproduction and the meanings of autonomy' *Melbourne University Law Review* 23: 286-307 p300

[143] Hedgecoe, A. M. op. cit. esp. p138-140

> In critical bioethics, the results of empirical research feed back to challenge, and even undermine, an analyst's cherished theoretical frameworks. While it is perfectly possible for social science research to support the principalist [sic] approach (for example), it is also quite likely that in some if not many cases, the evidence will not fit into this particular way of structuring the social world. In this situation it is important that the analyst not retreat into philosophical evasion ('all other things being equal…' or 'with the irrelevant complexities cleared away…') but accept that in this case the principalist [sic] ideas do not hold true.[144]

> All ethical theories are subject to revision. This, of course, undermines elements of the universalist stance adopted by traditional philosophical bioethics, a high, perhaps unacceptable, price for the philosopher to pay to engage with critical bioethics. But it is hard to see how one can take social science seriously and at the same time insist on one's ethical conclusions having an absolute and universal application, without evidence to support such a claim.[145]

Hedgecoe makes a valid point that, to some extent at least, claims such as 'all things being equal' can eradicate exactly those things the bioethicist ought to be considering. It seems sensible to draw up policy in light of the facts, and it is obvious that philosophical claims should be adjusted in light of empirical facts, but only if those data show those claims to be wrong (i.e. based on false premises). To let empirical data affect philosophical conclusions

[144] Ibid. p137
[145] Ibid. p138

for other reasons would affect the soundness of the claim, either by invalidating the argument with an is/ ought move, or by using false premises.

5.4.7 Choosing empirical data

Some final considerations should be made about the quality of empirical research that should be drawn upon. With the inclusion of empirical data in applied ethics, it is important to discriminate between types of empirical data. Some empirical studies are flawed and yield false or unreliable evidence. Some empirical studies will be irrelevant, or will be of limited value because of the type of data collected.

5.4..8 Reliability

For the conclusions of an argument to be true, the argument structure must be logically valid, and the premises must all be true. Where an argument has at least one empirical claim, that claim must be correct. Leaving to one side any detailed discussion of research methodology, research can produce data that are ambiguous, unreliable or open to interpretation. In practice, when we aim for arguments with premises that are true, we aim for ones that are at least plausible or defendable, and not known to be false.

In his paper 'towards the 'fair use' of empirical evidence in ethical arguments: Vaccination, MMR and disagreement', Dawson suggests four criteria for 'fair use' of empirical data;

1. Any argument appealing to empirical evidence on a topic should take into account all of the relevant published evidence.

2. Where there is uncertainty in the evidence this should be acknowledged.

3. Not all evidence is of equal value.

4. Consideration of the evidence should lead on to the development of the ethical perspective on that issue.[146]

As Dawson explains, empirical evidence must be considered and used appropriately with full awareness and declaration of its limitations. Where empirical findings are uncertain because of a limitation in the speed of progress of the field of study (for example, medicine), this should be recognised. Conclusions may then carry a conditional quality ('if w, x and y, then z'). For the sceptic, this is an inescapable epistemic problem, but it is not unreasonable in some fields to make advancements using the evidence available, while bearing in mind the conclusions are subject to change with the arrival of new empirical evidence.

5.4.9 Relevance

I argued earlier that moral relativism was not a strong metaethical position to hold, and so empirical research that seeks to discover the opinion of the public or the attitudes of a culture will be of no use in deciding what the basic moral truths are. But, as already

[146] Dawson, A. Forthcoming in: Häyri, M.; Takala, T. & Herissone-Kelly, P. (eds.) *Arguments and Analysis in Bioethics* (Amsterdam/ New York: Rodopi Publishers) See paper for full discussion of these criteria.

discussed, it is often essential that public opinion be taken into consideration for other reasons, including policy decision-making. Where researchers and policy-makers need to be careful is when the public might be poorly informed about a subject. It is quite possible, and has been demonstrated, that the public does not always know the facts. For example, if a survey was carried out on people's opinions on whether the MMR vaccination should be compulsory in Britain, results might show that the majority of people believe the MMR should not be compulsory, on the (yet to be proven) basis that the MMR vaccine leads to autism. Results of a survey such as this would have severe limitations; it could show only that most people are of the opinion that the MMR vaccine should not be compulsory, on the (yet to be proven) basis that the MMR vaccine leads to autism. This opinion is not in the least bit relevant to whether the MMR vaccine actually does lead to autism.

5.5 Conclusions about methodology in applied ethics

I hope to have shown that applied ethics requires a relationship between philosophy and empirical study within an assumption that ethics is objective not relative. An unstructured mixed-discipline approach is not sufficient as a method of engaging with ethics in pharmacy practice. It is detrimental to the valid empirical studies and the sound philosophical research that are essential if the pharmacy profession is to bring its policy on ethics up to speed in any defendable fashion. There are some psychological and sociological studies of the ethical conduct of pharmacists, but only a very minimal amount of philosophy. Most literature that exists on pharmacy ethics is interesting, useful and informative, but it makes up only part of the pharmacy ethics picture. For the most part, it is not lacking success in achieving particular aims within individual research projects but collectively it has failed to cover the full scope of what pharmacy ethics entails. It lacks the

contribution of an essential part of pharmacy ethics, namely philosophy. If recognised as incomplete, research into pharmacy ethics can progress in a multidisciplinary fashion, consisting of a well-considered collaboration between philosophy, empirical studies and any other relevant social, political, theological or psychological theories.

The next and final section of this chapter demonstrates the way empirical findings can feed into more philosophical debates in applied ethics. One of the points raised in the focus groups is used to challenge the current understanding of the concept of confidentiality. The following chapter shows how this multi-disciplinary approach works in the opposite direction too as philosophical argument is used to understand what the individual pharmacist's role in ethical decision-making ought to be.

5.6 Applied ethics at work: using empirical findings to challenge the concept of confidentiality

The aims of this section are fairly modest, the general purpose being to demonstrate how empirical investigation can provide philosophy with new subjects to contemplate. We need look only as far as recent scientific developments in cloning, or technological changes that affect social interactions, for example new societies such as Second Life[147] that exist on the Internet, to find a jungle of unexplored ethical territory.

The focus groups conducted for this thesis brought up some interesting questions regarding the type of information that should be considered confidential. The relevant discussions centred round two of the vignettes. The first was the Found Tablet vignette in which a man approaches a pharmacist and asks her to identify a tablet that he has found in

[147] See www.secondlife.com

his son or daughter's bedroom. Participants were asked to consider what they would do if the tablet was a contraceptive, and if it was an anti-depressant. This was similar to a story one of the participants told, in which a woman who phoned the pharmacy to ask what a particular tablet was for. The pharmacist told her and learned later that the husband of the woman was having an affair and had contracted a sexually transmitted infection.

The second vignette that raised questions about the nature of confidential information was the Zidovudine vignette, which described a situation in which a woman in her forties, whom the pharmacist remembers seeing with a seventeen-year-old hospital patient who had been admitted with a chest infection, approaches the pharmacist and asks her what Zidovudine is for. Zidovudine is used in the treatment of HIV. The implication, of course, is that the woman is the mother of the patient and does not know that her daughter is HIV positive. The case brought up some interesting ideas about the type of information that could be considered confidential, and the responsibilities of the pharmacist to disclose information that is also publicly available.

Usually, confidentiality is taken to be an explicit or implicit agreement between one individual or organisation (in this case a patient) and another individual or organisation (in this case a pharmacist) that information about the patient that the patient considers secret or private is kept secret by the pharmacist. Within this definition there are a few qualifications. For example, it is generally considered acceptable that the pharmacist can share the confidential information with other members of the healthcare team where necessary for the care of the patient. There are also well-known exceptions to the rule of confidentiality in cases in which it is thought that disclosing the information could prevent harm to the patient or a third party. Examples of this might be when a patient expresses her intentions to commit suicide, reveals that she has a highly infectious disease that is a threat to public health, or is a child who is being abused.

The type of information that is normally considered confidential is information that identifies an individual (name, address, or distinguishing characteristics), or information that is considered by the patient to be sensitive.

Confidentiality is essentially an agreement about the preservation of privacy. Privacy is, roughly, about respecting someone's right to her own 'space', where 'space' is interpreted as physical and non-physical, and includes anything in that individual's personal, rather than public, sphere. Confidentiality is an agreement about information that has been obtained about that person. Correspondingly, an invasion of privacy would involve prying into a patient's life or entering into his or her 'space', and violation of confidentiality would involve divulging information about that patient without her consent. What is interesting about the Found Tablet and the Zidovudine examples is that it is not obvious that the information being asked for is what we would normally class as private or secret. In the Found Tablet example, if the father simply asked what the tablet was for, he would be asking for what is essentially publicly available information, information that is about a tablet, not a specific patient. The matter to focus on is whether publicly accessible information is confidential information. I want to leave to one side any arguments about breaching confidentiality (such as prevention of harm) which would be to have a separate debate about whether and under what circumstances it would be acceptable to breach confidentiality. What is worth noting, though, is that whether we consider this type of information confidential or not will have significant bearing on what the pharmacist should do in these types of situations. We might, for example, consider the use of Zidovudine as general information that the enquirer might have the right to know. The information could be found out by asking another healthcare professional, or by going to the library, or browsing the Internet. Focus group participants cited the availability of this type of

information, which is perhaps influential on the way that pharmacists conceptualised responsibility ('If I don't tell her someone else will anyway').[148]

Consider a similar problem in genetics. There is a sense in which you own the genetic data relating to your body, and a sense in which you should be able to choose what is done with the information. Someone whose genetic material was tested without their consent would probably, quite reasonably, feel that their privacy had been invaded, that someone had found out personal information uninvited. However, the genetic information about you is not solely yours. The nature of genetics is such that each individual's genetic material is made up of half of each of her parents' genetic material so the ownership of an individual's genetic information is shared ownership. This type of ownership may not be problematic. It does not follow that because the genetic information about yourself is also genetic information about your parents it does not belong to you, since sharing something does not necessarily result in loss of ownership. The nature of ownership in relation to genetic information is unlike the nature of ownership of physical items, which is rivalled. If I share my tube of Smarties with a friend I will eat fewer than if I had kept them to myself. But genetic information is a different kind of property and is not owned competitively. It is intangible and as a result non-rivalous. Sharing genetic information with relatives is more like sharing a joke or a story with friends: like genetic information, no matter how many people hear or pass on a story, there will always be enough of it to go round.[149] More importantly, the information has several 'owners'.

There are similarities between shared, while also personal, genetic information and public, while also personal, medical information. What seems to be problematic in the case of genetic information is that shared, non-rivalous, information can be attached to an individual to reveal private facts about that person. Similarly, in the case of Zidovudine,

[148] See Chapter Six, section 6.5.1.1 for a discussion of dilution of responsibility.
[149] For a fuller discussion of rivalous and non-rivalous ownership see Wilkinson, S. (2003) *Bodies for Sale* (London: Routledge) pp183-184

what seems to make the information about the tablet personal information about the patient, rather than public information about the tablet, is that the person making the enquiry is able to use the information to make inferences about the personal life of the patient.

In the Found Tablet case, the father who is making the enquiries would also be able to draw these inferences and is explicit in saying the tablet was found in his son/ daughter's bedroom. The tablet does belong to someone, though we cannot be sure whom it belongs to. For example, the man's wife may have hidden her antidepressants or contraceptive pills in her child's bedroom. It is still not entirely clear that this is personal information, and yet there is something deeply unsettling about the idea that a pharmacist might be obliged to divulge the information on the grounds that it is public, and there is certainly a sense in which the father is asking for information about a specified person, in this case his son or daughter.

We could understand this situation in one of three ways. The first would be to treat the information as publicly available since the information is about a tablet and not a patient. The second would be to regard the information as confidential on the grounds that giving the information would reveal something about a particular person (whether this is the son/daughter, or the man's wife, or someone else). If we suppose the tablet belonged to, say, the man's daughter, even if that daughter was not a patient of this particular pharmacist we might have reason to think there was an implicit agreement of confidentiality between all patients and healthcare professionals, or the healthcare profession. The third view is that if the pharmacist were to divulge the information she would somehow be aiding and abetting the invasion of privacy of the patient, even if not breaking confidentiality. In other words, she would be helping the father to explore his son's or daughter's bedroom further in such a way that he has not just found a *tablet* in the

bedroom, but he has found an *antidepressant/ contraceptive* in the bedroom. For this to be the case, we would have to have reason to think there was no agreement, implicit or otherwise, of confidentiality, perhaps because the patient was not one of the pharmacist's patients. What might be of equal concern, though, is the privacy of the son/daughter.

Consider how one of the focus group participants changed the nature of the information being asked for by saying she would consider directing the enquirer to the Medicines Information phone line. Evidence suggests that those working in Medicines Information find themselves with the same problem.[150] Kelly, Krause, Krowinski, Small, and Drane conducted a survey of the answers pharmacists give in Medicines Information Centres in the USA. One of the questions presented to participants concerned a caller requesting the identification of a tablet she had found in the coat pocket of her roommate. Most respondents (67.5%) said they would answer the question, and the majority of these (79.2%) would be willing to identify the tablet and its use. Those who said they would not be willing to identify the tablet answered that they either did not have the necessary information, that it was against the policy of their organisation, or because of a possible invasion of privacy. The authors of the study claim, "the breach of confidentiality is on the part of the caller; no duty of confidentiality binds the drug information specialist. Additional information is needed, however, to clarify the pharmacist's appropriate role."[151]

A similar survey of ethical issues surrounding supply of information to members of the public by Medicines Information in the UK was carried out by Wills, Brown and Astbury.[152] Three of the scenarios they asked participants about involved the enquirer asking for information about medication that did not belong to them, or a condition that

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[150] Kelly, W. N., Krause, E. C., Krowinski, W.J., Small, T.R. & Drane, J. F. (1990) 'National Survey of ethical issues presented to drug information centres' *American Journal of Hospital Pharmacy* 47; 10: 2245-2250

[151] Ibid. p2247

[152] Wills, S.; Brown, D. & Astbury, S. (2002) 'A survey of ethical issues surrounding supply of information to members of the public by hospital pharmacy medicines information centres' *Pharmacy World and Science* 24; 2: 55-60

someone else was suffering from. Wills, Brown and Astbury use the term 'personal privacy' when describing the nature of these problems, while respondents cited as their reasons for withholding information as respect for 'confidentiality' as well as 'privacy'.[153] Fifteen out of 149 respondents said they would answer specific questions about a medical condition of the partner of an enquirer on the grounds that the information was in the public domain.

The questions these scenarios raise in relation to our understanding of confidentiality are to do with the nature of information, the relationship between confidentiality and privacy, the obligations a pharmacist might have towards protecting the privacy of a patient, and to whom pharmacists have a responsibility of confidentiality/ respect for privacy.

Confidentiality is mostly discussed in unambiguous terms, with the controversial debate focussing on disclosing information to prevent harm. The development of genetic testing has opened up some questions about information that is shared between persons, which is in some ways similar to the nature of some of the information pharmacists might be asked for, in that information about health and medication is very often in the public domain, but the problem as it occurs in pharmacy is little discussed despite it being sufficiently different in its context and possibly also different in the corresponding expectations and obligations. This brief glance at confidentiality and privacy is by no means a full conceptual analysis, but it serves to show as an example how empirical findings can throw up new considerations.

[153] It is not obvious from the paper that these were the exact terms respondents used, or whether they are the terms used as labels for certain categories of responses given.

5.7 Concluding comments

This chapter has presented reasons for using a balanced multi-disciplinary approach to applied ethics, supporting in particular the use of both empirical research and philosophical analysis in pharmacy ethics. The chapter started with an examination of relativism and, after highlighting some fundamental problems with the theory, moved on to consider a six-part approach to applied ethics, which involves collaboration between philosophy and empirical disciplines, such as social science, law and psychology.

In the final part of the chapter, confidentiality was used as an example of the way in which empirical research can bring to philosophy scenarios that are not necessarily fully explained by the standard conception of certain notions in applied ethics. It was shown that the problems pharmacists face were not easily categorised as being about confidentiality or privacy, and that more conceptual analysis was needed.

The next chapter, Professionalism, addresses some of the philosophical questions surrounding professionalism, professional autonomy and the role of the individual professional in ethical decision-making.

Chapter Six: Professionalism

6.1 Overview

One of the discussion points in the analysis of the empirical data in Chapter Three was pharmacists' understanding of 'personal morality' and 'professional ethics', with Pharm3 remarking, "It's a moral thing and sometimes you've just got to take that moral issue away from yourself." There was also a dominant theme of rules in pharmacists' discussion of ethics. These themes are of considerable philosophical interest. The individual professional's moral responsibility within her profession is not at all obvious, as being a member of a profession seems to involve a conflict between acting autonomously and acting in accordance with the rules of a profession. This particular subject of professionalism was chosen for this chapter because of its relevance throughout this research; it was a concern of the focus group participants, it connects with questions to do with whether acting in the way that is in agreement with the rest of the profession is necessarily correct, and it is of considerable philosophical interest.

As the previous chapter argued, philosophical problems are embedded in pharmacy practice, and an analytic and systematic approach must be taken to answer the relevant questions. There are many aspect of professionalism that involve sociological, political and psychological investigation into ideas about professional autonomy, professional identity, hierarchy and subordination, but there are also numerous philosophical questions about the relationship between morality, responsibility, the individual, and the profession. The central questions answered in this chapter are: is pharmacy a profession? If it is a profession, what is the role of the individual pharmacist in moral decision-making?

The first part of the chapter outlines the debate about whether pharmacy is a profession, and addresses the question whether an occupation can be classed as a profession if it contains a retail role. The discussion starts with a description of a profession as a self-regulating occupational body made up of specialists in a particular field of work, with a particular culture, with members having a certain authority and privilege over the laymen, to whom each member owes a duty of confidentiality. The discussion moves on to ask whether altruism is a necessary trait of a profession, and whether pharmacy has this quality. The conclusion is drawn that pharmacy is most reasonably thought of as a profession. Next, the chapter moves on to address the related questions as to what it is for a professional to act autonomously, and what is required in order to make an individual moral judgement. Specific reference is made to cases in pharmacy practice, most extensively to the conscientious objection to the supply of EHC. I argue that conscience clauses are defendable, but only under certain conditions. I hold that they are justified not for the reasons of moral integrity, but instead to reduce moral anguish and, possibly, to protect rights to professional autonomy. The chapter concludes that individual judgement is essential to being an ethical profession, and specifies the parameters of legitimate professional judgements.

6.2 Is pharmacy a profession?

6.2.1 What is a profession?

I will not attempt to give a precise definition of a profession, but rather will identify some of its key elements and will discuss to what extent pharmacy should be considered a profession. In very broad terms, any occupation that serves as a means of earning a living can be seen as a profession.[154] The debate I want to capture is about whether pharmacy deserves the same professional status that certain other occupational roles enjoy, such as medicine and law, which are similar to pharmacy in many respects. If pharmacy is not a profession it may be regarded instead as a trade or, as Denzin proposed, as an occupation that has not completed the professionalisation process.[155] For the purposes of this discussion I am going to restrict the debate to the question of whether pharmacy roughly fits this description of a profession. Other definitions include a profession as a political institution that has control over a particular market,[156] or an institution of organised autonomy,[157] and an institution with a functional role of supporting social progression by bringing an objective, rational expertise to individual situations.[158] The description of a profession as a loose set of certain characteristics I have chosen to use for this discussion could be more formally classified as a 'traits approach'. Such an approach has come up against criticism on the grounds that it is difficult to agree on a list of traits[159] but whilst it could be argued that this is perhaps less rigorous than devising a definitive list of criteria it is, arguably, a better fit with the concept of 'profession' as it is not clear that this concept

[154] Brown, L. (ed.) (1993) *The New Shorter Oxford English Dictionary* (Oxford: Clarendon Press)
[155] Denzin, N. K. (1968) 'Incomplete professionalization: the case of pharmacy' *Social Forces* 46; 3: 375-381
[156] Edmunds, J. & Calnan, M.W. (2001) 'The reprofessionalisation of community pharmacy? An exploration of attitudes to extended roles for community pharmacists among pharmacists and General Practitioners in the United Kingdom' *Social Science and Medicine* 53: 943-955 p944
[157] Freidson, E. (1994) Professionalism Reborn Theory, Prophecy, and Policy (Chicago: Chicago University Press)
[158] Parsons, T. (1954) *Essays in Sociological Theory* (New York: Free Press)
[159] Traulsen, J. M. & Bissell, P. (2004) 'Theories of professions and the pharmacist' *International Journal of Pharmacy Practice* 12: 107-114

has a set of necessary and sufficient conditions. Admittedly I am exposed to the criticism of begging the question in finding a description of the profession that matches a description of pharmacy, but one aspect of conceptual analysis is to modify conceptual terms where appropriate, and if the case of pharmacy challenges the notion of professionalism then we should be open to modifying our understanding of 'profession' and 'professionalism', not necessarily just accepting the non-professional status of pharmacy.

