



Ethics in pharmacy practice

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1. SUMMARY OF REPORT

1.1 Overview

This report focuses on the empirical findings from research carried out by Zuzana Deans for a doctoral thesis entitled, 'The ethics of pharmacy practice: an empirical and philosophical study'.¹ The empirical research provides evidence that ethics is present throughout the daily work of pharmacists and paints a picture of the kinds of ethical problems these are, how frequently they occur, how pharmacists handle them, and what pharmacists understand ethics to be. These data are useful for acknowledging that ethics has a significant presence in pharmacy practice today, and that pharmacists tend to take a commonsense approach to ethics in their work.

There is general agreement across community and hospital sectors about which ethically problematic situations occur most often, except in cases which are sector-specific (for example a community pharmacist would not come across a hospital-based situation at work). On the whole there was agreement across the profession about how ethical problems should be handled. Such a consensus implies certain attitudes and ethical values are embedded in the culture of pharmacy practice.

The data in this report provide useful indications of possible trends among pharmacists, but the quantitative data should not be regarded as statistically representative of the population of UK pharmacists. Similarly, the qualitative data are useful for gaining insight into pharmacists' attitudes and beliefs but are not intended to be representative.

The results show that pharmacists currently understand ethics as being a mixture of personal opinion, peer consensus, cultural influence and institutional rules. Pharmacists take a 'patchwork' approach to ethics, relying on a combination of common sense, official guidance, strict rules, professional obligations, and professional autonomy. One of the strongest themes emerging from the data was the prominence of institutional rules, and a concern for the interests of the patient. Pharmacists tend to be dutiful in regard to institutional 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. In fact, the majority of pharmacists across the sectors reported the patient's health interests as the most important factor to consider when making ethical decisions.

It is perhaps not surprising that ethics is a prominent feature in pharmacy practice given the change in the professional role of pharmacists and the corresponding shift towards being more patient-centred over the past forty years.² The important questions to follow will be about how ethics should be taught to pharmacists, how well pharmacists are dealing with the ethical problems of their work, and what impact this may have on the services the pharmacy profession delivers.

1.2 Structure of report

This report provides a summary and analysis of the empirical findings of the research.

¹ Deans, Z. (2008) PhD Thesis 'The ethics of pharmacy practice: an empirical and philosophical study' Keele University

² 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

Section 2 presents the background to the research, which includes discussion of the need and purpose of the research and a brief literature review. Section 3 is a description of the methods used for the research.

In Section 4 the key data from the focus groups and survey are presented in turn and discussed together. The implications of these results are considered in Section 5, and conclusions are drawn in Section 6.

1.3 Definitions

Community pharmacy: Most community pharmacists work in pharmacies that are independent or part of a franchise of pharmacies. Community pharmacists often run a commercial business alongside their healthcare service. Some community pharmacists are based in healthcare centres and general practice surgeries. Community pharmacists are 'front line' health care professionals and are involved in dispensing medicines and giving health advice about medicines and the treatment of minor ailments to members of the public. Some community pharmacists are Supplementary Prescribers, working alongside Independent Prescribers on a Clinical Management Plan agreed by the patient, the Supplementary Prescriber and the Independent Prescribers, or Independent Prescribers in their own right.

Hospital pharmacy: Hospital pharmacists work alongside other healthcare professionals to ensure appropriate, safe and cost-effective use of medicines, mostly within the hospital setting, working in the dispensary and on ward rounds, managing the purchase of medicines, managing patient care, making medicines and providing information. Hospital pharmacists may specialise in an area of clinical expertise.

Primary care practice pharmacy: Also known as 'practice pharmacy'. Primary care practice pharmacists are part of a multi-disciplinary health care team. They promote evidence-based prescribing and have an input in decisions concerning the practice's drugs budget.

Pre-registration pharmacy students: Graduates of the four-year MPharm degree complete a year in training before qualifying as pharmacists and registering with the pharmacy regulator, the Royal Pharmaceutical Society of Great Britain (RPSGB)³.

Ethics: Distinctions between ethics and morality are drawn (and debated) in philosophical literature⁴ and sometimes made in everyday life. The common distinction made is that morality is a personal or societal pursuit of right action, while ethics a systematic pursuit of morality on a larger scale (perhaps in a corporate organisation, or state government), or that ethics is the *study* of morality or moral systems. Academic ethics involves describing and analysing moral phenomena, forming normative ethical theory and analysing its application.

For the purposes of this report, it is taken that questions concerning ethics also concern morality, which is the phenomena of right, wrong, good, bad, virtuous and vicious.

³ At the time this study was undertaken the RPSGB was both the pharmacy regulator and professional leadership body for pharmacy.

⁴ Piercey, R. (2001) Not Choosing Between Morality and Ethics. *The Philosophical Forum* 32; 1: 53-72.

2. BACKGROUND AND PROJECT AIMS

2.1 Research background

Following a report by Cribb and Barber in 2000,⁵ which concluded there was a need for greater value literacy in pharmacy practice, the RPSGB funded two doctoral projects on ethics in pharmacy practice,⁶ and at least one other doctoral project on the subject was carried out in the UK at the same time.⁷

There is growing recognition that while pharmacy has retained much of the scientific and technical areas of expertise that partly define it, pharmacy is an increasingly values-based profession. Such a change in professional identity is gradual. With the exception of the doctoral work mentioned above, and related research stemming from it, there has been little work carried out to investigate what exactly the values of the profession are, and what they ought to be. Until recently, there had been only a small number of investigations into pharmacy practice by social scientists or ethicists.