The traits approach is, by definition, vague. However, it is not difficult to come up with a list of widely accepted features of a profession such as: that the members of the occupational group are answerable to a professional body, behave altruistically, have a confidential relationship between professional and client, have a body of knowledge to underpin the profession, have professional authority, "develop special codes of ethics, engage in formalized recruitment patterns, establish formal institutions to transmit the knowledge of the occupation, develop social organizations to ensure the perpetuation of the profession through time and finally, take on the characteristics of self-governing, autonomous institutions."[160] The following list, devised by Traulsen and Bissell, is of the most frequently mentioned characteristics:

- Professional authority (over the lay person)
- Sanction by the community of the power and privilege of professionals
- Confidential nature of the professional-client relationship
- Code of ethics (rules) regulating the professions
- Theory of knowledge underlying the practice of the professional (such as medical research/ theory)

[160] Denzin, Norman K. op. cit. p376

- The existence of a professional culture, i.e., involving a broad consensus about how to behave as a professional, said to be passed on to new recruits.[161]

It is fairly uncontroversial that pharmacy matches the description in the list above, and satisfies most other characteristics assigned to professions. Yet there has been a considerable resistance to calling pharmacy a profession. What follows is an account of pharmacy's efforts to become recognised as a profession.

6.2.2 Pharmacy's changing role and image

There has been a recent and on-going drive to bring about recognition of pharmacy as a profession. The focus groups participants regarded themselves as professionals (see Chapter Three), but this is not always how pharmacy is perceived from the outside. One of the biggest barriers to pharmacy being recognised as a profession is the retail aspect of community pharmacy. This sticking point in the acceptance of pharmacy's professional status arises from a perceived incompatibility between personal financial gain and altruism. Interestingly, it was most notably the community pharmacists in the focus groups who referred to the 'profession' and to themselves as 'professionals'. They referred to pharmacy as a vocation that has standards and a professional reputation, and spoke of individuals making professional judgements. Which, if either, of these views of pharmacy is correct?

[161] Traulsen, J. M. & Bissell, P. op. cit. p108

Historically, pharmacists have carried a relatively low professional status among their healthcare counterparts, namely general practitioners and hospital doctors. With a change in drug manufacturing, the role of pharmacists from drug-compiler and chemist to drug-dispenser and retailer has left pharmacists with skills and expertise that are underused.[162] A recent study carried out by Edmunds and Calnan showed that there "was a general feeling that ... [pharmacists'] skills were being under-used and that they could play a closer role in the PHCT [Primary Health Care Team]."[163] Pharmacists saw themselves as "over-qualified distributors of medicines".[164] At the same time, pharmacy has become much more patient-focused than ever before, a change that began forty or so years ago.[165, 166]

It has been suggested that pharmacists are regarded as non-professional because they are perceived as having a lack of control over their raison d'etre, dispensing what they are asked to by the doctor. Pharmacists can now train to become supplementary prescribers, and as a result have more power over prescribing decisions than previously. Perhaps the biggest hurdle now facing the profession is in changing the image rather than the role of pharmacy, and changing the perception of the status of pharmacy. Edmunds and Calnan's study[167] suggested that general practitioners welcome plans to raise the professional profile of pharmacists by expanding their role, but the findings also revealed a tension between pharmacy and medicine. While some pharmacists involved in the study welcomed doctors sharing some of their work with them, most pharmacists saw an

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[162] Kramer A. H., McCarvey, M.C., Holmes, P.D.,Zwidb, R.,Pitsch, P.K. & Lean, D.F. (1979) *Drug Product Selection: Staff Report to the Federal Trade Commission* Washington: Bureau of Consumer Protection & Tyler, V.E. (1968) 'Clinical Pharmacy: The need and an evaluation of the concept' *American Journal of Pharmaceutical Education* 32: 764-71

[163] Edmunds, J. & Calnan, M.W. (2001) 'The reprofessionalisation of community pharmacy? An exploration of attitudes to extended roles for community pharmacists among pharmacists and General Practitioners in the United Kingdom' *Social Science and Medicine* 53; 7; 13: 943-955 p948

[164] Ibid. p948

[165] Mesler, Mark A. (1991) 'Boundary encroachment and task delegation: clinical pharmacists on the medical team'; *Sociology of Health and Illness*; 13; 3: 310-330 p313

[166] This reference is to the socio-professional change in America in the 1950's and 60's.

[167] Edmunds, J. & Calnan, M.W. op. cit.

extension of their role as a way of relieving the doctors of some of their workload and were wary of taking on certain other tasks for fear of 'boundary encroachment'.[168] Similarly, GPs were happy to delegate tasks to pharmacists within certain limitations.[169]

This overlap between the role of doctors and pharmacists has been brought about by an encouragement from the RPSGB to significantly change the role the pharmacist plays in patients' healthcare. The recent push took the form of the Pharmacy in a New Age (PIANA) project, with the ambition that five aspects of pharmacy would become the key features of the profession: 1) management of prescribed medicines; 2) management of long-term conditions; 3) management of common ailments; 4) the promotion and support of healthy life-styles; 5) advice and support for other health care professionals.[170] This list of features constitutes a considerable shift in the central aims of pharmacy, and consequently in its identity. This may well have impact on whether pharmacy should be considered a profession or not. Well before PIANA (twenty-seven years before), Denzin claimed that pharmacy had not succeeded in becoming a profession.[171] Although Denzin's paper was written a considerable time ago, some of the points Denzin makes are not outdated, and are still worth challenging.

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[168] For an exploration of boundary encroachment of pharmacists into medicine, see Mesler, M. A. (1991) 'Boundary encroachment and task delegation: clinical pharmacists on the medical team' *Sociology of Health and Illness* 13; 3; 310-330

[169] Edmunds, J. & Calnan, M.W. op. cit. p952

[170] Savage, M. (2007) *Conservative Research Development consultation on public health policy* http://www.rpsgb.org.uk/pdfs/consdoc1334.pdf p5 visited 31/08/07

[171] Denzin, N. K. op. cit.

6.2.3 The defence of pharmacy as a profession

It is worth considering Denzin's arguments in light of the new character of pharmacy in order to address the question of whether pharmacy qualifies as a profession. Although he allowed that pharmacy resembled a profession in many ways, Denzin claimed that, partly because they were involved in retail, pharmacists were unable to act entirely altruistically. There are additional aspects to Denzin's case that pharmacy is not a profession, but these are no longer relevant to the debate. For example, Denzin made the assertion that pharmacists were occupied with distributing drugs rather than providing a service. Changes in the occupational role of pharmacists are such that this premise is no longer true since it is notable that pharmacists are now service providers. Similarly, Denzin's claim that the hospital pharmacist has "failed to associate with the dispensing of drugs a set of skills which only he possesses"[172] is simply not true today.

The point Denzin raises which needs addressing now is the characteristic that community pharmacists have a hybrid occupational role in healthcare service and retail. The role of the community pharmacist includes a significant amount of selling both medicinal and non-pharmaceutical products and dispensing prescriptions, which is done for remuneration from the NHS, and constitutes a significant proportion of the community pharmacist's work. One of Denzin's reasons for claiming that pharmacy has "achieved a state of incomplete professionalization"[173] is that pharmacists advertise their goods. Pharmacy "has failed to abide by the requirement of a profession that 'you do not advertise'."[174] This is an inevitable feature of the retail business. Whether advertising itself, rather than *unscrupulous* advertising, detracts from professionalism is questionable. Certainly, there are various ways of conducting advertisements. The RPSGB regards

[172] Denzin, N. K. op. cit. p378
[173] Denzin, N. K. op. cit. p375
[174] Denzin, N. K. op. cit. p376

advertising as compatible with professionalism if done correctly. Its guidelines on advertising include the following statement: "Medicines are not ordinary items of commerce and there is a professional responsibility to ensure that promotions emphasise the special nature of medicines and do not encourage inappropriate or excessive consumption or use of them."[175] If Denzin's claim was just about the characteristic of retail, then it could be argued that exclusion from being classed as a profession on this basis is arbitrary. The existence of a retail role does not necessarily exclude community pharmacy from being a profession. Rather, retail can be thought of as an additional characteristic to what we recognise as a profession. Biologists do not classify the duck-billed platypus as a bird just because it has a bill and lays eggs. Instead it is considered a mammal because it satisfies essential criteria for being a mammal. Similarly, community pharmacists are, perhaps, best thought of as professionals who are also involved in retail.

Instead of having an objection to retail in a profession per se, what Denzin seems to find problematic about advertising is that it reveals that the pharmacist is motivated at least partially by sale profits, and therefore has not pursued her vocation for purely altruistic reasons. This seems to place a high, perhaps impossible, demand upon any profession. There are three lines of defence for the idea of the acceptability of profit as an element in a profession. The first is to question altruism as an essential element, rather than just a typical characteristic, of a profession. The second is to question whether having an aspect of retail indicates a lack of altruism. Certainly, an absence of profit through retail does not guarantee altruism, and instances of profit making (or, as many community pharmacists would doubtless put it, simply making a living) do not exclude altruism. General practitioners and lawyers who are known to earn relatively large salaries enjoy the status of professionalism without facing the accusation that high salaries might draw in non-

[175] RPSGB (2007) *Code of Ethics for Pharmacists and Technicians* (London: Pharmaceutical Press) p57

altruistic people who would then jeopardise the status of the occupation as a profession. Denzin also claims that pharmacy recruits people who are interested not in values but "have mixed interests which range from the humanitarian goal to intrinsic-self-rewarding activities to extrinsic-economically-based ideals."[176] The RPSGB has taken steps to match up the goals of its recent and future recruits with the ethos of the profession, which the RPSGB recognises as values-based.[177]

A third point of defence against the Denzinian claim that any occupation that includes retail is non-altruistic and therefore not a profession is that the claim simply does not fit the description of the occupational role of the community pharmacist. This claim rests on the interpretation of community pharmacy as a largely retail business, and as such Denzin's point would not stand today as community pharmacy's defining occupational role is not in fact retail. To persist with Denzin's claim that pharmacy cannot reach professionalisation until the retail aspect of the role is eradicated would be to misunderstand the part retail plays in community pharmacy. The essential elements of community pharmacy include medicines management, the provision of a range of healthcare services, health promotion and the provision of support and advice for other healthcare professionals. To regard retail as a defining aspect of community pharmacy would be false, and as such to assess professionalism on these grounds would be a mistake. As Cribb and Barber explain, "Values definitely are at the core, or at the heart, of pharmacy...[P]harmacy exists to serve certain human values, and this should be obvious to anyone who thinks about it."[178] The occupational role of community pharmacists should be assessed on its essential characteristics, not its subsidiary activities, however sizeable. The general medical surgery of which I am a patient sells nick-knacks at the surgery reception.

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[176] Denzin, N. K. op. cit. p379

[177] See Cribb, A. & Barber, N. (2000) *Developing Pharmacy Values: Stimulating the Debate - A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain) for a discussion of this.

[178] Ibid. p16

At worst this could be regarded as unprofessional, but it does not undermine general practice as a profession, and were such sales common practice it would not deprive general medical practice of its status as a profession, since the defining elements of the occupational role would remain. Provided the essential elements of the occupational role remain altruistic Denzin's arguments about retail do not stand. Undoubtedly, there have been cases in which community pharmacists have compromised their professionalism by putting profit above certain professional obligations, and indeed an instance of this was revealed in the community pharmacy focus group when Pharm1 admitted processing prescriptions that were not signed, "We're professionals but we're also businessmen. Put it that way" [Pharm3]. However, this does not mean pharmacists would put financial gain above patients' best interests if they were to conflict and, even if there were a strong temptation to put profit above professional integrity at times, this could be accounted for on the individual level.[179] An unprofessional person can exist within a profession, and any individual in that profession can carry out an unprofessional action without stripping the profession of its status. In summary, poor retail management and poorly prioritised values could render an individual unprofessional, but sound retail would not negate professionalism. In addition, retail is an aspect of community pharmacy only, with the pharmacy body being made up of pharmacists working in hospitals, GP practices, and in veterinary and industrial settings.

[179] It is worth noting that in some cases a strong argument could be made for processing an unsigned prescription for professional, rather than business, reasons.

6.2.4 Conclusions of discussion about whether pharmacy is a profession

We can be satisfied that in all relevant ways, pharmacy fits our understanding of a profession. "Conventional definitions of the professions emphasise factors such as their unique knowledge and skill base and exclusive rights to practice. They link their functions as protectors of their members' rights and interests to their standard setting, accreditation, registration and disciplinary roles.... [The professional] is trusted to put the well-being of the patient or service user before the monetary profit."[180] So it seems that pharmacy qualifies as a profession as far as the vague concept will allow. The arguments against pharmacy being a profession centre on the fact that community pharmacists are involved in retail, but there seems to be no argument that this retail element necessarily excludes pharmacy from being a profession. Rather it seems to be the case that most, but not all, occupations that involve retail or trade are not professions, and that community pharmacy presents an interesting case of a profession that also manages retail business. Whilst pharmacy is not perhaps a paradigm case of a profession, it shares enough of the characteristics of a profession to qualify as one. Certainly, retail should not be seen as an impediment to being thought of as a profession.

[180] Taylor, David (2001) 'Choosing a professional future' *Pharmaceutical Journal* 266; 7150; 753

6.3 Professional autonomy

On the basis of the above argument, I will now assume that pharmacy is a profession, and move on to discuss professional autonomy. Professional autonomy is normally used to mean the self-regulation of the whole profession, which is usually manifested in the use of a code of ethics, a set of standards, peer judgement, and discipline. However, I am interested here in professional autonomy in terms of the autonomy of the individual professional and how this conflicts with the standards set out by the professional body, especially in light of the fact that those standards are set by members of the profession. The focus group discussions raised some interesting questions about the role of the code of ethics, about whom pharmacists should turn to for advice and guidance, and when it is appropriate to go against the rules. These matters are not unique to the pharmacy profession, and the arguments given here may apply equally to other health care professions. The discussion will then turn to conscientious objections against the supply of EHC, and the peculiar position in which this case sits as an exceptional moral judgement in a profession that apparently consists of individuals who make ethical judgements that are in line with the profession's core values.

Chapter Three, 'Analysis of qualitative data', explored the role of rules in pharmacy practice. The focus group participants had mixed attitudes towards rules, but overwhelmingly the reason given for breaking rules was when doing so would be in the best interests of the patient. This type of consideration is clearly a professional one, and from informal discussions with key decision-makers in the RPSGB, breaking the rules for these reasons is generally considered sound professional practice (depending, of course, on the particular circumstances). What I am interested in is how a professional makes the decision to act in such a way that is contrary to standard practice given that the standards

are set by the professional body. The tension I want to highlight is that between the consensus opinion of the profession and the viewpoint of the individual who, after all, is a member of that profession.

There is a sense in which 'professional autonomy' is a contradiction in terms. When Wingfield writes that pharmacists' judgements should be valued and their professionalism should not be compromised,[181] this can only be on the assumption that pharmacists' judgements are in keeping with the profession's values. If they are not, then how can the profession possibly value the judgement?[182] One possibility is that the code may in some cases be at odds with the values of the profession. The other possibility is that the individual's values are at odds with the core values of the profession. If professionals are subject to the scrutiny of the profession, then how can the individual be said to be autonomous?

Traditional versions of autonomy are that a competent person has governance over herself, and is a moral agent. This is usually regarded individually; a moral agent makes decisions that are independent of other persons (even if the decisions made are *about* other persons or things).[183] One possible way of unfolding the apparent paradox of an individual professional being simultaneously autonomous and bound to a profession is to understand autonomy not as simply the freedom from interference from others, but as a relational state. This feminist idea of relational autonomy is typically understood as being about making decisions that are considered within a context of one's relationships with others,

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[181] Wingfield, J. (2007) 'New emphasis in the code of ethics' *Pharmaceutical Journal* 279: 237-240 p238

[182] Wingfield may be referring in part to relationships between professionals, for example between pharmacists and their non-pharmacist managers who may put pressure on pharmacists to meet targets that the pharmacist may think compromises the service she can provide for her patients (for example pressure to meet targets for Medicines Use Reviews, which generate revenue).

[183] For detailed discussion of the main accounts of autonomy see Kant, I. (Translated by Paton, H. J.) (1964) *Groundwork of the Metaphysic of Morals* (New York: Harper Torchbooks) and Beauchamp, T. L. & Childress, J. F. (2001) *Principles of Biomedical Ethics* 5th edition (Oxford: Oxford University Press)

but it can also apply to an individual's relationship with an institution.[184] MacDonald explains how apparent independency of judgement is actually set within a social context:

> [T]he autonomy that professionals enjoy as individuals is socially constructed. The ability to do the things that physicians do depends crucially on a whole range of social relations and social institutions. The physician's freedom to treat patients according to her best judgement, for example, is a direct result of her membership in a supporting institution – namely, a self-regulating professional body. When she acts according to the shared standard of her profession, her colleagues will (normally) lend her their support. On the other hand, when a physician decides to act according to her own interests (or even values), she may find herself at odds with her profession's code of ethics and thus may find her right to practice either curtailed or revoked.

What, then, should we take 'professional autonomy' to mean? If we understand it relationally then, crudely put, professional autonomy means acting in such a way that is approved by those around us, and that includes fellow professionals and the profession. If, on the other hand, we take professional autonomy to mean acting in such a way that is not necessarily in keeping with the profession, then it looks as though we just have 'autonomy', or acting without interference from others. It is startlingly clear that doing just as one thinks is best, without regard to the core values of the profession, is not compatible

[184] MacDonald, C. (2002) 'Relational professional autonomy' *Cambridge Quarterly of Healthcare Ethics* 282-289 p285

with belonging to a profession, which is, after all, a self-regulating institution made up of members that have to answer to it. So it looks like relational autonomy best fits our understanding of professional autonomy. The standards accepted by those we have professional relationships with are set out in a code of ethics, and it is to the use of such codes I now want to turn. Before such a discussion I want to point to one remaining problem. A professional acts autonomously within the accepted standards set by those around her, including members of the professional body, which includes herself. This need not be very significant if the numbers are large and if everyone's opinion counts equally, but it might be a problem for smaller professions, or in cases in which a minority has particularly high influence, in which case 'professional autonomy' becomes less relational and closer to independence.

6.4 Codes of ethics

In what follows I will first briefly explore the role of the code of ethics, and will conclude that a well-placed code of ethics will allow freedom of the independent professional within the confines of the core values. The RPSGB's Code of Ethics has, until recently, been understandably vague, and a pre-2007 version quite fairly states, "The exercise of professional judgement requires identification and evaluation of the risks and benefits associated with possible courses of action. On occasions there may not be a right or wrong answer. Different people may reach different decisions on a single set of circumstances and each may be justifiable."[185] However, this raises the question of how useful the code of ethics is. Deans and Dawson reported that pharmacists felt the code of ethics was

[185] RPSGB (2005) 'Code of ethics' *Medicines, Ethics and Practice* (London: Pharmaceutical Press) p85

protective, and set standards for the profession, but criticisms of it were that it was too rigid ("I think it kind of gives you a ... rigid guide. To me, that is, 'You do this, you do this, you don't do this' whereas sometimes you've got to be a bit more rubbery.") and, contrary to this, very general ("It doesn't tell you about each situation. It is just generalised so you've just got to...put your situation into that [principle].").[186] In terms of guiding actions, the half-page text of ethical guidance in the Code was followed by more extensive and rigid rules of conduct and standards. The Code has recently undergone revision and has been re-vamped as a lengthier, and possibly more accessible, seven principle-led guide.

As mentioned earlier, a code of ethics is one of the marks of a profession. A code is a sign of standards, a gauge against which to measure professional conduct, and a sign of professional integrity. It also signifies something of the ethos of a profession, and an individual who is not in line with at least the spirit of the code may be considered unprofessional. Even so, robotically obeying the code of ethics is not what is considered to be ethical conduct. A virtue-based theory of professionalism would ideally see the professional acting in line with a code of ethics. A deontologist would see the professional duty-bound, requiring understanding and action in line with the appropriate moral duty. Even a consequentialist, who regards the eventual outcome, rather than the intentions or moral reaction, as morally important would most coherently argue that an understanding of morality is vitally important, not just the ability to obey principles. I do not want to bring into this discussion a debate about which moral theory best explains and guides morality, as it is far too complex and enormous a topic for this thesis. Instead, I want to focus on how codes of ethics relate to moral understanding and moral knowledge.

[186] Deans, Z. & Dawson, A. (2005) 'Why the royal pharmaceutical society's code of ethics is due for review' *Pharmaceutical Journal* 275: 445-446

In 'Professional Codes of Practice and Ethical Conduct'[187] Dawson invites us to understand the function of ethical codes by considering the way ethical theory works, drawing on McDowell's[188] ideas about the relationship between conduct and ethical theory, and Wittgenstein's[189] ideas about rules. McDowell makes a distinction between what he calls 'inside out' and 'outside in' views of ethics. Those ethical theories operating from the inside out conceive of ethics as something whose core is in the character; the person acts according to her judgement as a virtuous person. Ethical theories that interpret ethics as a set of guiding principles perceive ethics as operating from the outside in, such that people's actions are guided by a set of externally decided principles. The inside out approach, Dawson explains, is compatible with Wittgenstein's description of what it is to have understanding. Simply following a set of principles is to miss the point of morality. Wittgenstein draws an analogy in mathematics, likening the difference between knowledge and following a set of principles to the difference between understanding the mathematical explanation behind a number sequence and simply seeing one of many possible patterns and extending the sequence this way. Dawson suggests that the outside in perspective is the "assumption that seems to lie behind a professional code of practice."[190]

If professionals are not to simply follow a code, but are to instead think independently, and therefore possibly morally, how much independence should these actions have? Crucially for this discussion, the RPSGB Code of Ethics explains that pharmacists are "expected to use [their] professional judgement *in light of the Code*"[191] (my emphasis). The purpose of a code of ethics, then, might be to give general guidance and emphasise core values. These questions invite a return to the debate about what exactly

[187] Dawson, A. (1994) 'Professional codes of practice and ethical conduct' *Society for Applied Philosophy* 11; 2: 145-153
[188] McDowell, J. (1979) 'Virtue and reason' *The Monist* 62: 331-50
[189] Wittgenstein, L. (1953) *Philosophical Investigations* (Oxford: Blackwell)
[190] Dawson, A. op. cit. p147
[191] RPSGB (2007) *Code of Ethics for Pharmacists and Technicians* (London: Pharmaceutical Press) p5

professional autonomy should be taken to mean, and what justification there might be for a conscience clause, which is essentially a case in which there is an exception to following the code of ethics as it is meant to be applied in most cases.

6.5 Conscientious objections

The following discussion explores what is considered morally important about conscientious objections, and questions whether their use in pharmacy practice is appropriate. In what follows, I will argue that independent decision-making and moral responsibility are extremely important for professional conduct, but that if a profession is to be ethical it must understand exactly the role and limits of this independent judgement.

In the course of the discussion I ask and answer two fundamental questions: 1) are conscientious clauses ever justified?; 2) if they are, are there some decisions for which a conscientious objection is not acceptable? Section 6.5.1 deals mostly with the first question, and section 6.5.2 answers the second.

Contrary to some of the usual claims about professional autonomy I argue that the *right* to this autonomy plays only a small part in arguments for conscientious objections. A defence could be made along the lines that pressurising someone to act against their conscience to carry out the morally right action is itself morally wrong. However, I hope to show that an equally strong case can be made to show that, in the professional context, this is at least sometimes morally better than acting in accordance with one's conscience to do the wrong thing.

I argue that conscience clauses are only morally acceptable if they are invoked in very particular circumstances and if conscience clauses are understood to be objections to standard practices. I claim that to an extent it is harmful to force an individual to act

against their conscience because of the moral angst that results. I go on to argue that that allowing a person to act against the core values of their profession is inherently inconsistent and therefore a conscience clause can only arise from a metaphysical disagreement. Any other type of conscientious objection is unacceptable. There are situations that are typically regarded as being subject to conscience clauses because they require the professional to refuse to do something that is standard practice (e.g. refusal of supply of EHC). I argue here that when there is a refusal on a case-by-case basis, under certain conditions, it is morally acceptable. I give arguments as to why a principled blanket refusal is not morally permissible. The question comes down to the individual case to determine whether the harm or wrong done to the individual whose conscience is violated by applying a certain standard practice would outweigh the harm or wrong done as a result of a refusal to perform the action in question.

I ask why pharmacy tends to privilege decisions to carry out wrong actions that are made on the basis of *incorrect* metaphysical beliefs and values *shared* by the profession, over decisions to carry out wrong actions made in good faith on the basis of *correct* metaphysical and scientific beliefs, based on values that are *not* shared by the profession. I conclude that three conditions must be satisfied for a conscientious objection to stand:

1) The distress caused to the pharmacist must outweigh the harm or wrong to the patient, or the rights of the patient. The relationship between the pharmacist and the patient is unequal, and the measure of distress must be of considerable magnitude to outweigh the harm or wrong to the patient, or the rights of the patient.

2) The conscientious objection must be based on core values of the profession.

3) There must be epistemic barriers to knowing the objective answer.

In addition, I criticise the message that follows from attaching special status to conscience clauses, which is that some moral questions are exempt from the standard values of the profession. I argue that blanket objections, rather than case-by-case judgements, are wrong. I use as an example the decision over whether to supply EHC in community pharmacy. This example has been chosen for a number of reasons. It came up in the focus groups conducted for this research, and other research has also shown that pharmacists talk about it being an ethical problem,[192] and so is well worth addressing purely for the fact that it is considered an important matter in the field of pharmacy ethics. The problem is a fairly new one, with legislation on the supply of EHC over-the-counter coming about in 2001, and controversy about it has been bubbling ever since. The disagreement has been about three things: the morality of its use, the morality of its supply, and whether pharmacists should be able to refuse to supply on moral grounds. This last question has been raised in the context of two considerations, the first being whether *anyone* should be able to refuse to supply EHC on moral grounds and, secondly, whether pharmacists are of the professional status deemed necessary to make this kind of decision.

The objection to the supply of EHC is widely taken to be to the prevention of pregnancy and/ or the termination of pregnancy.[193] This discussion will not enter any arguments specifically about the morality of the use of EHC, since to address those

[192] Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham p161

[193] This is controversial; some claim emergency hormonal contraception is a contraceptive only, while others claim it is contraception because in some cases it takes effect after fertilisation. In each successful use it works in one of three ways: 1) ovulation is inhibited; 2) mucous of the cervix thickens, blocking sperm; or 3) a fertilised blasotcyst is prevented from attaching to the lining of the uterus. The RPSGB states, in agreement with the Department of Health (Department of Health (2002) Department of Health Judicial Review of Emergency Contraception (London: Department of Health)) that 'EHC does not cause abortion' (RPSGB (2004) *Practice guidance on the supply of emergency hormonal contraception as a pharmacy medicine* http://www.rpsgb.org.uk/pdfs/ehcguid.pdf p7)

questions would be to go further than the remit of the thesis. However, at times it will be relevant to draw on some of the specific moral arguments about its use because in places the coherence of the arguments for the use of a conscientious objection about EHC depend on the coherence of specific arguments about the morality of the use of EHC.

6.5.1 Are conscience clauses ever justified?

6.5.1.1 Responsibility, integrity and moral anguish

A conscience clause allows an individual to opt out of performing a specific action she has a moral objection to. The RPSGB grants that pharmacists may 'choose not to supply EHC on the grounds of religious or moral beliefs.'[194] More broadly, pharmacists are urged to ensure that if their "religious or moral beliefs prevent ... [them] from, providing a particular professional service, the relevant persons or authorities are informed of this and patients are referred to alternative providers for the service they require."[195] Conscience clauses are usually put in place in exceptional circumstances in which the moral problem is controversial (in the sense that there is variety of opinion and strong feelings on both or all sides of the argument and it is regarded by the professional body that the answer to the moral problem is unknown or disputed).[196] In these cases it is accepted that the individual professional can make her own decision in a way that to some extent goes against the standard practice of the profession.

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[194]RPSGB (2004) *Practice guidance on the supply of emergency hormonal contraception as a pharmacy medicine* http://www.rpsgb.org.uk/pdfs/ehcguid.pdf p8

[195] RPSGB (2007) *Code of Ethics for Pharmacists and Technicians* (London: Pharmaceutical Press) p8

[196] Subjectivists regard the answer as varied and that a conscientious objection is just an instance of morality (instantiated by the belief held by the individual). The subjectivist would regard conscience clauses as incoherent, since morality is determined by the individual. For the relativist a conscience clause would operate in much the same way as it would for the objectivist.

The argument that follows is based on the assumption that morality is objective. In this section I give the main arguments for conscientious objections, namely protection of integrity and the right to professional autonomy, and present some challenges to them.

Broadly speaking, arguments in favour of conscience clauses centre round the idea of individual moral integrity. As Benn puts it, "Many people believe that acting with integrity involves more than doing things which merely happen to be right. It also means following one's own conscience and not doing what one believes to be wrong."[197]

One of the ways in which a conscience clause might be thought to preserve integrity is in allowing the individual to have 'clean hands'; whatever immoral action eventually occurs, she is not the one responsible for it. An individual who sees responsibility this way will not be concerned with whether or not the deed (in this case the supply of EHC) will occur, as long as *she* is not the one to carry it out. Bernard Williams illustrates just this concern in his story of Jim and the Indians, in which Jim is asked to kill one innocent man to stop nine other innocent men from being killed by someone else.[198] The divide in opinion over what Jim should do is essentially a divide between consequentialists' and non-consequentialists' understandings of morality. A consequentialist will argue that what matters morally is whether the supply of EHC is a good thing, and a non-consequentialist might ask whether *she* should supply EHC given the fact she believes it to be immoral. The "reason why utilitarianism [or consequentialism] cannot understand integrity is that it cannot coherently describe the relations between a man's projects and his actions."[199] Is Jim acting with integrity when he does not kill a man, or is he acting irresponsibly when he refuses to act to save nine men?

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[197] Benn, P. (2007) 'Conscience and health care ethics' in Ashcroft, R.; Dawson, A.; Draper, H. & McMillan, J. (eds.) (2007) *Principles of Healthcare Ethics* (UK, John Wiley & Sons Ltd.) p345

[198] Williams, B. & Smart, J. J. C. (1998) *Utilitarianism: for and against* (Cambridge: Cambridge University Press) p98-100

[199] Ibid. p100

In the case of the supply of EHC, pharmacists cannot wash their hands entirely. Although pharmacists are allowed to refuse supply, they are obliged by the RPSGB to direct the patient to another source of EHC. In interviews carried out by Cooper,[200] one pharmacist talked about the fact that she was happy to make a supply of EHC if it had been prescribed by a doctor but was not prepared to sell EHC over the counter. Cooper discusses this situation in relation to subordination and shifting responsibility. Does re-directing a patient to another pharmacist who is prepared to supply EHC amount to the same thing as making the supply? One justification for doing what is instructed of you,[201] but not what you have singularly decided, or for re-directing the patient elsewhere, might be that the responsibility is diluted. Philosophically, diluted responsibility is a notion that is difficult to defend. There are varying proposals about how much responsibility an individual may have when she is involved in an act that is jointly dependent on the actions of others. In this case, the first pharmacist who directs the patient to a second pharmacist is enabling the second pharmacist to help the patient to carry out a contraceptive action. As Mellema[202] argues, the pharmacist who does the re-directing holds just as much moral responsibility for the act of taking EHC as the second pharmacist and the person who takes EHC, something Mellema calls 'moderate anti-dilutionism'.[203] Transferring Mellema's own

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[200] Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham p281

[201] That a pharmacist is 'instructed' by a doctor is to some extent a matter of perception. For a discussion of subordination see Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham.

[202] Mellema, G. (1985) 'Shared responsibility and ethical dilutionism' *Australasian Journal of Philosophy* 63; 2: 177-187

[203] Other models of responsibility for a multi-agency action include dilutionism, co-operative dilutionism, contributory dilutionism, threshold dilutionism, and maximal anti-dilutionism. According to dilutionism, an agent's responsibility is proportionate to the number of people involved in the action, and the extent to which she was involved. Co-operative dilutionism requires that the agents involved co-operated in bringing about the action. Contributory dilutionism holds that each individual agent is responsible for an outcome resulting from a multi-agency action if and only if that agent's part was not sufficient for the action to occur (i.e. the involvement of other agents was necessary). Threshold dilutionism holds that all agents are equally responsible for an action up until the point at which the number of agents reaches the number of people necessary to carry out the action (e.g. if the patient requires only one dose of EHC but is given EHC by six pharmacists, the responsibility of each pharmacist is diluted by six). In contrast, maximal anti-dilutionism holds that an agent who is involved in a multi-agent action is responsible for all actions on the causal chain

example and arguments into the example of EHC, he would ask us to imagine that the second pharmacist and the person taking EHC are replaced by robots, so that the only moral agent in the picture is the first pharmacist. On this basis it is evident that the moral agency of the first pharmacist is in no way diminished by the presence of other actors. Even if the actions of the first pharmacist are not sufficient for the patient to take EHC (i.e. re-directing does not guarantee that EHC will eventually be taken and other agents are necessarily involved), her involvement is necessary in this particular set of circumstances, or in this particular causal chain of events.

If acting with integrity requires 'clean hands', then it seems the RPSGB guidelines on EHC supply may need to be moderated to accommodate a genuine conscience clause on this matter, since re-directing a patient is to have moral responsibility for that patient using EHC.[204] Let us leave to one side questions about *how* the first pharmacist would preserve her integrity under conditions in which she is obliged to re-direct a patient to a supplier of EHC. The question I want to ask now concerns what is important about integrity. There are two aspects to the value of integrity. The first is that acting in accordance with one's conscience is seen by some as a necessary condition for acting morally. The second is that pressurising someone to act against their conscience is morally wrong.

As Benn explains, it could be argued that it would be wrong to push someone into acting against her conscience because "obeying one's conscience is necessary, but not sufficient, for acting in a morally permissible way [emphasis removed]."[205] Under some conceptions of morality, if a person sincerely thought that to do *x* would be morally wrong,

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leading to the final outcome (by this understanding the first pharmacist is responsible for re-directing the patient, for the supply of EHC, and for the patient taking EHC). Moderate anti-dilutionism holds that each agent is wholly responsible for the part she played in the causal chain leading to an action resulting in an outcome. (Mellema, G. (1985) 'Shared responsibility and Ethical Dilutionism' *Australasian Journal of Philosophy* 63; 2: 177-187)

[204] By my analysis of conscience clauses, honouring integrity in this way is not important unless the individual believes it is.

[205] Benn, P. op. cit. p348

but did *x* regardless, this would be wrong. Also, if a person mistakenly thought that *x* was morally wrong, and so did not do *x*, when in fact *x* was morally right and not-*x* was morally wrong, this would also be to act immorally. By this understanding, what matters in a conscience clause is whether a person should be coerced into doing something she believes is wrong even if she is mistaken about it. "The idea is that if acting against one's conscience is morally wrong, then no one should be required to do so because that amounts to being required to act wrongly. It is beside the point that one may be morally mistaken and one's conscience misguided. No one, on this argument, should be professionally required or pressurized into doing something they consider wrong, because to accede to such pressure would itself be wrong."[206] Being wronged in this way is different to being harmed, which I will come to in due course. For now, the claim is that forcing someone to act against their conscience is to force someone to do something that is wrong, and forcing someone to do the wrong thing is to wrong them.

There are two possible responses to this. The first is that the argument contains a conditional proposition ('*if* acting against one's conscience is morally wrong then no one should be required to do so'). So a supporting argument would have to be made to show that acting against one's conscience was morally wrong. While it might be *desirable* to act in accordance with one's conscience, it is not clear that doing so holds moral value in itself. If you take the position that what matters morally are the actions or the outcomes of a situation, then the psychological states that lead to that action are neither here nor there. The full argument that acting against one's conscience is amoral rather than immoral concerns arguments that it is outcomes, not intentions or responsive feelings, that have moral properties. Unfortunately, giving an account of the metaethical debate about this would reach beyond the scope of this thesis. Even so, it is important to bear in mind that

[206] Benn, P. op. cit. p348

both sides of the argument would require metaethical premises to support their claims. At the very least, the conclusion at this point is that it is questionable that acting in accordance with one's conscience is a moral good in and of itself.[207] Let us give the supporter of the conscience clause the benefit of the doubt, and suppose that acting in accordance with one's conscience is something to be considered in the moral equation. It does not follow from this that this is necessary for the morality of an act. Take the case of the sincere Nazi who carries out executions of Jews because he genuinely believes Jews are satanic and ought to be killed. Suppose there is a particular Jewish woman the Nazi recognises as a neighbour, and the Nazi cannot bring himself to sentence her to death. He is sincere in his beliefs about Jews, and his conscience tells him he ought to treat his neighbour as all other Jews ought to be treated. However, he cannot bring himself to kill his neighbour, and he does what he believes to be the morally wrong thing and he lets her go free. Surely we want to be able to say that the act of letting the neighbour go free was right, no matter what the Nazi's conscience was telling him. If so, acting in accordance with one's conscience is not necessary for doing the right thing.

Is acting in accordance with one's conscience sufficient for doing the right thing? That answer can be easily reached by looking at the instances in which the sincere Nazi acts in accordance with his conscience.

Let us accept, then, that it is not necessary to act in accordance with one's conscience in order to do the morally right thing, but let us allow that acting in accordance with one's conscience is a moral, rather than an amoral, consideration. This would mean that acting in accordance with one's conscience would carry moral weight, which would come into consideration in cases in which the conscience of the professional was in conflict with the rights or the best interests of the patient.

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[207] See Mackie, J. L. (1977) *Ethics- Inventing right and wrong* (Middlesex: Penguin) and Baron, M. Pettit, P. & Slote, M. (1997) *Three Methods of Ethics* (Oxford: Blackwell) as introductions to the relevant debates.

The second response is that, for the argument to be compelling, even if we were to accept that acting in accordance with one's conscience was in and of itself morally right, and that acting against one's conscience was in and of itself morally wrong, we would have to agree that to pressurise someone to act against her conscience to do the right thing would be morally worse than to let her act in accordance with her conscience to do the wrong thing. If pressurising someone to act against her conscience is wrong, then there will be two potentially wrong actions from which to choose the lesser of two evils: pressurising someone to act against her conscience, or letting her do the wrong thing. Using the example of the supply of EHC, there might be a choice between, on the one hand, denying the patient's welfare needs, her right to access healthcare, and her right to make an autonomous decision and, on the other hand, pressurising the professional to act against her conscience. Is the moral mechanism of decision-making really so sacred that interfering with the process by which a decision is reached is always worse than allowing a different morally wrong action to occur? This would seem a highly untenable position to hold, even for those who think that acting in accordance with one's conscience is important for ethical behaviour.

By my analysis that follows, the only successful argument for allowing a person to act in accordance with her conscience to do the wrong thing is that it is harmful to force someone into such moral distress. As I will show, this is not an argument the conscientious objector will like. The conscientious objector wants her position to be respected for the position it is, as she sincerely believes she is doing the right thing. She does not want to be humoured with nods of agreement intended only to save her from distress. "A person's integrity may be violated if she is made to act against her conscience; the deepest values by which she defines her life are under assault. It is a cause of distress and anger that she

should have to do what she thinks is wrong."[208] That a person comes under assault when forced to act against her conscience initially appears to be a persuasive declaration, and indeed it seems to be the main motivating force behind the conscience clause. However, it is a rather misplaced argument. Its strength is emotive and its only rational persuasion is in saving people from the distress of acting against their conscience. To understand why it would be important to have a conscience clause one imagines being asked to perform an action that strongly conflicts with one's conscience and of course, by definition, this is an uncomfortable thought that most of us feel strongly repelled by, but alone it should not convince us that there is any moral value to it. Using the example of EHC, in its most simple form the conscience clause is giving credence to the pharmacist's preferences, put up against the patient's rights and welfare considerations that concern the patient's need for EHC. Why should a profession support a preference for something that is contrary to the most fundamental values of the profession? That a decision makes a pharmacist feel uncomfortable is not enough of a reason to allow a wrong decision to go ahead. Indeed, Benn dismisses such arguments as "weak", pointing out that health care professionals routinely do things that cause distress and make them feel uncomfortable.[209]

Maybe this is an unfair representation of the argument on two counts. First, the 'discomfort' can be of great magnitude. Cohen describes it as "excruciating moral anguish"[210] and Wicclair as a "significant loss of self-respect".[211] Second, the argument is perhaps less about avoiding this anguish and more about honouring integrity. But even if such a distinction can be made, is this enough to override the patient's rights or interests? Why is it so important to allow the pharmacist to act in accordance with what she considers to be right, as set by the standards of her conscience?

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[208] Benn, P. op. cit. p348
[209] Ibid. p348
[210] Cohen, C. (1968) 'Conscientious objection' *Ethics* 78; 4: 269-279 p.269
[211] Wicclair, M. R. (2000) 'Conscientious objections in medicine' *Bioethics* 14; 3: 205-227 p214

In conclusion, it seems right to take into account a person's distress caused by carrying out an action that is against her conscience, but the notion of integrity should have no further impact than this. As will be explained later, this harm to the professional is to be weighed on asymmetric scales due to the special nature of the professional/ patient relationship.

6.5.1.2 The right to professional autonomy

The next consideration is whether professionals have the *right* to act according to their consciences. This stems from the notion that pharmacists have professional autonomy. Cantor and Baum's argument for pharmacists being allowed a conscientious objection is that "it seems inappropriate and condescending to question a pharmacist's right to exercise personal judgement in refusing to fill certain prescriptions."[212] Let us allow for the moment that such a right exists. At times this right will come into conflict with the rights of the patient. In the example of EHC, the pharmacist's right to abstain from supplying EHC will conflict with the patient's right to access it. It is worth recognising a particular point made by Wicclair about how autonomy can fit into this context: "Only certain limited types of reasons (e.g. ethical or religious objections) can serve as a basis for a claim for conscientious objection). For example, suppose Dr. K objects to participating in forgoing aggressive treatment on the grounds that it would deny her an opportunity to test a new drug...This type of reason has *no weight* as a ground for a claim of *conscientious objection.*"[213] By definition, a conscientious objection can only be made on moral grounds, and appealing to professional autonomy as a reason for allowing conscientious objections

[212] Cantor, J. J. D.& Baum, K. (2004) 'The limits of conscientious objection – May pharmacists refuse to fill prescriptions for emergency contraception?' *New England Journal of Medicine* 351; 19; 2008-2010
[213] Wicclair, M. R. op. cit. p212

is to attempt to apply a principle that is wider than the gap it is intended to fill. The solution, then, is to make exceptions: a professional can exercise her autonomy by making objections to something, but only if those objections are made on moral grounds. What might be the rationale behind this? There are, after all, all kinds of non-moral arguments put against moral ones, for example legal or practical ones. The onus is on the advocate of the conscientious objection to show why a professional has the right to exercise this narrow version of autonomy for only *moral* preferences rather than a preference of *any* kind. If justification for such a distinction cannot be shown, then it will be hard to accept that pharmacists have the right to exercise autonomy, since what would remain would be the argument that professionals have the right to exercise autonomy in the broader sense, which simply cannot be accommodated by a conscientious objection, which by definition is only about matters of the conscience, which are moral or religious in nature.

Even if we did allow that pharmacists had a right to autonomy in this context, it would be difficult to see how respecting the pharmacist's autonomy could trump the right of a patient who is seeking a service from that person in her capacity as a professional. One reason for this might be that in some cases there is an imbalance of interests between satisfying the pharmacist's conscience and the welfare and autonomy of the patient (for example, if a patient wants to purchase EHC to stock up her medicine cabinet and the pharmacist has strong objections to the use of EHC). But there is more to it than this, and it lies in the nature of the relationship between the pharmacist and the patient. It is not paternalism and an interest in patient welfare that is driving the pharmacist to refuse access to EHC through her; it is the *personal* autonomy of the *professional*. Stripped of any arguments about the instrumental role of integrity (which we shall come to in section 6.5.3), it is hard to see why the professional's personal autonomy should carry greater weight than the patient's (autonomy and welfare). Unless (possibly) the pharmacist is

behaving paternalistically (i.e. in the best interests of the patient), under what circumstances is a pharmacist entitled to interfere in a patient's decision?

The only remaining possible defence for the advocate of the conscientious objection on this point of professional autonomy is that a pharmacist's autonomous decision not to participate in an action she thinks is wrong is of greater moral weight than her obligation to meet a patient's autonomous decision simply because, all things being equal, one is not automatically obliged to fulfil another's autonomous choices. But by the nature of the pharmacy/patient relationship this is not a case of 'all things being equal'. Often, where a right exists, there is a corresponding duty. This is especially true of relevant rights in relationships of service and care. For example, my right to receive emergency healthcare from the UK government would correspond with the state's obligation to provide me with emergency healthcare because I am a citizen of the UK. Where an individual becomes a pharmacist and enters into this relationship of care with patients she is entering into a relationship in which she will aid the fulfilment of certain rights. This does not mean she has written a blank cheque and has signed away all of her own rights, but she may have a moral obligation to fulfil all relevant rights within reason. For example, it would be unreasonable for me to expect a particular pharmacist to keep working for an extra two hours for my convenience; she has a right to go home after a day's work. However, that pharmacist *is* obliged to be available during advertised hours, regardless of whether she has a personal objection to working between three and four o'clock. What is it about some standard practices (for example the supply of EHC) that set them apart as something about which it would be unreasonable to expect a pharmacist to fulfil a duty that corresponds with the right to access it? In the case of demanding that the pharmacist keeps working beyond her set hours, and being available during advertised hours, the profession would accept there were objective answers. Why is this different for other practices? Why,

on some matters, for example EHC, does the profession allow that the pharmacist's rights are more important than her obligation to provide healthcare, support the patient's welfare and fulfil the patient's right to make an autonomous decision? Broadly, the only reasonable answers that can be given to this are that some practices cause moral anguish of great and significant magnitude, *and* are sufficiently unsettled in their metaphysical foundations. The first part of this claim was dealt with in the previous section, and the second part is dealt with in the next.

6.5.1.3 Core values

When an individual becomes a professional pharmacist she agrees to the ethos of the profession and to the core values laid out in the code of ethics. Anything that contradicts that individual's fundamental moral beliefs will be outside the core values of the profession. When a pharmacist makes a judgement that is contrary to the standard action she does so while bearing in mind the core values of the profession. Take for example the scenario described by one of the focus group participants, Pharm3, in which he illegally dispensed methadone to a pregnant woman. It is fairly uncontroversial that, in general, methadone should not be dispensed illegally. There are several reasons for this, mostly to do with the welfare and safety of those requesting methadone and those dispensing it. What happened in this particular case, though, was that the pharmacist exercised his professional judgement to act in a way that was consistent with the code of ethics and the core values of the profession by acting in the best interests of the patient. There is scope for debate about whether supplying methadone was in fact in the patient's best interests in this case, but we can be quite sure that the desired outcome (to fulfil the patient's best interests) was morally right. Contrast this with a pharmacist who refuses the supply because he does not think a woman should be pregnant if she is dependent on drugs, or a pharmacist who believes the woman must have become pregnant through promiscuous behaviour resulting from drug use, and does not want to encourage such behaviour, or a pharmacist who has a moral objection to drug-taking and does not want to be part of it even if this were to mean the patient would find herself in greater danger. None of these reasons would be deemed 'professional', and none of them could be described as applications of core values of the profession, or the spirit or ethos of the profession, and indeed may directly contradict the core values. Such views would probably be covered negatively by the new Code of Ethics: "Make sure your views about a person's lifestyle, beliefs... or other perceived status do not

prejudice their treatment or care."[214] Suppose a pharmacist were to object to dispensing medication that had been tested on animals, or that used animal products. Such a position could be based on strong moral convictions, or religious beliefs, and yet to refuse the supply of certain medication to patients who needed it and who themselves had no objection to consuming animal products would probably be considered unprofessional. Better, one might say, to not become a pharmacist if one has objections to experiments on animals or the use of animal products. This is a view shared by Savulescu, who writes about the conscience clause offered to physicians: "If people are not prepared to offer legally permitted, and beneficial care to a patient because it conflicts with their values, they should not be doctors. Doctors should not offer partial medical services or partially discharge their obligations to care for their patients."[215] Alternatively, an individual objecting to the use of animals in medicine might become a pharmacist and continue to supply the medicine tested on animals or containing animal products, but lobby the profession with reasonable arguments as to why there should be a policy against their use. When an individual signs up to a profession, she does so as someone who either acts in accordance with the core values and is prepared to make compromises with her conscience, or she wholeheartedly accepts those very same values. Freedman writes, "morality is not...like a jacket which you may put on or take off (perhaps exchanging it for a white coat)."[216]

Wicclair proposes that conscientious objections should only be allowed in cases in which the core moral values that form the basis of the objection correspond with the core moral values of the profession: "taking account of the profession's values when attributing appeals to conscience can be defended by appealing ...to the objective of promoting the

[214] RPSGB (2007) *Code of Ethics for Pharmacists and Technicians* (London: Pharmaceutical Press) p8
[215] Savulescu, J. (2006) 'Conscientious objection in medicine' *British Medical Journal* 332: 294-296 p294
[216] Freedman, B. (1978) 'A meta-ethics for professional morality' *Ethics* 89; 1: 1-19 p1

moral integrity of the *...profession.*"[217] Intuitively, it is easier to understand that a pharmacist should be allowed to object to supplying EHC on the grounds that he wants to protect the potential patient (which he regards to manifest in the egg and sperms cells) than to understand that a pharmacist should be allowed to object to the use of EHC because he believes medicine should not be used in any circumstances because it interferes with nature. The value expressed by the first pharmacist concerns the welfare of the patient, and is in keeping with the core values of the profession. The value expressed by the second pharmacist concerns a disapproval of the purpose of medicine, and is in conflict with the core values of the profession. Allowing a conscientious objection on the basis of values that oppose those of the profession would be a contradiction, and so it is straightforward that a conscience clause that entertained other values could not exist. Objecting on the grounds of values not shared by the profession would be contrary to the profession and would require resignation.

It is important to point out that some of the values a professional will draw on will not themselves be contrary to the profession's core values as stated (for example the value that life is sacred is not itself contrary to any core values of pharmacy) but might lead to a contradiction in core values (for example if this provokes action that is against a patient's best interests and against her autonomous decisions). So unrelated values could indirectly contradict core values.

Values are not the only kinds of entity that must go under the scrutiny of consistency. As Wicclair points out, the professional must also have her facts right.[218] If a pharmacist based his objection to the supply of EHC on the mistaken belief that it was an abortifacient his objection would not be granted. What we do seem to allow is a divergence

[217] Wicclair, M. R. op. cit. p223
[218] Wicclair, M. R. op. cit. p244

in the understanding of metaphysical facts. The only justification I can see for this is their low epistemic accessibility.

Suppose one pharmacist (P1) believes life begins when the soul is created, which, he believes, is when egg and sperm unite to become the two-celled zygote. P1 understands that EHC is not an abortifacient, but he is correct in his belief that the use of EHC could destroy a zygote. P1 believes all humans that are presented to him at his pharmacy are his patients. Subsequently, P1 believes the zygote constitutes a patient. P1 shares the core values of the profession, and so believes the interests of his patients are of prime importance. Suppose another pharmacist (P2) does not believe in souls, and believes that a person does not come into existence until after birth when it gains the faculties of autonomy and sentience. P2 also understands that EHC is not an abortifacient. P2 shares the core values of the profession, and believes he is only presented with one patient when a pregnant woman enters his pharmacy, and that she, as his patient, is his prime concern.

Leaving to one side other arguments about the woman's right to choose, and the interests of the pregnant woman, P1 has a conscientious objection to supplying EHC. P2 has no such objection. The only difference in their positions is their beliefs about the ontological status of the united egg and sperm cells. At least one, and possibly both, of these pharmacists is mistaken. As already noted, mistakes about scientific facts are not entertained because there is far less controversy about them. When a pharmacist disagrees with the profession about an accepted scientific fact, the profession can be confident the individual is (probably) wrong. Similarly, when a pharmacist disagrees with the profession about an accepted value, the profession can also be confident the individual is (probably) wrong. However, when a pharmacist disagrees with the profession about a metaphysical fact, the profession cannot have this confidence. This is not true of all cases, however. For example, a pharmacist who thought chairs had souls, could feel pain, and were his patients

might object to people sitting on chairs in his pharmacy. The profession would be more likely to consider this pharmacist as having mental health problems, or as being eccentric, than to think of him as having a controversial metaphysical belief. Consider a hospital pharmacist in palliative care who thinks personal identity is dependent on psychological existence, and believes a break in psychological continuity results in the termination of personhood.[219] As a consequence, this pharmacist believes one of his patients, who is in the late stages of Alzheimer's, is not the same person as the one who, five months ago, insisted that expensive and aggressive treatment be used to treat a physical condition she had. Because of his metaphysical beliefs, the pharmacist does not think he is overriding the patient's wishes when he decides not to issue the patient an expensive and aggressive treatment for a physical condition she has. The pharmacist certainly shares at least one of the core values of the profession, which is to respect patient autonomy, he just does not think it is applicable in this case. This is not insanity or eccentricity, but a metaphysical belief.

This does not mean we can never know that an individual has made a false metaphysical claim. Metaphysics is not entirely unknowable, and certainly an individual can be challenged on grounds of inconsistency. Further, social claims, which arguably fit into neither the scientific nor metaphysical category, may be mistaken. These types of social facts will be explored in more detail in section 6.5.2 when discussing the specific case of EHC, but the arguments for agreement on them work exactly the same way as scientific facts do.

What the profession allows, then, is that decisions based on metaphysical controversy are left to the individual so long as the scientific facts and ethical values the

[219] This view, which is basically that we are fundamentally psychological beings, is an extremely common philosophical understanding of personal identity. See Locke, J. (1975) *An Essay Concerning Human Understanding* (Oxford: Oxford Clarendon Press) and Baker, L. R. (2000) *Persons and Bodies – A constitution View* (USA: Cambridge University Press)

decision is based on correspond with those of the profession. This has the consequence that at least sometimes the wrong action will result.

6.5.1.4 Summary of 'Are conscience clauses ever justified?'

I have considered conscience clauses as a mechanism for preserving an individual's integrity, and for respecting a professional's right to professional autonomy. I have argued that integrity is not itself a viable notion, since it relies on the assumption that acting in accordance with one's conscience is what matters morally. We saw that forcing someone to act against their conscience was not necessarily to force them to act wrongly, since acting in accordance with one's conscience is not necessary for moral action. What is worthy of moral consideration is the harmful effect on the individual who is being forced to act against her conscience, and this has to be weighed against the effects and wrongs done to the patient who is affected by the conscientious objection. Drawing on Wicclair's work, the notion of professional autonomy was challenged as being too broad to apply to conscience clauses. Even if arguments for professional autonomy did work for conscience clauses, again this would have to be weighed against the rights and interests of the patient with consideration of the imbalanced relationship and the special duties pharmacists have towards their patients.

It was argued that consistency forced conscience clauses in a profession to apply only to cases in which the reasons for the objection were based on values that corresponded with the values of the profession. Where these values diverge, the individual

should not be in the profession, or should behave as if she did hold these values.[220] Agreement of scientific and social facts was also a necessary condition. The only divergence in agreement, then, can be in metaphysical beliefs, which are epistemically problematic. The broad conclusion, then, is that conscience clauses are morally permissible under certain conditions for the sake of avoiding harm to the individual professional and, possibly, to respect that professional's rights to autonomy. The imbalance of the relationship between the professional and the patient means that considerations of the rights and interests of the professional will rank lower than considerations of the rights and interests of the patient.

The following section asks whether there are cases in which the conscience clause should not apply and uses the supply of EHC as an example.

6.5.2 If conscientious objections are morally permissible, are there some decisions for which a conscientious objection is not acceptable?

The purpose of this section is to illustrate how a conscience clause might work in practice using the case of the supply of EHC. This will act as an argumentative tool for showing that there are cases in which conscience clauses should not apply. Using the supply of EHC as an example is helpful in drawing out some remaining points about which types of facts a profession should tolerate a divergence of belief in, when these beliefs affect a conscientious objection. This discussion does not specifically aim to answer questions about the morality of supplying EHC. Any such arguments are incidental to showing that in some cases the *types* of arguments used to make a conscientious objection do not fulfil

[220] Realistically, this might not be possible, since moral judgement often do call upon the conscience and an appreciation of what is morally important, rather than an indoctrinated following of rules.

the criteria for making a sound conscientious objection under the conditions laid out in the previous section. The discussion will focus specifically on social facts and judgements.

The questions to ask, then, are:

a) Are the reasons for a conscientious objection in the case of the supply of EHC based on values that are shared by the profession? If they are unrelated, do they contradict any of the core values of the profession?
b) Are the reasons for a conscientious objection in the case of the supply of EHC based on correct scientific and other (non-metaphysical) facts?
c) Are the reasons for a conscientious objection in the case of the supply of EHC based on metaphysical beliefs that are plausible, and are not rivalled by a significantly more certain metaphysical theory?
d) Is the harm that would be done to the pharmacist (and possibly the violation of the pharmacist's autonomy) if she was pressurised into supplying EHC of sufficient magnitude to outweigh the wrong and harm done to the patient who is refused EHC?

The answer to the first question (a) is at first sight fairly easy to give. Objections to supplying EHC are commonly that the use of EHC can destroy human life, and that human life is valuable or sacred. The pharmacy profession may not hold as a core value that life is sacred, but it is quite feasible that it would hold that life is valuable.[221] Other values that might come into play are that individuals should not interfere with God's will, or that we should not interfere with nature. As a non-religious institution, the pharmacy profession cannot possibly hold as a core value the idea that God's will should not be interfered with.

[221] Note that the core values of the profession might differ from what pharmacists hold to be the core values of the profession.

And as a medical institution it cannot possibly hold that one ought not interfere with nature. Matters become more complicated when we consider that the value that human life is valuable is being held up against another core value of the profession, namely that of the patient's autonomy.

Answering (b) will depend on whether the individual pharmacist has understood and accepts the scientific evidence about EHC. What might be more contentious are beliefs held about social facts, and beliefs formed as a result of certain social values. Recall the discussions about EHC in the focus groups in which some pharmacists, in keeping with reports from other research,[222] expressed reasons for not wanting to supply EHC to those under sixteen that were not based on evidence or reasoned argument. Whether or not there were other, rational, reasons, there were in some cases reasons based on prejudice and the misconception that EHC promotes promiscuity.

The answer to the third question (c) is remarkably difficult. The metaphysical basis of common reasons not to supply EHC are religious. Other lines of reasoning might also rely on a zygote being a person, or a potential person, or on it being a patient, or a potential patient. Reaching a consensus on the basis of religious beliefs is notoriously difficult, and the uncertainty of this alone is enough to accept that the common religious positions are plausible, and are not rivalled by a significantly more certain metaphysical theory.

The answer to (d) will depend very much on the particular circumstances surrounding a request for EHC, and on the individual pharmacist and patient. For example, the answer might fall in favour of the pharmacist if he has a strong objection against

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[222] Bissell, P.; Anderson, C.; Savage, I.; Goodyear, L. (2001) 'Supplying emergency hormonal contraception through patient group direction: a qualitative study of the views of pharmacists' *The International Journal of Pharmacy Practice* 9: Supplement pR57
See also P. Bissell and C. Anderson (2003) 'Supplying emergency contraception via community pharmacies in the UK: reflections on the experience of users and providers' *Social Science and Medicine* 57: 2367-2378 and Bissell, P.; Savage, I. & Anderson, C. (2006) 'A qualitative study of pharmacists' perspectives on the supply of emergency hormonal contraception via patient group direction in the UK' *Contraception* 73; 3: 265-270 and Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham p162

supplying EHC and a patient wants to stock up her medicine cabinet but has no immediate need for EHC, and can easily go to the next door pharmacy instead. In other cases, it will be quite clear that the pharmacist would be obliged to make the supply. For example, if a pharmacist has no strong feelings about supplying EHC, but would just 'rather not', and if the patient is in desperate need of EHC and is very distressed, it seems obvious that the decision should fall in the favour of the patient.

One remaining, and highly significant, problem with having a conscience clause is highlighted by the EHC example. The problem is in the fact that a conscience clause implies that ethics is built of absolute principles. The arguments I have presented for having a conscience clause are mostly consequentialist ones, but having a conscience clause inevitably gives the impression that professionals can object to something because it is against their principles, and implies that morality comprises principles. Further, it gives the impression that the principle guarded by the conscience clause can be separate from, and superior to, the obligation to safe-guard the interests of the patient, even within the pharmacy profession that explicitly states that the care of the patient is the first concern.[223]

While this need not be a problem if the pharmacist's decisions are based on *prima facie* principles or, to use the vocabulary used so far, a set of values, it would be a problem if pharmacists exercised absolute principles. *Prima facie* principles would allow some flexibility in choosing between principles or values that would ultimately affect a decision. Consider instead the pharmacist who always objects to supplying EHC. That a pharmacist can categorically say that the use of EHC is immoral is to take a very particular deontological approach to ethics, and not one that exists in the profession. There are modifications of this principle against the use of EHC; some literature implies that some

[223] RPSGB (2007) *Code of Ethics for Pharmacists and Technicians* (London: Pharmaceutical Press) p4

pharmacists think the use of EHC is immoral except in cases of rape.[224] Perhaps the wide-sweeping principle relates to the value that life is sacred. That life is *valuable* may be a core value of the profession, but recall that the value that life is *sacred* is unlikely to be deemed a core value. If life is valuable rather than sacred, then presumably there are circumstances in which life is up for negotiation. This is not an extreme view; consider war and self-defence. A categorical approach to the supply of EHC would be inconsistent with the core values of the profession. If a pharmacist never finds it right to supply EHC this should only be because, in each individual instance, refusing the supply would have been justifiable on the basis of the core values. As a reminder, one of the core values of the pharmacy profession is that the patient's interests are of paramount importance. It is difficult to see how, in most cases, supplying EHC upon request would be contrary to the patient's best interests. A pharmacist cannot successfully argue, *a priori* that objections to the supply of EHC are consistent with the values of the profession and, given the nature of the circumstances that surround the supply of EHC, it seems that in many cases the patient's interests and rights will override the pharmacist's interests and rights.

6.5.3. Individual judgement

Given these arguments for a more restrictive use of a conscience clause than might normally be expected, it might be thought that the role of individual judgement is limited. What is it we want from professional ethics in pharmacy? For pharmacists to do the morally right thing. This requires judgement, and making decisions about particular

[224] Hopkins Tanne, J. (2005) 'Emergency contraception is under attack by US pharmacists' *British Medical Journal* 330 p983; Cantor, J. & Baum, K. (2004) 'The limits of conscientious objection – may pharmacists refuse to fill prescriptions for emergency contraception?' *New England Journal of Medicine* 351; 19: 2008-2012; Sutkin, G.; Grant, B.; Irons, B.K. & Borders, T. F. (2006) 'Opinions of West Texas pharmacists about emergency contraception' *Pharmacy Practice* 4; 4: 151-155

situations. Because of the vast variety of situations a pharmacists might be presented with, and the precise particulars of each case, the pharmacist must be able to exercise freedom of judgement. The conscience is a useful tool for arriving at the right answer. As Benn explains, the conscience acts as a kind of intuitive guide to what the right thing to do is, but it is by no means the definitive answer. "There is an endless range of ethical issues on which sincere and reflective people profoundly disagree. If they disagree, then as a matter of logic they cannot all be right. Therefore many people have erring consciences."[225]

Advocates of the conscience clause sometimes claim it is condescending to disallow the flexibility the conscience clause offers, because this is effectively mistrusting the individual's judgement. However, when a pharmacist makes decisions based on values that are alien to the profession, it would be unethical to turn a blind eye, and when a pharmacist's reasons for exercising the conscience clause are based on misunderstanding of scientific, social or metaphysical facts it would be insulting to her to allow these postulations to go unchallenged.

Even in the absence of valid arguments in favour of a conscience clause in all, or even most, situations there is a very compelling argument in favour of allowing professionals to be guided by their conscience within the confines of the code of ethics. Personal judgement by pharmacists is needed because the pharmacist is acting as a sensitive judge of particular situations, being privy to details and understanding the context in which they sit; how else can a moral judgement be made?

[225] Benn, P. op. cit. p346

6.6 Conclusions

It was shown that in all relevant respects, pharmacy should be regarded as a profession. With professionalism comes moral identity, and individual professionals with moral responsibility. Given that individuals are moral agents and make judgements based on their own understanding of morality, this raised the question of what pharmacists should do when their fundamental beliefs came into conflict with the standard policies of the profession.

The chapter went on to show that many of the arguments for having a conscience clause are unsound. If it were morally wrong for one pharmacist to supply EHC, then it would be morally wrong for all pharmacists to supply it. To allow a pharmacist to exercise a conscientious objection over a matter the profession has already decided the answer to is to acknowledge that the negative experience the individual pharmacist would have if she were to act against her conscience is of significant magnitude to outweigh any wrong or harm done by the professional not carrying out the action she objects to. Existence of a conscience clause is only justifiable when the individual professional would undergo considerable anguish if pressurised to act against her conscience *and* if the wrong or harm to the patient caused by the exercising of the conscience clause carried less weight than the anguish that the pharmacist would suffer if pressurised to act against her conscience *and* if the reasons for the conscience clause are based on values the individual pharmacist shares with the profession *and* if the reasons the pharmacists had for exercising the conscience clause were based on scientific knowledge, true beliefs of social facts, and true or plausible metaphysical beliefs. If we understand the professional framework to include proportionate considerations of the professional's interests, the bottom line is that the matter in question can either be accounted for by the profession's ethical and factual framework (in which

case it is justified), or it cannot (in which case it is immoral within the context of the profession).

It was shown that in the case of the supply of EHC, the only circumstances in which a conscience clause could be exercised would be if refusal of supply would be a fairly trivial matter for the patient, and supply a cause for major concern for the pharmacist, and if the pharmacist did not exercise a categorical refusal of the supply of EHC.

Conclusions from the arguments about conscience clauses are not incompatible with individual professional decision-making, and the role of the individual in making moral decisions is wholly recognised and appreciated. The conclusions of this chapter are that the profession must be wary of equating the value of professional judgement with a subjective view of morality.

Chapter Seven: Conclusions

7.1 Overview

This research set out to address a number of questions about pharmacy practice ethics that spanned two broad disciplines of academia and required three methods of research to answer. In simple terms, the research's aims were to discover what pharmacists' understandings of ethics were, the moral problems pharmacists came across in their work, how often these problems arose and how pharmacists dealt with them. The research had a second agenda, which was to explore the place of philosophy and empirical research in the field of pharmacy ethics. The argument presented was that pharmacy practice ethics requires input from several co-operating disciplines, and that philosophy is central to this multi-disciplinary approach.

This final chapter brings together the findings, arguments and conclusions of the thesis, and suggests areas for further research.

7.2 Empirical findings

The focus groups and questionnaire were designed as separate pieces of research to address different aims, and so there was no attempt to use one method to confirm the results of the other. However, as it happens, there were some areas of over-lap between the results of the questionnaire and the data from the focus groups, and these over-laps were in findings

about pharmacists' appreciation of the law and the difficulties associated with the problem of identifying a tablet to a person who does not own that tablet.

Data from both suggest community pharmacists' main concerns are for the interests of the patient and for the law. The questionnaire results indicated that pharmacists gave the patient's interests higher priority than the law. The focus groups offered insight into how important each of these considerations was for pharmacists and also shed light on how pharmacists handled conflicts between the law and the patient's interests. Given that legal considerations are not necessarily ethical considerations (unless one holds that laws are set as part of a democratic system and as such each citizen has a moral obligation to obey them), it is interesting that some respondents to the questionnaire put the law above the patient's best interests in considering ethical problems. The focus group data suggest that pharmacists regard the law as important for several reasons, including that there are moral reasons for following any law (because they are made through democratic means), and because some pharmacists consider law as almost synonymous with ethics. It may also be that pharmacists regard the law as important for other reasons, for example to avoid getting into trouble (interestingly, when making ethical decisions many pharmacists also gave most consideration to whether they would be struck off).

The apparent agreement among pharmacists, mostly across and within sectors, about the decisions they would make is very interesting, especially given pharmacists' understanding of what ethics is and how ethical problems should be approached. The focus group data suggested that pharmacists took a commonsense approach to ethics, and so it is interesting to discover that this mostly brings about the same decision. Where the questionnaire showed a divide in responses to questions, in most cases this appeared to be a difference between sectors, which is perhaps accountable in the differences in exposure

to problems through the professional makeup of the respective teams, and the professional relationships within those teams.

The scenario in the questionnaire that divided opinion among the participants most noticeably was also a scenario that raised interesting ideas through the focus groups, namely that in which someone asks the pharmacist to identify a tablet that does not belong to them. Complications about patient safety through taking (or neglecting to take) the drug, combined with the complexities of the concept of confidentiality, made the scenario particularly problematic. Strong arguments could be made for both of the options given in the questionnaire as possible actions to take. The questionnaire showed a division in opinion among all pharmacists in each sector over whether to inform or not inform the person of the tablet's identity. Discussions in the focus group on this scenario provoked philosophical questions about the types of information that should be regarded as confidential. It is possible that the ambiguous nature of the status of information that is in both the public and private domain caused the divide in responses from the questionnaire participants.

In the next section I will draw upon various points of the thesis to reiterate the importance of a multi-disciplinary approach to applied ethics in pharmacy.

7.3 The necessity of a multi-disciplinary approach

The need for both philosophical and empirical research in pharmacy practice ethics has been displayed in several instances in this thesis. This ranges from the need for the individual pharmacist to critically engage with ethics and to challenge any prejudices she might hold, to the need for both disciplines in academic pharmacy ethics.

When analysing the focus group data I was struck by how little philosophical reflection there was. Of course, my own expectations are not a measurement for what the level of philosophical engagement of pharmacists ought to be, but I was at least able to see where there was a lack of critical thought and an under-use, and sometimes a misuse, of ethical terms. As argued in the last substantive chapter, to be consistent, decisions by the individual professional ought to be in keeping with the core values of the profession. Pharm3 made the intriguing remark that if something is a moral matter it ought to be dealt with at a distance from one's personal judgements. This was perhaps a statement about making rational and objective judgements about potentially emotive matters. Where decisions are made largely on the basis of regulation, to avoid getting into trouble, or on the basis of personal opinion and beliefs that do not coincide with the core values of the profession, pharmacists might be making decisions that are wrong. Personal engagement plays an essential role in ethical decision-making, but this should not be confused with ethics being relative, or based on commonsense or opinion. Reasoned moral discourse has a very important role too, and this involves philosophy at some level. Consider this approach to teaching ethics to pharmacists: "Discussion of the [ethical] theories can be brief because one can come to the same conclusion in resolving an ethical dilemma using

different theories of ethics."[226] There may be sound pedagogic reasons to exclude ethical theory from an applied ethics syllabus, but this is not one of them, and it misunderstands ethics entirely. If pharmacists are not expected to critically engage with ethics, then one might question what they are expected to do in such a values-based profession.

In the academic sphere there are sound reasons for approaching applied ethics with both empirical and philosophical methods. Arguments were given for this in Chapter Five, which gave a demonstration of the respective roles of empirical and philosophical research in applied ethics in pharmacy. It was shown how points raised in the focus groups regarding practice informed our understanding of the ethical concept of confidentiality. Chapter Six consisted of a philosophy-led discussion about the role of the individual professional in decision-making, which drew important conclusions about integrity, responsibility, conscience clauses and what the profession should expect from its members. The conclusions that were drawn, though some of them may seem intuitive, could not be validly reached through mere commonsense.

The relevant questions came partly as a result of reflecting on certain themes in the focus groups. The themes were rules, personal morality and professional ethics. Pharmacists have ideas about what morality is and what their obligations and rights are as professionals. These conceptions of the role of the professional in individual decision-making can be understood using empirical methods, but what is fascinating from a philosophical point of view is what *ought* the role of the professional be in ethical decision-making? Is it consistent to act on personal morals that may conflict with the normal procedure of the profession?

The argument I presented was that acting as a professional requires making decisions as an individual, but only if that is in keeping with the core values of the

[226] Lowenthal, W. (1991) 'Teaching and learning about ethical dilemmas in pharmacy' *American Journal of Pharmaceutical Education* 55, 1: 55-59

profession. The reason I gave for this was that it would be inconsistent to be a member of a professional body and act in such a way that was against the ethos of that profession. This point was explored in the debate about conscience clauses, in which I argued that certain conditions would have to be met for the use of a conscience clause to be justified. Use of conscience clauses outside these conditions would simply be unprofessional. The argument also included a discussion of moral responsibility, and whether a pharmacist's responsibility is diluted when other moral agents are involved in bringing about a particular outcome.

These philosophical arguments drew conclusions relevant to pharmacy ethics and served as a demonstration of how the relationship between philosophical and empirical research operates. Applied ethics needs philosophy to understand the concepts involved, and to ensure the arguments are sound and not based on poor reasoning or false premises. Equally, applied ethics needs empirical research to keep it relevant, and to give impetus to the pursuit of the suitable philosophical questions.

7.4 Suggestions for further research

There is great scope for further research in this area. Academia is turning its attention to pharmacy ethics, and the RPSGB is pushing to increase awareness of ethics in the profession. Along with doctoral research by Benson[227] and Cooper,[228] which has gone some way to answering the empirical questions, this doctoral thesis enters at a fairly early stage of the change in awareness of pharmacy practice ethics and there are still gaps in the broader field that should be addressed. For example, this thesis provokes questions about how best to educate pharmacists in ethics. Perhaps the most obvious set of questions in pharmacy practice ethics that remain largely unaddressed concern how pharmacists ought to behave. Such a study would be largely normative in orientation, but would build upon the empirical work contained in this research and that of others mentioned above.

[227] Benson, A. (2006) PhD Thesis 'Pharmacy values and ethics -a qualitative mapping of the perceptions and experiences of UK pharmacy practitioners' King's College, London

[228] Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham

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Appendix 1

The following are the three questionnaires sent to primary care practice pharmacists, community pharmacists and hospital pharmacists, respectively. The format of the questionnaires has been changed slightly to conform with the format of the thesis.

PRIMARY CARE PRACTICE

Anonymous Questionnaire

Ethical Dilemmas in Primary Care Practice Pharmacy

Who can complete this questionnaire?

Please only complete this questionnaire if you spend *more* of your working time as a primary care practice pharmacist than in any other sector.

- If you spend more time working in a sector other than primary care practice, please do not complete this questionnaire, but do please complete the questionnaire corresponding to that sector you spend most time in.
- If your main area of work is not community pharmacy, hospital pharmacy of primary care practice pharmacy, please return the reply postcard to avoid receiving unnecessary reminder letters.

What is this questionnaire about?

This survey is part of a wider project to identify and raise awareness of the kinds of ethical dilemmas pharmacists face at work. I invite you to take part by completing this questionnaire, which asks questions about situations you might find yourself in at work.

How to complete the questionnaire

- The questionnaire will take **between 10 and 20 minutes** to complete.
- By returning the questionnaire and the postcard separately you will not be sent reminder letters and your answers in the questionnaire cannot be traced back to you. The information sheet explains exactly how this works.
- You do no have to answer all questions if you do not want to.

What to do after completing the questionnaire

- Please post the questionnaire using the prepaid envelope provided by **20th September 2005.**
- Please also post the reply postcard separately. Sending the postcard separately will ensure the anonymity of your answers to the questionnaire. Please post the reply postcard even if you do not wish to complete the questionnaire. This will allow me to send reminders only to those who have not responded

An important note about the questions

All questions included in this questionnaire have been generated from preliminary research, and all situations described are true situations pharmacists have reported in their workplace. Most questions take the format of describing to you a situation and then asking you what you usually do when in this situation, or what you would do if you were in this situation.

The questions have been simplified and you may want to know more detail about the situation being described. For example, you could be asked something like the following:

e.g. i. You see someone take something from the shelf and put it in his/her pocket.

ii. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

iii. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You called the police
☐ You did not call the police

You may want more details of the situation before you feel you can answer the question fairly. You may want to know who the person is (do you know the person, how old is s/he?). You may want to know about what the person has put in his/her pocket (an inexpensive item, a valuable item, a medicine from behind the counter?). You may want to know more about the actions of the person (is the person stealing the item, or just holding it before paying for it?). You will not be given any details of this kind.

The questions have been designed in this way to keep the questionnaire simple and to find out what you end up doing most often when a situation of this kind comes about, or what you think you would do if it did arise.

You may find the options available as answers are limiting because there are only two options available to you. The questions are designed to ask you to commit to the action you take (or would take) most often. For example, you may decide that, given the two options in the question, you would call the police given that you generally believe people only pocket things in a pharmacy with the intention of stealing, and given you generally have a strict attitude towards criminals. If the person were your cousin you might take different action, but it's unlikely this would be your cousin.

In addition to the specific questions, please also add comments at the end of the questionnaire (p9) if you would like to.

Thank you.

Zuzana Deans

Keele University
June 2005

SECTION 1

ABOUT YOU AND YOUR WORKPLACE

1. Age:

☐ 20- 25 ☐ 31-35 ☐ 41-45 ☐ 51-55 ☐ 61-65
☐ 26-30 ☐ 36-40 ☐ 46-50 ☐ 56-60 ☐ 66-70
☐ 71-75 ☐ 76+

2. Year of qualification _____

3. Are you qualified as a supplementary prescriber?

☐ Yes
☐ No

4. Approximately how much of your working time is spent working directly with patients?

☐ Less than 10% ☐ 51 – 60%
☐ 11 - 20% ☐ 61 – 70%
☐21 - 30 % ☐ 71 – 80%
☐ 31 - 40% ☐ 81 – 90 %
☐ 41 - 50% ☐ 91 – 100%

Please complete the questionnaire by writing in the spaces provided or ticking the appropriate boxes.

SECTION 2
ABOUT YOUR WORK AS A PRIMARY CARE PRACTICE PARMACIST

- For the questions that follow, please indicate how often each situation occurs in your work. If you have come across this situation before, please indicate what you actually did when you were in this situation. If the situation has occurred often and you have acted differently on different occasions, please indicate what you did *most often.*
- If you have not come across the situation, please indicate what you think you would actually do if this situation arose.
- You will notice there is no middle ground available to answer these questions. The questions are designed to ascertain the end result of your actions most of the time.

1. You believe that withholding the truth from, or deliberately misleading, a patient would mean s/he will be compliant with a treatment you believe is very important to him/her.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You withheld the whole truth from or deliberately misled the patient
☐You talked very frankly with a patient about his/ her medication

2. Someone asks you to identify a particular tablet that does not belong to them. You are able to identify the tablet.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You informed the enquirer of what the tablet was
☐You did not inform the enquirer of what the tablet was

3. The husband or wife, or another close family member (other than a parent of a child under 16 years) of a patient asks for confidential information about that patient's treatment.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never know	Don't

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You passed the information on

☐You did not pass the information on

4. You feel something a colleague has done is unethical.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You talked to your colleague about it

☐ You took no action

The mother or father of a patient asks for confidential information about his/her fifteen-year-old son/ daughter's treatment.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You passed the information on

☐You did not pass the information on

6. You suspect a child, who is one of your patients, may be subject to abuse at home.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You went through the appropriate channels to get help

☐ You were unsure about what to do and took no further action

7. You feel something a colleague has done is unethical and you talk to your colleague, but still s/he does not change his/her behaviour.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You took no further action

☐You reported your colleague

8. While speaking to a patient about his/her condition (e.g. epilepsy) you discover s/he has not, and will not, inform the Driving and Vehicle Licensing Authority (DVLA) even though his/her condition might affect him/her while driving (e.g. s/he she has suffered a seizure in the last twelve months).

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You reported the patient to the DVLA

☐ You talked to the patient about it but accepted that s/he was very unlikely to inform the DVLA

9. A terminally ill patient asks you for a diagnosis or prognosis, telling you s/he doesn't feel the doctor is telling the whole truth. You know the full case history.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You answered the patient's questions fully

☐You answered the patient's questions in such a way as to avoid giving him/her the whole story and later talk to the doctor

10. A consultant has asked the practice to dispense a drug for an unlicensed indication and tells you s/he knows it is used with great effect in America. The GP asks for your opinion.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You advised against prescribing the medication

☐You advised the medication should be prescribed

11. A GP asks you for advice on whether to prescribe a relatively inexpensive, low- risk of harm medication that is not licensed and not on the formulary (e.g. low-dose naltrexone for secondary-progressive MS). There are no other treatment options.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You advised against prescribing the medication

☐ You advised the medication should be prescribed

12. A GP asks for your advice on a patient whose treatment is incompatible with his/her lifestyle. (As an example, the patient may be following treatment with warfarin while consuming varying and large amounts of alcohol. It could then be difficult to maintain the patient's INR within the target range. The patient may insist s/he will change his/her lifestyle to allow him/her to continue with warfarin but his/her behaviour is to the contrary.)

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You advised to continue with treatment as the patient wishes

☐ You advised the GP to prescribe a less effective treatment (eg aspirin)

13. A patient arrives at the desk very breathless asking for an inhaler, which s/he has run out of. The GP is out on call so is not available. Members of the administrative staff are asking you to authorise the prescription of a salbutamol inhaler.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You authorised the prescription of the inhaler

☐ You did not authorise the prescription of the inhaler

14. A patient expects treatment and advice from you, but you do not think s/he is telling the full story to his/her GP. (As an example, a midwife may have referred a pregnant patient to join your pharmacy-led smoking cessation advice clinic. The patient has not told her GP she is attending your clinic, and is expecting you to write a prescription for nicotine replacement therapy treatment. You do not consider this wise and explain you think it unlikely the GP will sign the prescription.)

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You refused to write a prescription without open dialogue with the GP and midwife

☐ You wrote the prescription for the GP to choose to sign or not

15a. Thinking over the situations you have just reviewed, what were the main considerations when making a decision in your work? Please indicate how important you regard each of these factors when facing a problem by ticking one of the boxes marked 1-5 on the table below. The scale below indicates the meaning of 1-5.

	1	2	3	4	5		
	No consideration	Little consideration	Some consideration	Quite a lot of consideration	A great deal of consideration		
Consideration	**1**	**2**	**3**	**4**	**5**	N/A	Most important
Patient's interests: health							
Patient's interests: non-health e.g. financial, social/ personal							
Keeping within the law							
Keeping within the guidelines of the RPSGB							
Financial interests of yourself							
Financial interests of the practice you work for							
Your reputation							
Your relationship with the patient							
Your relationship with the relevant prescriber							
Your relationship with pharmacy colleagues							
Patient's relationship with the prescriber							
Whether you will be struck off							
Other (please specify and rate)							

b. Please indicate which <u>one</u> of the above is most important to you when making decision in your work by ticking the appropriate box in the column labelled 'most important'.

SECTION 3

We would welcome any additional comments you would like to make about ethical dilemmas in pharmacy. Please write them here.

Thank you very much for taking the time to complete this questionnaire.

Please now return it to Zuzana Deans in the pre-paid addressed envelope provided. Please also send the pre-paid addressed postcard separately. This will assure you are not sent reminder letters. Sending the postcard and questionnaire separately will also ensure the anonymity of your answers to the questionnaire.

Zuzana Deans
Pharmacy Practice Research Project (PEAK)
Keele Hall
Keele University
Keele
Staffordshire
ST5 5BG

June 2005

COMMUNITY

Anonymous Questionnaire

Ethical Dilemmas in Community Pharmacy

Who can complete this questionnaire?

Please only complete this questionnaire if you spend *more* of your working time as a community pharmacist or locum community pharmacist than in any other sector.

- If you spend more time working in a sector other than community, please do not complete this questionnaire, but do please complete the questionnaire corresponding to that sector you spend most time in.
- If your main area of work is not community pharmacy, hospital pharmacy of primary care practice pharmacy, please return the reply postcard to avoid receiving unnecessary reminder letters.

What is this questionnaire about?

This survey is part of a wider project to identify and raise awareness of the kinds of ethical dilemmas pharmacists face at work. I invite you to take part by completing this questionnaire, which asks about situations you might find yourself in at work.

How to complete the questionnaire

- The questionnaire will take **between 10 and 20 minutes** to complete.
- By returning the questionnaire and the postcard separately you will not be sent reminder letters and your answers in the questionnaire cannot be traced back to you. The information sheet explains exactly how this works.
- You do not have to answer all questions if you do not want to.

- **What to do after completing the questionnaire**

- Please post the questionnaire using the prepaid envelope provided by **20th September 2005.**
- Please also post the reply postcard separately. Sending the postcard separately will ensure the anonymity of your answers to the questionnaire. Please post the reply postcard even if you do not wish to complete the questionnaire. This will allow me to send reminders only to those who have not responded

An important note about the questions

All questions included in this questionnaire have been generated from preliminary research, and all situations described are true situations pharmacists have reported in their workplace. Most questions take the format of describing to you a situation and then asking you what you usually do when in this situation, or what you would do if you were in this situation.

The questions have been simplified and you may want to know more detail about the situation being described. For example, you could be asked something like the following:

e.g. i. You see someone take something from the shelf and put it in his/her pocket.

ii. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

iii. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You called the police
☐ You did not call the police

You may want more details of the situation before you feel you can answer the question fairly. You may want to know who the person is (do you know the person, how old is s/he?). You may want to know about what the person has put in his/her pocket (an inexpensive item, a valuable item, a medicine from behind the counter?). You may want to know more about the actions of the person (is the person stealing the item, or just holding it before paying for it?). You will not be given any details of this kind.

The questions have been designed in this way to keep the questionnaire simple and to find out what you end up doing most often when a situation of this kind comes about, or what you think you would do if it did arise.

You may find the options available as answers are limiting because there are only two options available to you. The questions are designed to ask you to commit to the action you take (or would take) most often. For example, you may decide that, given the two options in the question, you would call the police given that you generally believe people only pocket things in a pharmacy with the intention of stealing, and given you generally have a strict attitude towards criminals. If the person were your cousin you might take different action, but it's unlikely this would be your cousin.

In addition to the specific questions, please also add comments on at the end of the questionnaire (p12) if you would like to.

Thank you.

Zuzana Deans

Keele University
June 2005

SECTION 1

ABOUT YOU AND YOUR WORKPLACE

1. Age:

☐ 20- 25 ☐ 31-35 ☐ 41-45 ☐ 51-55 ☐ 61-65
☐ 26-30 ☐ 36-40 ☐ 46-50 ☐ 56-60 ☐ 66-70
☐ 71-75 ☐ 76+

2. Year of qualification _____

3. Sex: ☐ Male
☐ Female

4. What is your current role?

☐ Owner manager ☐ Employee manager ☐ Second/ third etc pharmacist
☐ Locum

5. In which of the following do you currently work?

☐ Single outlet independent ☐ Small chain (2 –10)
☐ Medium-sized chain (11-40) ☐ Large multiple (40 +)

6. Where is your pharmacy located?

☐ Independent Premises ☐ Post office
☐ Large supermarket ☐ Health centre
☐ Small supermarket

7. What percentage of your prescriptions are exempt? _____

8 a. Do you have a consultation area?

☐ Yes *(If 'yes', please continue with question 5b)*
☐ No *(If 'no' please go to question 6)*
☐ N/A I am a locum in more than one premises

b. What is the consultation area in your pharmacy like at present (please tick all boxes that apply)?

☐ Too big
☐ About the right size
☐ Too small
☐ Spacious
☐ Too crowded
☐ A room separate from the public area
☐ A screen cordons the consultation area off from the public area
☐ No separation, just a couple of chairs
☐ We use a storage room
☐ Other comments/ description

_____

c. Do you think the consultation area is sufficiently private and/or large?

☐ Yes ☐ No ☐ N/A ☐ Don't know

Please complete the questionnaire by writing in the spaces provided or ticking the appropriate box(es).

SECTION 2

ABOUT YOUR WORK AS A COMMUNITY PHARMACIST OR LOCUM COMMUNITY PARMACIST

- For the questions that follow, please indicate how often each situation occurs in your work. If you have come across this situation before, please indicate what you actually did when you were in this situation. If the situation has occurred often and you have acted differently on different occasions, please indicate what you did *most often.*
- If you have not come across the situation, please indicate what you think you would actually do if this situation arose.
- You will notice there is no middle ground available to answer these questions. The questions are designed to ascertain the end result of your actions most of the time.

1. You are presented with a prescription for something like paracetamol. You see the prescription is not signed.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You refused to dispense the medicine from the prescription

☐ You dispensed the medicine

2. You are presented with a prescription for something like an opioid analgesic. You see the prescription is not signed. You know the GP but cannot contact him/her.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You refused to dispense the medicine from the prescription

☐ You dispensed the medicine

3. A patient hands you a prescription. Ideally, you would receive further clarification/ information about the prescription from the prescriber.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You contacted the prescriber

☐ You did not contact the prescriber

4. You believe that withholding the truth from, or deliberately misleading, a patient would mean s/he would be compliant with a treatment you believe is very important to him/her.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You withheld the whole truth from or deliberately misled the patient

☐ You talked very frankly with a patient about his/ her medication

Someone comes into the pharmacy/ phones you asking you to identify a particular tablet that does not belong to them. You are able to identify the tablet.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You informed the enquirer of what the tablet was

☐ You did not inform the enquirer of what the tablet was

6. The husband or wife, or another close family member (other than a parent of a child under 16 years) of a patient asks for confidential information about that patient's treatment.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You passed the information on

☐ You did not pass the information on

7. You feel something a colleague has done is unethical.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You talked to your colleague about it

☐ You took no action

8. The prescription states a specific brand of drug. You do not have this in stock but you do have a generic clinically equivalent brand in stock.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You dispensed the alternative brand

☐ You made other arrangements

9. A doctor is self-prescribing, on NHS scripts, medication you suspect s/he is abusing. You've already talked to him/her about it but s/he has clearly ignored you.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You reported the doctor to the General Medical Council

☐ You talked to the doctor about it, and continued to supply if s/he wanted you to

10. The mother or father of a patient asks for confidential information about his/her fifteen-year-old son/ daughter's treatment.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You passed the information on

☐ You did not pass the information on

11. A doctor is self-prescribing, on <u>private</u> scripts, medication you suspect s/he is abusing. You've already talked to him/her about it but s/he has clearly ignored you.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You reported the doctor to the General Medical Council

☐ You talked to the doctor about it, and continued to supply if s/he wanted you to

12. A customer asks for an over-the-counter treatment. After talking to the patient you come to the conclusion s/he does not really need the treatment, though it would do no harm for him/her to use it.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You sold the product

☐ You advised against the purchase

13. You suspect a child, who is one of your patients, may be subject to abuse at home.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You went through the appropriate channels to get help

☐ You were unsure about what to do and took no further action.

14. You feel something a colleague has done is unethical and you talk to your colleague, but still s/he does not change his/her behaviour.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You took no further action

☐ You reported your colleague

15. You receive a request to supply emergency hormonal contraception over-the-counter.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, when you made the decision to supply or not, were you influenced by your personal beliefs (or if this has not happened to you, do you think you would be influenced by your personal beliefs?)?

☐ Yes; your personal beliefs affected your decision to supply or not supply

☐ No; your personal beliefs did not affect your decision to supply or not supply

16. A patient comes in for his/ her methadone treatment but it is the day after the date specified on the prescription.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You refused to supply

☐ You supplied

☐ N/A; you do not dispense prescriptions for methadone for treatment for drug dependency

17. A girl comes in and asks for emergency hormonal contraception. She says she is 16 years old, but you suspect she is not. There is no Patient Group Direction for girls under 16.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You supplied the EHC after counselling and after having satisfied all other criteria

☐ You insisted upon identification. If she could not produce any, you refused to supply

☐ N/A; you have a conscientious objection to supplying EHC anyway

18. You suspect a pharmacist you work with is using prescription medicine from the controlled drugs cabinet without a prescription. You've already talked to him/her about it but s/he has clearly ignored you.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You reported your colleague to the pharmacy inspector/ local Primary Care Trust

☐ You did not report your colleague

19. After questioning, a patient makes it known s/he is going to use the medication s/he is asking to buy against guidelines (e.g. hydrocortisone cream for his/ her face).

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You refused to supply

☐You supplied, while emphasising advice not to misuse the medication

20. A customer asks to buy an over-the-counter medicine you suspect s/he might be abusing (maybe this appears likely after speaking to him/ her about it). The customer does not want an alternative.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You sold the product

☐ You refused to sell it

21. A patient returns unused, unopened, in-date medication for disposal one day after it had been dispensed.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You put it back on the shelf

☐ You disposed of it

22. While speaking to a patient about his/her condition (e.g. epilepsy) you discover s/he has not, and will not, inform the Driving and Vehicle Licensing Authority (DVLA) even though his/her condition might affect him/her while driving (e.g. s/he she has suffered a seizure in the last twelve months).

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You report the patient to the DVLA

☐You talk to the patient about it but accept that s/he is very unlikely to inform the DVLA

23. As a locum you are told the usual pharmacist does things a certain way, and are asked to work in that way too. You regard this as unethical.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You did as is normal for that particular pharmacy

☐ You refused to work in such a way, regardless of the normal workings of the pharmacy

☐ N/A You do not work as a locum

24. You have objections to selling emergency hormonal contraception. You are asked to do locum work for a pharmacy that advertises the fact that it sells emergency hormonal contraception.

a. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You declined the locum placement

☐ You took up the locum placement and decide you will sell EHC if a customer asks for it

☐ You took up the locum placement and decide you will direct a customer who asks for EHC to another pharmacy

☐ N/A; you do not work as a locum

☐ N/A; you do not have an objection to emergency hormonal contraception

25 a. Thinking over the scenarios you have just reviewed, what were the main considerations when making a decision in your work? Please indicate how important you regard each of these factors when facing a problem by ticking one of the boxes marked 1-5 on the table below. The scale below indicates the meaning of 1-5.

1	2	3	4	5
No consideration	Little consideration	Some consideration	Quite a lot of consideration	A great deal of consideration

Consideration	1	2	3	4	5	N/A	Most important
Patient's interests: health							
Patient's interests: non-health e.g. financial, social/ personal							
Keeping within the law							
Keeping within the guidelines of the the RPSGB							
Financial interests of yourself							
Financial interests of the company you work for							
Your reputation							
Your relationship with the patient							
Your relationship with the relevant prescriber							
Your relationship with pharmacy colleagues							
Patient's relationship with the prescriber							
Whether you will be struck off							
Other (please specify and rate)							

25 b. Please indicate which <u>one</u> of the above is most important to you when making decision in your work by ticking the appropriate box in the column labelled 'most important'.

SECTION 3

We would welcome any additional comments you would like to make about ethical dilemmas in pharmacy. Please write them here.

Thank you very much for taking the time to complete this questionnaire.

Please now return it to Zuzana Deans in the pre-paid addressed envelope provided. Please also send the pre-paid addressed postcard separately. This will assure you are not sent reminder letters. Sending the postcard and questionnaire separately will also ensure the anonymity of your answers to the questionnaire.

Zuzana Deans
Pharmacy Practice Research Project (PEAK)
Keele Hall
Keele University
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Staffordshire
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June 2005

HOSPITAL

Anonymous Questionnaire

Ethical Dilemmas in Hospital Pharmacy

Who can complete this questionnaire?

Please only complete this questionnaire if you spend *more* of your working time as a hospital pharmacist or locum hospital pharmacist than in any other sector.

- If you spend more time working in a sector other than hospital, please do not complete this questionnaire, but do please complete the questionnaire corresponding to that sector you spend most time in.
- If your main area of work is not community pharmacy, hospital pharmacy of primary care practice pharmacy, please return the reply postcard to avoid receiving unnecessary reminder letters.

What is this questionnaire about?

This survey is part of a wider project to identify and raise awareness of the kinds of ethical dilemmas pharmacists face at work. I invite you to take part by completing this questionnaire, which asks questions about situations you might find yourself in at work.

How to complete the questionnaire

- The questionnaire will take **between 10 and 20 minutes** to complete.
- By returning the questionnaire and the postcard separately you will not be sent reminder letters and your answers in the questionnaire cannot be traced back to you. The information sheet explains exactly how this works.
- You do no have to answer all questions if you do not want to.

What to do after completing the questionnaire

- Please post the questionnaire using the prepaid envelope provided by **20th September 2005.**
- Please also post the reply postcard separately. Sending the postcard separately will ensure the anonymity of your answers to the questionnaire. Please post the reply postcard even if you do not wish to complete the questionnaire. This will allow me to send reminders only to those who have not responded

An important note about the questions

All questions included in this questionnaire have been generated from preliminary research, and all situations described are true situations pharmacists have reported in their workplace. Most questions take the format of describing to you a situation and then asking you what you usually do when in this situation, or what you would do if you were in this situation.

The questions have been simplified and you may want to know more detail about the situation being described. For example, you could be asked something like the following:

e.g. i. You see someone take something from the shelf and put it in his/her pocket.

ii. How often has this happened *to you* in the last year?

☐	☐	☐	☐	☐	☐	☐
At least once a day	Once or twice a week	Once or twice a month	Every few months	Hardly ever	Never	Don't know

iii. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐You called the police
☐You did not call the police

You may want more details of the situation before you feel you can answer the question fairly. You may want to know who the person is (do you know the person, how old is s/he?). You may want to know about what the person has put in his/her pocket (an inexpensive item, a valuable item, a medicine from behind the counter?). You may want to know more about the actions of the person (is the person stealing the item, or just holding it before paying for it?). You will not be given any details of this kind.

The questions have been designed in this way to keep the questionnaire simple and to find out what you end up doing most often when a situation of this kind comes about, or what you think you would do if it did arise.

You may find the options available as answers are limiting because there are only two options available to you. The questions are designed to ask you to commit to the action you take (or would take) most often. For example, you may decide that, given the two options in the question, you would call the police given that you generally believe people only pocket things in a pharmacy with the intention of stealing, and given you generally have a strict attitude towards criminals. If the person were your cousin you might take different action, but it's unlikely this would be your cousin.

In addition to the specific questions, please also add comments at the end of the questionnaire (p10) if you would like to.

Thank you.

Zuzana Deans

Keele University
June 2005

SECTION 1

ABOUT YOU AND YOUR WORKPLACE

1. Age:

☐ 20- 25 ☐ 31-35 ☐ 41-45 ☐ 51-55 ☐ 61-65
☐ 26-30 ☐ 36-40 ☐ 46-50 ☐ 56-60 ☐ 66-70
☐ 71-75 ☐ 76+

2. Year of qualification _____

3. Sex: ☐ Male
☐ Female

4. What is your grade?

☐ A-C
☐ D-E
☐ F
☐ Locum

5. Is the hospital in which you work NHS or private?

☐ NHS ☐ Private

6. Is the hospital in which you work community, district or teaching?

☐ Community ☐ District ☐ Teaching

7. Approximately how many beds does the hospital have? _____

8. How many FTE pharmacists are there? _____

9 a. Do you have a consultation area?

☐ Yes *(If 'yes', please continue with question 5b)*
☐ No *(If 'no' please go to question 6)*
☐ N/A I am a locum in more than one hospital

b. What is the consultation area in your pharmacy like at present (please tick all boxes that apply)?

☐ Too big
☐ About the right size
☐ Too small
☐ Spacious
☐ Too crowded
☐ A room separate from the public area
☐ A screen cordons the consultation area off from the public area
☐ No separation, just a couple of chairs
☐ We use a storage room
☐ Other comments/ description

_____

c. Do you think the consultation area is sufficiently private and/or large?

☐ Yes ☐ No ☐ N/A ☐ Don't know

Please complete the questionnaire by writing in the spaces provided or ticking the appropriate box(es).

SECTION 2

ABOUT YOUR WORK AS A HOSPITAL PHARMACIST OR LOCUM HOSPITAL PARMACIST

For the questions that follow, please indicate how often each situation occurs in your work. If you have come across this situation before, please indicate what you actually did when you were in this situation. If the situation has occurred often and you have acted differently on different occasions, please indicate what you did *most often.*

If you have not come across the situation, please indicate what you think you would actually do if this situation arose.

You will notice there is no middle ground available to answer these questions. The questions are designed to ascertain the end result of your actions most of the time.

1. A patient hands you a prescription. Ideally, you would receive further clarification/ information about the prescription from the prescriber.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know / Don't work in dispensary

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You contacted the prescriber

☐ You did not contact the prescriber

☐ N/A; you do not work in the dispensary

2. You believe that withholding the truth from, or deliberately misleading, a patient would mean s/he will be compliant with a treatment you believe is very important to him/her.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You withheld the whole truth from or deliberately misled the patient

☐ You talked very frankly with a patient about his/ her medication

3. Someone comes into the pharmacy/ phones you asking you to identify a particular tablet that does not belong to them. You are able to identify the tablet.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You informed the enquirer of what the tablet was

☐ You did not inform the enquirer of what the tablet was

4. The husband or wife, or another close family member (other than a parent of a child under 16 years) of a patient asks for confidential information about that patient's treatment.

a. How often has this happened *to you* in the last year?

☐ At least ☐ Once or twice once a day ☐ Once or twice a week ☐ Every few a month ☐ Hardly ever months ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You passed the information on

☐ You did not pass the information on

5. You feel something a colleague has done is unethical.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You talked to your colleague about it

☐ You took no action

6. The mother or father of a patient asks for confidential information about his/her fifteen-year-old son/ daughter's treatment.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You passed the information on

☐ You did not pass the information on

7. You suspect a pharmacist you work with is using prescription medicine from the controlled drugs cabinet. You've already talked to him/her about it but s/he has clearly ignored you.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You reported your colleague to the pharmacy inspector/ local Primary Care Trust

☐ You did not report your colleague

8. You suspect a child, who is one of your patients, may be suffering abuse at home.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You went through the appropriate channels to get help

☐ You were unsure about what to do and took no further action.

9. You feel something a colleague has done is unethical and you talk to your colleague, but still s/he does not change his/her behaviour.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You took no further action

☐ You reported your colleague

10. A patient returns unused, unopened, in-date medication for disposal one day after it had been dispensed.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You put it back on the shelf

☐ You disposed of it

10. While speaking to a patient about his/her condition (e.g. epilepsy) you discover s/he has not, and will not, inform the Driving and Vehicle Licensing Authority (DVLA) even though his/her condition might affect him/her while driving (e.g. s/he she has suffered a seizure in the last twelve months).

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You reported the patient to the DVLA

☐ You talked to the patient about it but accept that s/he is very unlikely to inform the DVLA

☐ You told a medical consultant about the situation and took no further action

11. As a locum you are told the usual pharmacist does things a certain way, and are asked to work in that way too. You regard this as unethical.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You did as is normal for that particular pharmacy.

☐ You refused to work in such a way, regardless of the normal workings of the pharmacy

☐ N/A You do not work as a locum

12. A terminally ill patient asks you for a diagnosis or prognosis, telling you s/he doesn't feel the doctor is telling the whole truth. You know the full case history.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You answered the patient's questions fully.

☐ You answered the patient's questions in such a way as to avoid giving him/her the whole story and later talk to the doctor

13. A member of the public comes to the pharmacy and asks for some medication for someone else who is waiting at home (e.g. his wife, who is in great distress). S/he tells you the person for whom the medication is for has used the medication several times before and is very familiar with it. The wait for A&E is extremely long.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You supplied the medication

☐ You explained why you could not supply the medication

14. A paediatric consultant has asked you to dispense, for a child, a dose of medicine which is outside the SPC limits, but is still not at a toxic level. You speak with the consultant about it who confirms these are his/her wishes.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You agreed to dispense the medication at the specified dose

☐ You refused to dispense the medication at the specified dose

15. A consultant asks you to dispense a drug for an unlicensed indication and tells you s/he knows it is used with great effect in America.

a. How often has this happened *to you* in the last year?

☐ At least once a day ☐ Once or twice a week ☐ Once or twice a month ☐ Every few months ☐ Hardly ever ☐ Never ☐ Don't know

b. If this has happened, what did you actually do (most often)? If this has never happened to you, what do you think you actually would do?

☐ You refused to dispense the medication

☐ You agreed to dispense the medication

16. a. Thinking over the scenarios you have just reviewed, what were the main considerations when making a decision in your work? Please indicate how important you regard each of these factors when facing a problem by ticking one of the boxes marked 1-5 on the table below. The scale below indicates the meaning of 1-5.

☐-----☐-----☐-------☐-------☐

1	2	3	4	5
No consideration	Little consideration	Some consideration	Quite a lot of consideration	A great deal of consideration

Consideration	1	2	3	4	5	N/A	Most important
Patient's interests: health							
Patient's interests: non-health e.g. financial, social/ personal							
Keeping within the law							
Keeping within the guidelines of the RPSGB							
Financial/ resource interests of the hospital/ trust							
Financial interests of yourself							
Financial interests of the company you work for							
Your reputation							
Your relationship with the patient							
Your relationship with the relevant prescriber							
Your relationship with pharmacy colleagues							
Patient's relationship with the prescriber							
Whether you will be struck off							
Other (please specify and rate)							

b. Please indicate which <u>one</u> of the above is most important to you when making decision in your work by ticking the appropriate box in the column labelled 'most important'.

SECTION 3

We would welcome any additional comments you would like to make about ethical dilemmas in pharmacy. Please write them here.

Thank you very much for taking the time to complete this questionnaire.

Please now return it to Zuzana Deans in the pre-paid addressed envelope provided. Please also send the pre-paid addressed postcard separately. This will assure you are not sent reminder letters. Sending the postcard and questionnaire separately will also ensure the anonymity of your answers to the questionnaire.

Zuzana Deans
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June 2005

Appendix 2

Table A2.1 Table of ten null hypotheses tested by means of either a chi-squared test or, where Cochran's rule for the chi-square test was violated, the Fisher's exact test. The data are presented as contingency tables, with column percentages. If the column percentages differ across the grouping variable, 'Sector', this is an indication of an association (i.e. that the percentage giving a particular response).

			Contact prescriber	Do not contact prescriber	Total
There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **A patient hands you a prescription. Ideally, you would receive further clarification/ information about the prescription from the prescriber.**	Community	Count	166	5	171
		% within sector	97.1%	2.9%	100.0%
	Hospital	Count	53	1	54
		% within sector	98.1%	1.9%	100.0%
	Total	Count	219	6	225
		% within sector	97.3%	2.7%	100.0%
Owing to violation of Cochran's rule, a Fisher's exact test was run to test this null hypothesis. No association (exact test, p> .999)					

			Put back on shelf	Dispose of medication	Total
There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **A patient returns unused, unopened, in-date medication for disposal one day after it had been dispensed.**	Community	Count	22	146	168
		% within Sector	13.1%	86.9%	100.0%
	Hospital	Count	3	55	58
		% within Sector	5.2%	94.8%	100.0%
	Total	Count	25	201	226
		% within Sector	11.1%	88.9%	100.0%
A chi-square test was run to test this null hypothesis. No association. (χ^2= 2.751; df=1; p=.097).					

			Report colleague	Do not report colleague	Total
There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **You suspect a pharmacist you work with is using prescription medicine from the controlled drugs cabinet without a prescription. You've already talked to him/her about it but s/he has clearly ignored you.**	Community	Count	149	6	155
		% within Sector	96.1%	3.9%	100.0%
	Hospital	Count	51	1	52
		% within Sector	98.1%	1.9%	100.0%
	Total	Count	200	7	207
		% within Sector	96.6%	3.4%	100.0%
Owing to violation of Cochran's rule, a Fisher's exact test was run to test this null hypothesis. No association (Fisher's exact test, p= .682).					

There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **You suspect a child, who is a patient of yours, may be subject to abuse at home.**			Go through appropriate channels	Unsure what to do. Take no action	Total
	Community	Count	141	18	159
		% within Sector	88.7%	11.3%	100%
	Hospital	Count	48	4	52
		% within Sector	92.3%	7.7%	100%
	Total	Count	189	22	211
		% within Sector	89.6%	10.4%	100%
A chi-square test was run to test this null hypothesis. No association. (χ^2= 2.751; df=1; p=.097).					

There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **The husband, wife or another close family member (other than a parent of a child under 16 years) of a patient asks for confidential information about that patient's treatment.**			Pass information on	Do not pass information on	Total
	Community	Count	13	152	165
		% within Sector	7.9%	92.1%	100.0%
	Hospital	Count	3	51	54
		% within Sector	5.6%	94.4%	100.0%
	Total	Count	16	203	219
		% within Sector	7.3%	92.7%	100.0%
Owing to violation of Cochran's rule, a Fisher's exact test was run to test this null hypothesis. No association (Fisher's exact test, p=.766).					

There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **The mother or father of a patient asks for confidential information about his/her fifteen-year-old son/ daughter's treatment.**			Pass information on	Do not pass information on	Total
	Community	Count	53	110	163
		% within Sector	32.5%	67.5%	100.0%
	Hospital	Count	22	31	53
		% within Sector	41.5%	58.5%	100.0%
	Total	Count	75	141	216
		% within Sector	34.7%	65.3%	100.0%
A chi-square test was run to test this null hypothesis. No association (χ^2= 1.427; df=1; p=.323).					

There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **Someone asks you to identify a particular tablet that does not belong to them. You are able to identify the tablet.**			Informed	Did not inform	Total
	Community	Count	84	80	164
		% within Sector	51.2%	48.8%	100.0%
	Hospital	Count	28	27	55
		% within Sector	50.9%	49.1%	100.0%
	Total	Count	112	107	219
		% within Sector	51.1%	48.9%	100.0%
A chi-square test was run to test this null hypothesis. No association (χ^2= .002; df=1; p=.968).					

There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **You believe that withholding the truth from, or deliberately misleading, a patient would mean s/he would be compliant with a treatment you believe is very important to him/her.**			Withhold the truth	Talk frankly	Total
	Community	Count	19	140	159
		% within Sector	11.9%	88.1%	100.0%
	Hospital	Count	5	44	49
		% within Sector	10.2%	89.8%	100.0%
	Total	Count	24	184	208
		% within Sector	11.5%	88.5%	100.0%
A chi-square test was run to test this null hypothesis. No association (χ^2= .112; df=1; p=.738).					

There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **You feel something a colleague has done is unethical.**			Talk to colleague	Take no action	Total
	Community	Count	134	32	166
		% within Sector	80.7%	19.3%	100.0%
	Hospital	Count	51	3	54
		% within Sector	94.4%	5.6%	100.0%
	Total	Count	185	35	220
		% within Sector	84.1%	15.9%	100.0%
A chi-square test was run to test this null hypothesis. No association (χ^2= 5.734; df=1; p= .017).					

There is no association between the sector pharmacists work in and the decisions pharmacists make when faced with the following problem: **You feel something a colleague has done is unethical and you talk to your colleague, but still s/he does not change his/her behaviour.**			Take no further action	Report colleague	Total
	Community	Count	28	123	151
		% within Sector	18.5%	81.5%	100.0%
	Hospital	Count	4	48	52
		% within Sector	7.7%	92.3%	100.0%
	Total	Count	32	171	203
		% within Sector	15.8%	84.2%	100.0%
A chi-square test was run to test this null hypothesis. No association (χ^2= 3.43; df=1; p= .064).					

Figures A2.2- A2.13 relate to the following twelve hypotheses, which were tested using the Mann-Whitney test.

Null hypothesis 1 There is no association between the sector participants work in and how much consideration they give to the patient's health interests when faced with an ethical problem.

Null hypothesis 2 There is no association between the sector participants work in and how much consideration they give to the patient's non-health interests (e.g. financial, social, personal) when faced with an ethical problem.

Null hypothesis 3 There is no association between the sector participants work in and how much consideration they give to the law when faced with an ethical problem.

Null hypothesis 4 There is no association between the sector participants work in and how much consideration they give to the guidelines of the RPSGB when faced with an ethical problem.

Null hypothesis 5 There is no association between the sector participants work in and how much consideration they give to their own financial interests when faced with an ethical problem.

Null hypothesis 6 There is no association between the sector participants work in and how much consideration they give to the financial interests of the company/ hospital/ trust they work for when faced with an ethical problem.

Null hypothesis 7 There is no association between the sector participants work in and how much consideration they give to their reputation when faced with an ethical problem.

Null hypothesis 8 There is no association between the sector participants work in and how much consideration they give to their relationship with the patient when faced with an ethical problem.

Null hypothesis 9 There is no association between the sector participants work in and how much consideration they give to their relationship with the relevant prescriber when faced with an ethical problem.

Null hypothesis 10 There is no association between the sector participants work in and how much consideration they give to their relationship with pharmacy colleagues when faced with an ethical problem.

Null hypothesis 11 There is no association between the sector participants work in and how much consideration they give to the patient's relationship with the prescriber when faced with an ethical problem.

Null hypothesis 12 There is no association between the sector participants work in and how much consideration they give to whether they would be struck off when faced with an ethical problem.

It can be seen that the null hypothesis of no association was retained in respect of Hypothesis 1 (U= 4998.5; n_1=175; n_2=64; p= .657); Hypothesis 2 (U= 4287;n_1=175; n_2=64; p= .024); Hypothesis 3 (U= 4909;n_1=175; n_2=64; p= .473); Hypothesis 4 (U= 4399; n_1=175; n_2=64; p= .035); Hypothesis 7 (U= 4158; n_1=175; n_2=64; p= .024); Hypothesis 8 (U= 5234;n_1=175; n_2=64; p= .932); Hypothesis 9 (U= 4815;n_1=175; n_2=64; p= .343); Hypothesis 10 (U= 5035;n_1=175; n_2=64; p= .673); Hypothesis 11 (U= 4160;n_1=175; n_2=64; p= .012); and Hypothesis 12 (U= 4281.5;n_1=175; n_2=64; p= .081).

It can be seen that the null hypothesis was rejected in relation to Hypothesis 5 (U= 3634.5; n_1=175; n_2=64; p= .003). Community pharmacists were more likely than hospital pharmacists to give greater consideration to their own financial interests when making ethical decisions. The null hypothesis was also rejected in relation to Hypothesis 6 (U= 3609.5; n_1=175; n_2=64; p< .005) with hospital pharmacists more likely to give greater consideration to the financial interests of the trust or hospital they worked for than community pharmacists gave to the financial interests of the company they worked for.

Figure A2.2 Box plot of the distribution of scores of the level of consideration community (n=168) and hospital pharmacists (n=61) give to the patient's health interests. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2=Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

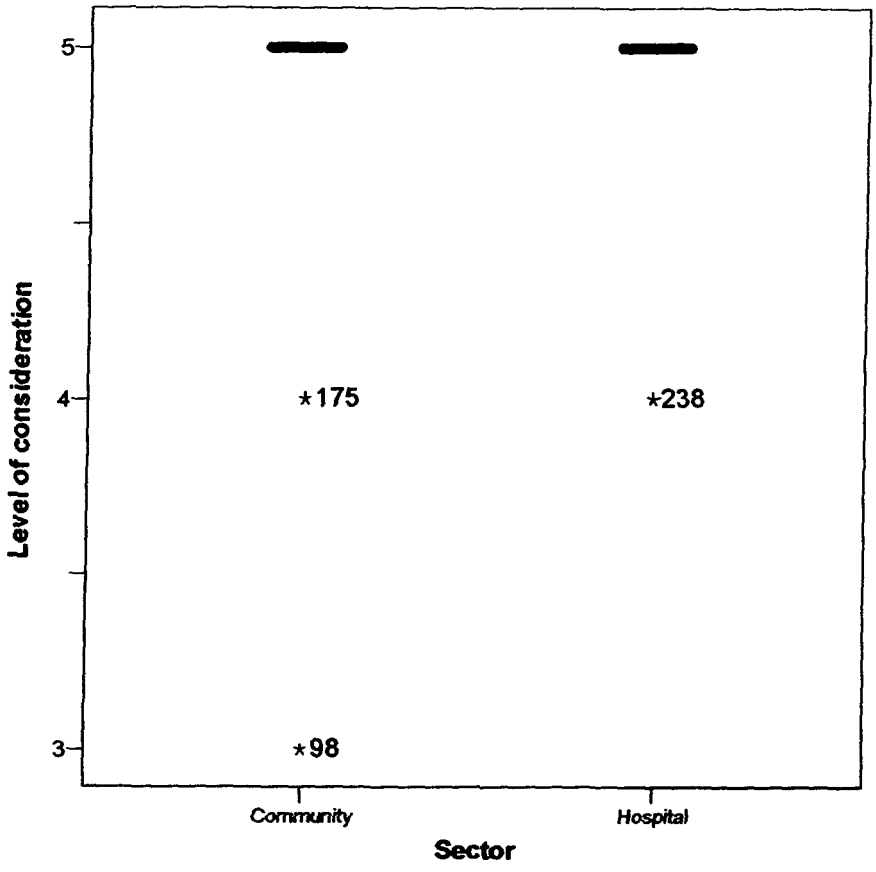

Figure A2.3 Box plot of the distribution of scores of the level of consideration community (n=169) and hospital pharmacists (n=61) give to the patient's non-health interests. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2=Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

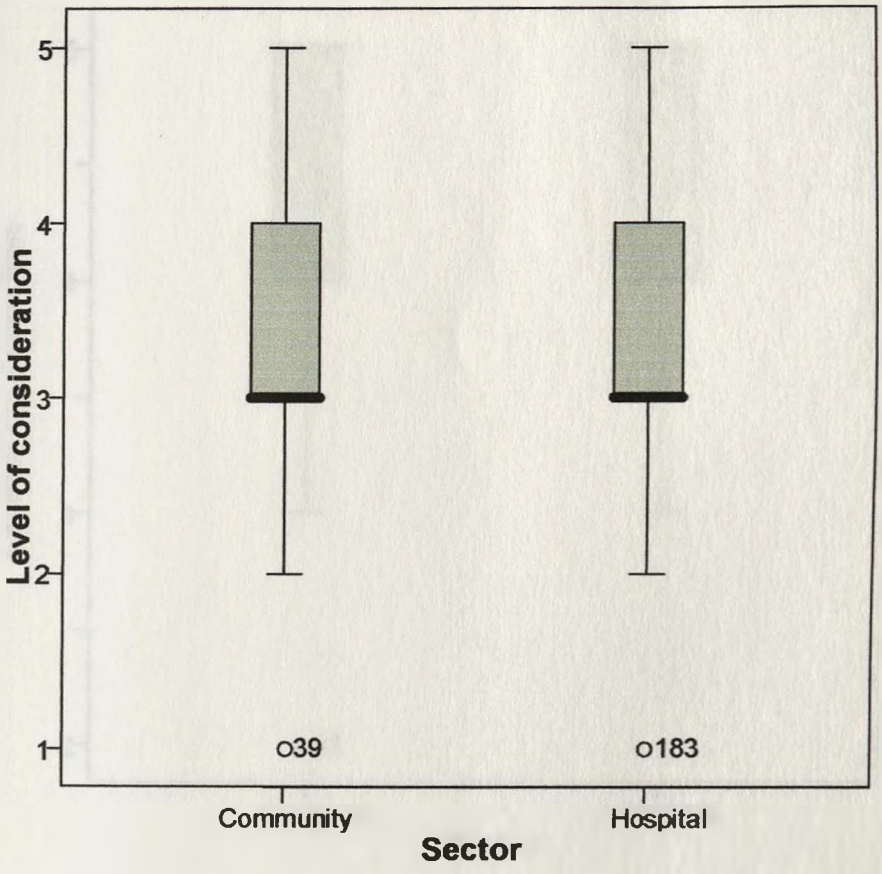

Figure A2.4 Box plot of the distribution of scores of the level of consideration community (n=169) and hospital pharmacists (n=61) give to the law. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2=Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

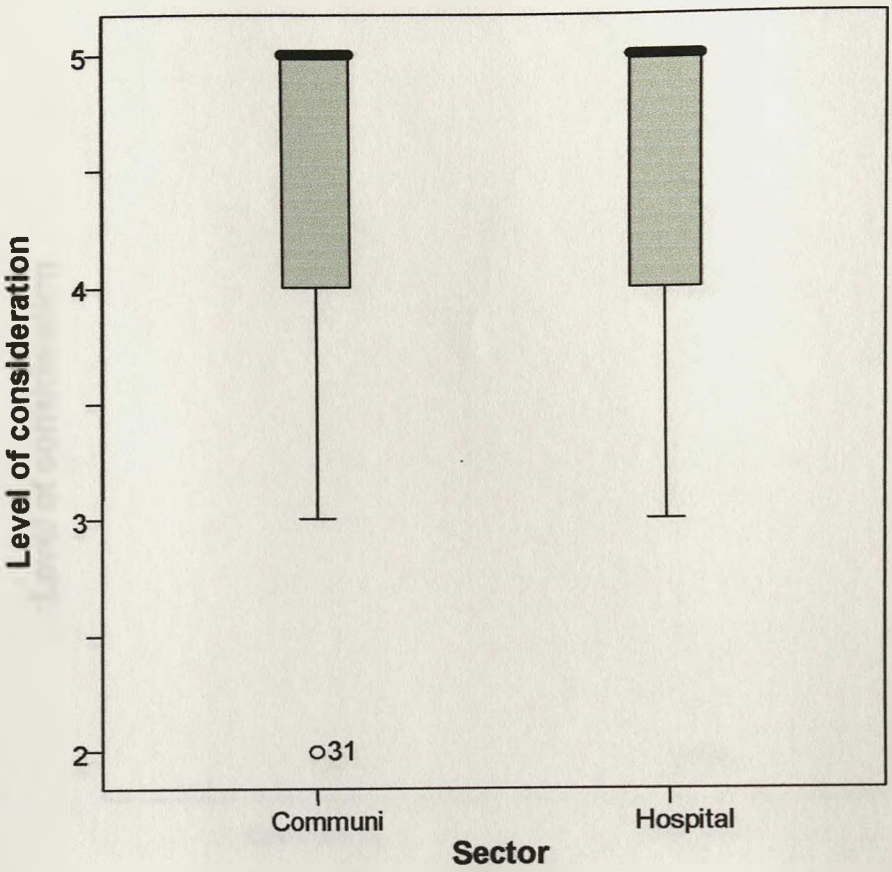

Figure A2.5 Box plot of the distribution of scores of the level of consideration community (n=169) and hospital pharmacists (n=62) give to the RPSGB guidelines. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2=Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

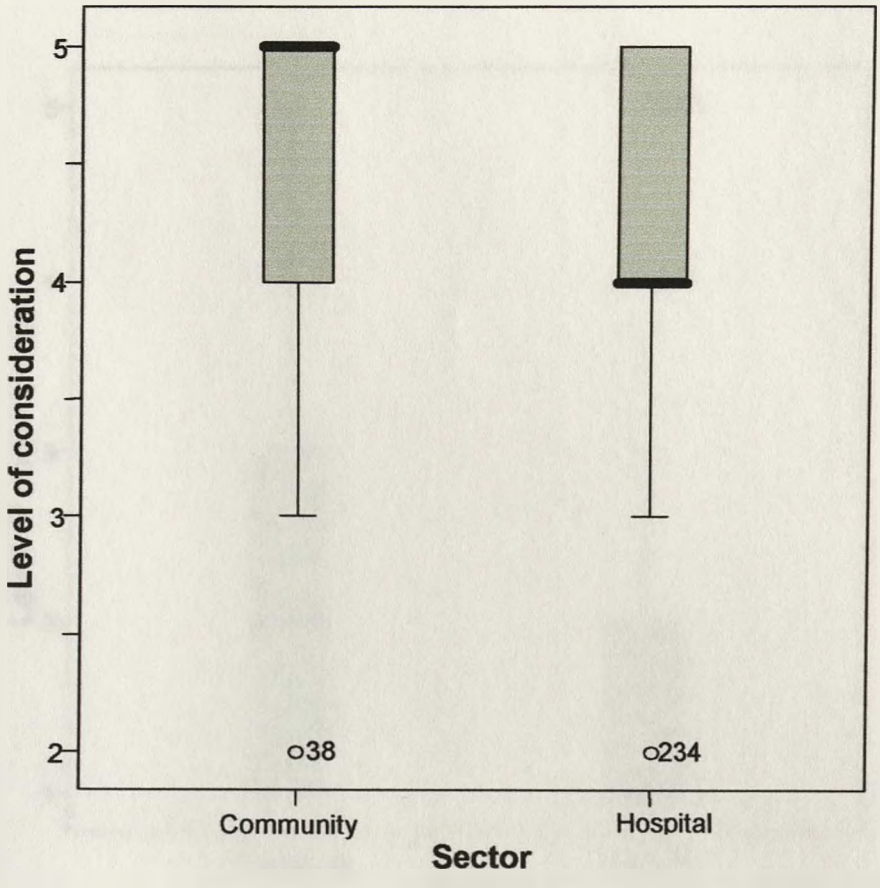

Figure A2.6 Box plot of the distribution of scores of the level of consideration community (163) and hospital pharmacists (n=59) give to their own financial interests. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2=Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

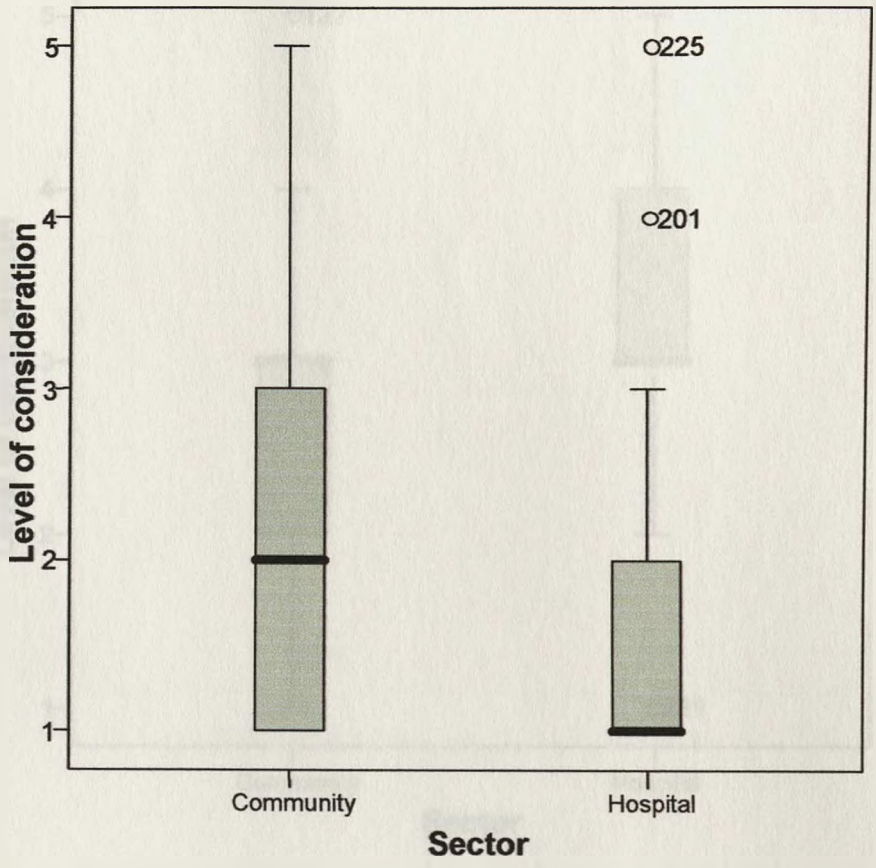

Figure A2.7 Box plot of the distribution of scores of the level of consideration community (n=169) and hospital pharmacists (n=51) give to the financial interests of the company, hospital or trust they work for. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2= Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

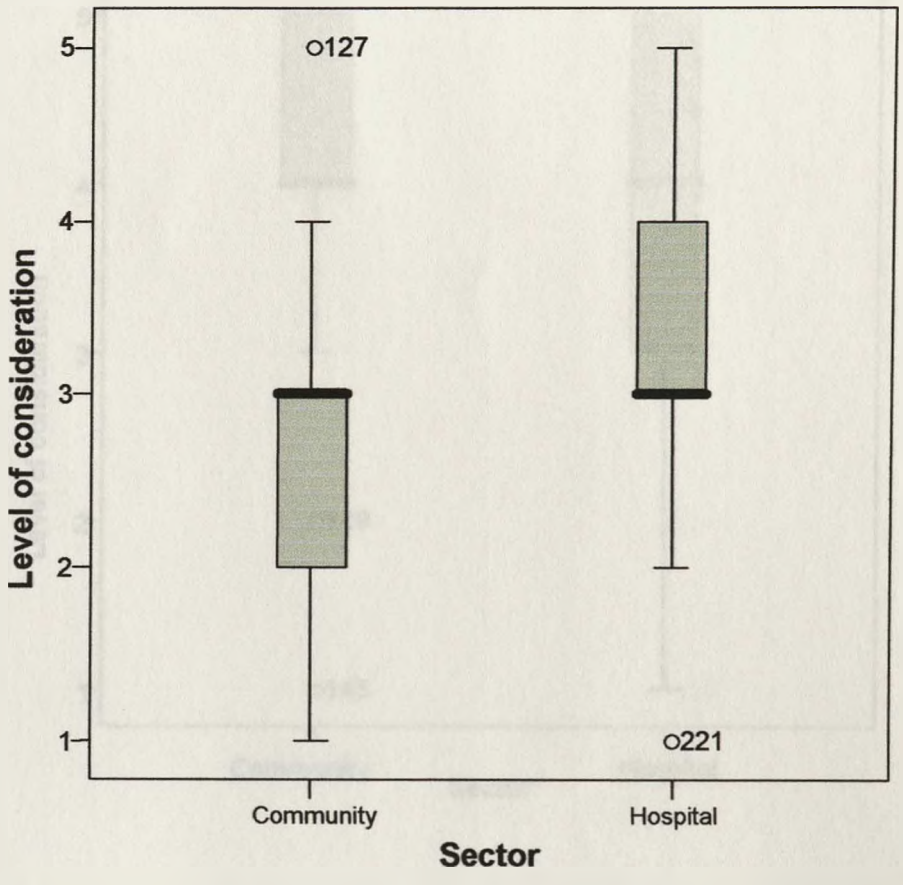

Figure A2.8 Box plot of the distribution of scores of the level of consideration community (n=164) and hospital pharmacists (n=62) give to their reputation. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2= Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

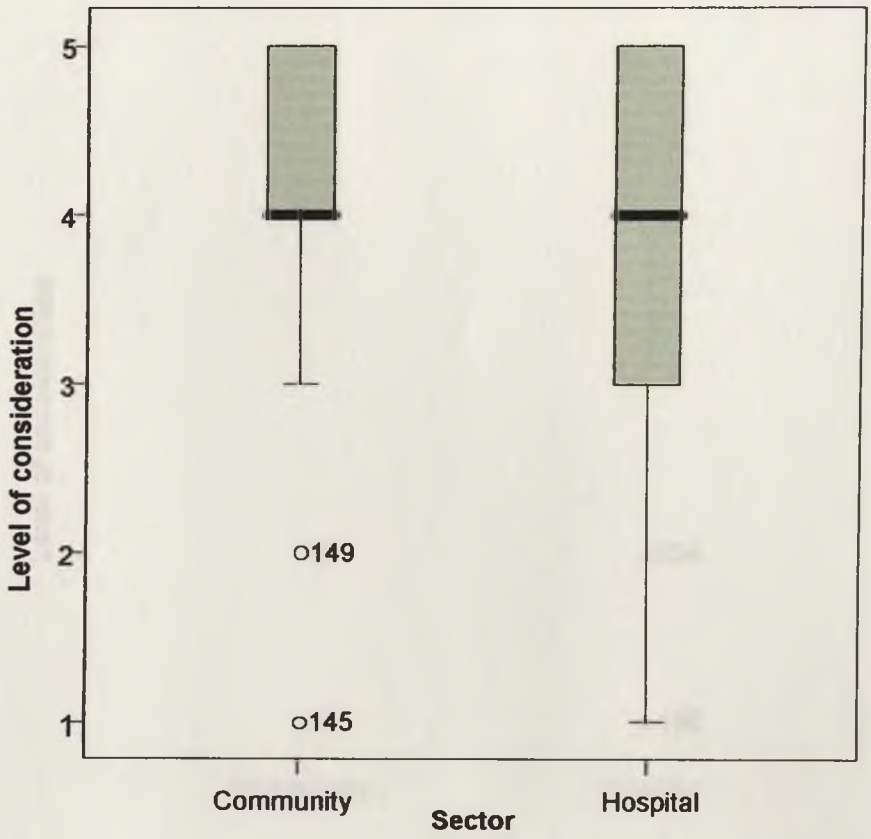

Figure A2.9 Box plot of the distribution of scores of the level of consideration community (n=170) and hospital pharmacists (n=62) give to their relationship with the patient. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2= Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

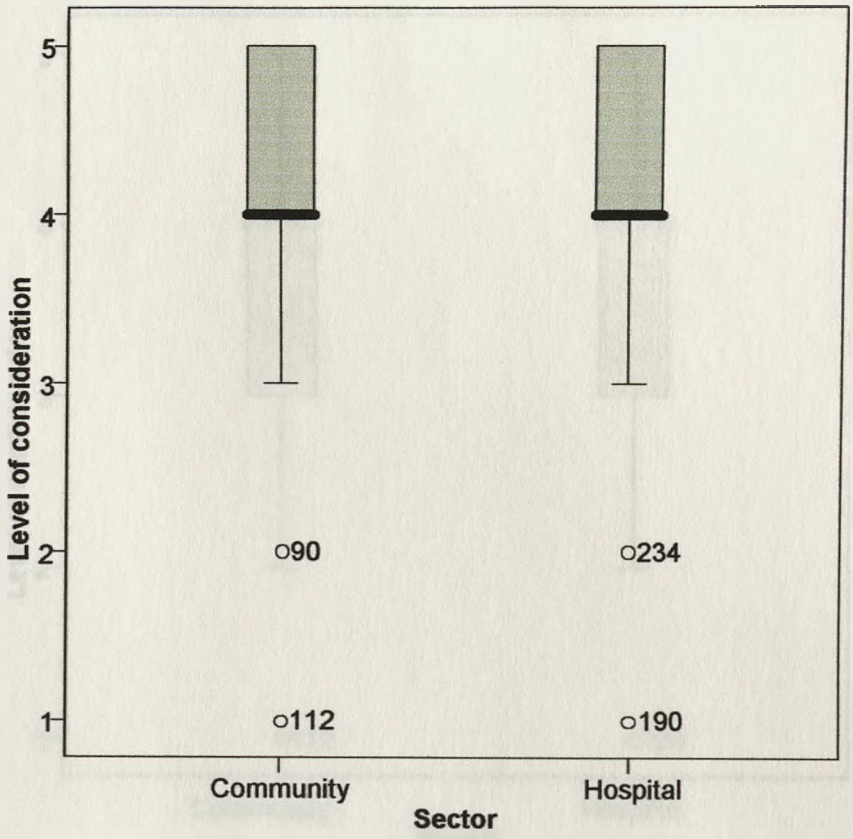

Figure A2.10 Box plot of the distribution of scores of the level of consideration community (n=171) and hospital pharmacists (n=61) give to their relationship with the relevant prescriber. The level of consideration was indicated on 5-point adjectival rating scale: 1=No consideration; 2= Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

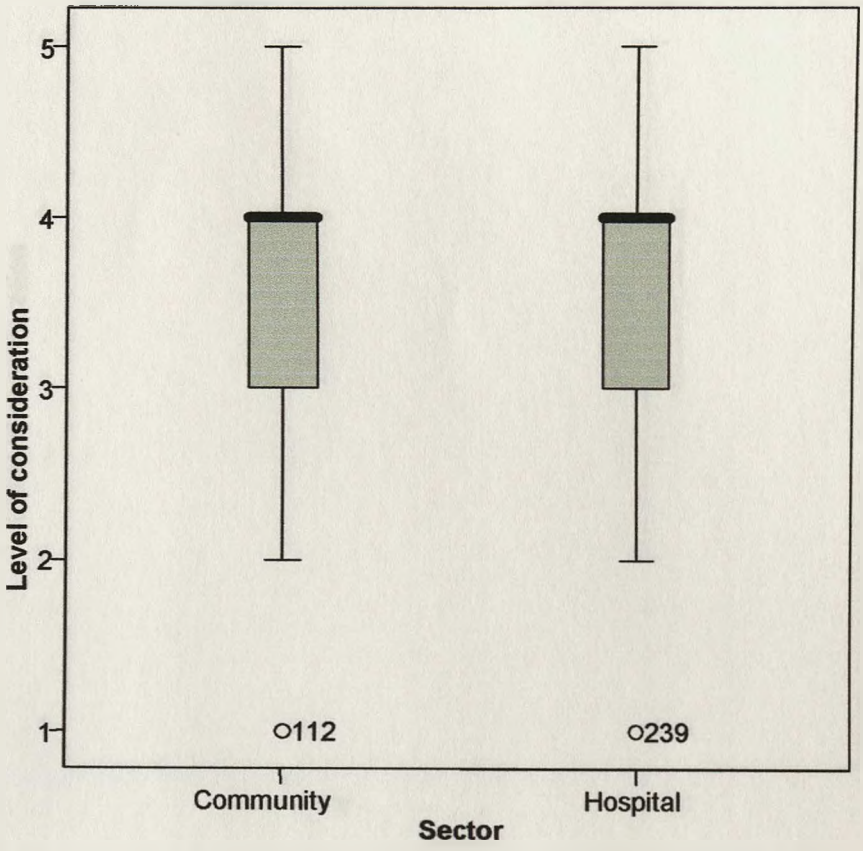

Figure A2.11 Box plot of the distribution of scores of the level of consideration community (n=175) and hospital pharmacists (n=61) give to their relationship with pharmacy colleagues. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2= Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

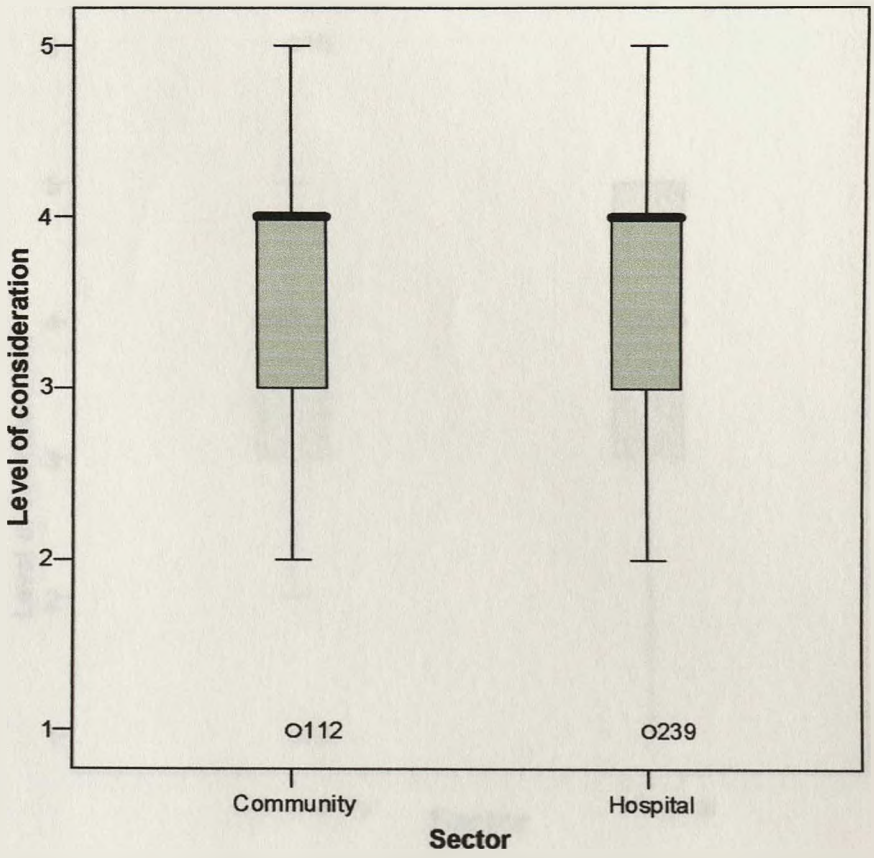

Figure A2.12 Box plot of the distribution of scores of the level of consideration community (n=171) and hospital pharmacists (n=61) give to the patient's relationship with the prescriber. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2= Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

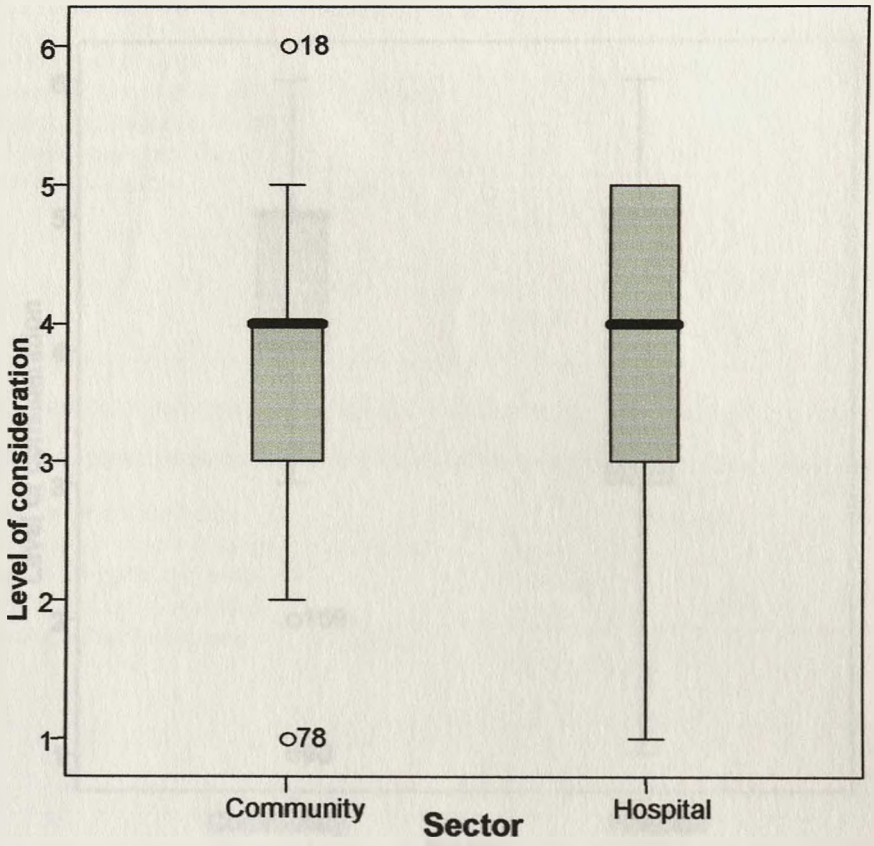

Figure A2.13 Box plot of the distribution of scores of the level of consideration community (n=162) and hospital pharmacists (n=59) give to whether they'll be struck off. The level of consideration was indicated on a 5-point adjectival rating scale: 1=No consideration; 2= Little consideration; 3= Some consideration; 4=Quite a lot of consideration; 5=A great deal of consideration.

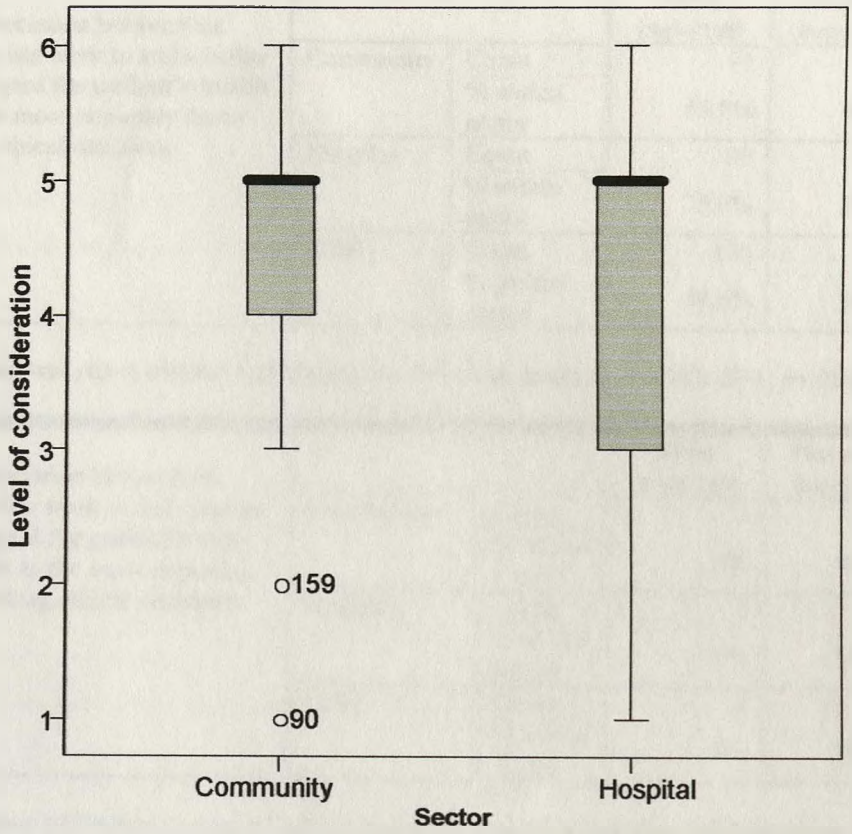

Table A2.14 Table of ten null hypotheses tested by means of either a chi-squared test or, where Cochran's rule for the chi-square test was violated, the Fisher's exact test. The data are presented as contingency tables, with column percentages. If the column percentages differ across the grouping variable, 'Sector', this is an indication of an association (i.e. that the percentages giving a particular response depends on the sector).

There is no association between the sector pharmacists work in and whether pharmacists regard the **patient's health interests** as the most important factor when making ethical decisions.

		Most important	Not most important	Total
Community	Count	91	72	163
	% within sector	55.8%	44.2%	100.0 %
Hospital	Count	39	13	52
	% within sector	75.0%	25.0%	100.0 %
Total	Count	130	85	215
	% within sector	60.5%	39.5%	100.0 %

A chi-square test was run to test this null hypothesis. No association. (χ^2= 6.062; df=1; p=.014).

There is no association between the sector pharmacists work in and whether pharmacists regard the **patient's non-health interests** as the most important factor when making ethical decisions.

		Most important	Not most important	Total
Community	Count	1	162	163
	% within Sector	.6%	99.4%	100.0 %
Hospital	Count	1	51	52
	% within Sector	1.9%	98.1%	100.0 %
Total	Count	2	213	215
	% within Sector	.9%	99.1%	100.0 %

Owing to violation of Cochran's rule, a Fisher's exact test was run to test this null hypothesis. No association (Fisher's exact test, p= .426).

There is no association between the sector pharmacists work in and whether pharmacists regard the **law** as the most important factor when making ethical decisions.

		Most important	Not most important	Total
Community	Count	25	138	163
	% within Sector	15.3%	84.7%	100.0 %
Hospital	Count	8	44	52
	% within Sector	15.4%	84.6%	100.0 %
Total	Count	33	182	215
	% within Sector	15.3%	84.7%	100.0 %

A chi-square test was run to test this null hypothesis. No association. (χ^2= .0; df=1; p=.993).

There is no association between the sector pharmacists work in and whether pharmacists regard the **RPSGB guidelines** as the most important factor when making ethical decisions.

		Most important	Not most important	Total
Community	Count	12	151	163
	% within Sector	7.4%	92.6%	100.0 %
Hospital	Count	1	51	52
	% within Sector	1.9%	98.1%	100.0 %
Total	Count	13	202	215
	% within Sector	6.0%	94.0%	100.0 %

Owing to violation of Cochran's rule, a Fisher's exact test was run to test this null hypothesis. No association (Fisher's exact test, p= .196).

There is no association between the sector pharmacists work in and whether pharmacists regard **their reputation** as the most important factor when making ethical decisions.

		Most important	Not most important	Total
Community	Count	5	158	163
	% within Sector	3.1%	96.9%	100.0 %
Hospital	Count	3	49	52
	% within Sector	5.8%	94.2%	100.0 %
Total	Count	8	207	215
	% within Sector	3.7%	96.3%	100.0 %

Owing to violation of Cochran's rule, a Fisher's exact test was run to test this null hypothesis. No association (Fisher's exact test, p=.404).

There is no association between the sector pharmacists work in and whether pharmacists regard **whether they will be struck off** as the most important factor when making ethical decisions.

		Most important	Not most important	Total
Community	Count	16	147	163
	% within Sector	9.8%	90.2%	100.0 %
Hospital	Count	3	49	52
	% within Sector	5.8%	94.2%	100.0 %
Total	Count	19	196	215
	% within Sector	8.8%	91.2%	100.0 %

Owing to violation of Cochran's rule, a Fisher's exact test was run to test this null hypothesis. No association (Fisher's exact test, p=.575).