2.3 Literature review

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*,⁸ collections of articles in *Ethical Issues in Modern Medicine*⁹ and *Principles of Healthcare Ethics*,¹⁰ and the journals *Bioethics*¹¹ and the *Journal of Medical Ethics*.¹² Yet none of these addresses pharmacy ethics and, as Cribb and Barber note, before recent doctoral research and related publications, there had been very little literature produced on the subject of ethical values in pharmacy practice at all.¹³

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

⁵ Cribb and Barber (2000) *Developing Pharmacy Values: Stimulating the Debate - A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain)

⁶ This report is based on one of the doctorates. See also 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 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)

⁷ Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham

⁸ Beauchamp and Childress (2001) *Principles of Biomedical Ethics* (USA: Oxford University Press)

⁹ Steinbock, B., Arras, J. D. & London, A. J. (2003) *Ethical Issues in Modern Medicine* (USA: McGraw Hill)

¹⁰ Ashcroft, R. E.; Dawson, A.; Draper, H & McMillan, J. R. (2007) *Principles of Healthcare Ethics*, 2nd edition (Chichester: John Wiley & Sons, Ltd)

¹¹ *Bioethics* (Oxford: Blackwell)

¹² *Journal of Medical Ethics* (BMJ Publishing Group Ltd)

¹³ Cribb and Barber (2000) *Developing Pharmacy Values: Stimulating the Debate - A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain)

philosophical issues or values for pharmacy ethics.”¹⁴ A notable exception to this is philosophical literature on conscientious objections in pharmacy practice,^{15,16,17,18,19} much of which has been published since the doctoral thesis this report is based on, and the literature review by Wingfield, Bissell and Anderson.

Wingfield, Bissell and Anderson found that what little research had been done had not specifically addressed pharmacy ethics as a philosophical problem. Research into the area tends to comprise psychological studies²⁰ or description of the legal aspects of pharmacy practice. Often, too, the geographical focus is the United States of America, not Great Britain.

Much of the research that does set out to address ethics in pharmacy is concerned with specific issues such as confidentiality,^{21,22} the beginning and end of life,²³ drug-promotion and profit,^{24,25} advertising,²⁶ the supply of emergency hormonal contraception,^{27,28,29} professionalism^{30,31} and ethical decision-making,^{32,33} rather than surveying ethical views and understanding more generally.

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- ¹⁴ 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
- ¹⁵ Brock, D. (2008) ‘Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?’ *Theoretical Medicine and Bioethics* 29; 3 :187 -200
- ¹⁶ Wicclair, M. R. (2006) ‘Pharmacies, pharmacists and conscientious objection’ *Kennedy Institute of Ethics Journal* 16; 3: 225-250
- ¹⁷ Wicclair, M. R. Conscientious Objections in Medicine. *Bioethics* 2000; 15, 3: 205-227: 217.
- ¹⁸ Wicclair, M. R. (2008) ‘Is conscientious objection incompatible with a physician’s professional obligations?’ *Theoretical Medicine and Bioethics* 29; 3: 171-85
- ¹⁹ La Follette, E. & La Follette, H. (2007) Private conscience, public acts. *Journal of Medical Ethics*. 33; 5: 249-254
- ²⁰ Latif and colleagues have carried out several studies of this kind. See for example 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
- ²¹ 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
- ²² 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*
- ²³ Naffs, N.J. (2001) ‘Pharmaceutical care until the end: the role of pharmacists in euthanasia in The Netherlands’ *Pharmacy World Science* 23; 4: 129-31
- ²⁴ Gibson B. ‘Pharmacists and tobacco: dollars before duty’ *CMAJ*. 1990 Mar 15;142; 6: 621-632
- ²⁵ Nelson, V. (1988) ‘Promotion and selling of unnecessary food supplements: quackery or ethical pharmacy practice?’ *American Pharmacy*; 10: 34-6
- ²⁶ Crompton, G. K. (1979) ‘Ethics of Drug Promotion’ *British Medical Journal* Nov 3; 2 (6198):1141
- ²⁷ 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
- ²⁸ 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
- ²⁹ Seston, E. M.; Smith, I. & Watkins, L. K. (2002) ‘The views of pharmacists supplying emergency hormonal contraception through a patient group direction’ *International Journal of Pharmacy Practice* Supplement 10: R23
- ³⁰ Denzin, N. K. (1968) ‘Incomplete professionalization: the case of pharmacy’ *Social Forces* 46; 3: 375-381

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.”³⁴

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. 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.”³⁵

But in fact, it seems 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 are inherent in every facet of pharmacy.”³⁶ 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 their technical expertise in matters unique to

³¹ 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

³² Cooper R.J., Bissell P., Wingfield J. (2009) ‘Islands’ and ‘Doctor’s tool’: the ethical significance of isolation and subordination in UK community pharmacy’ *Health (London)* 13; 3: 297-316

³³ These citations form a set of examples of pharmacy practice ethics; this summary is not intended to be a comprehensive account of existing literature.

³⁴ 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

³⁵ Brazier, Margaret (2005) Foreword in Appelbe, G. E. & Wingfield, J. (2005) *Dale and Appelbe’s Pharmacy Law and Ethics* 8th Edition (London: Pharmaceutical Press) pxxii

³⁶ Cribb and Barber (2000) *Developing Pharmacy Values: Stimulating the Debate - A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain) p9

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.³⁷

Benson's research involved mapping the values of the profession, and as a result we now have a greater understanding of the kinds of values pharmacists hold.³⁸ However, knowing what these values are is only part of the picture; we also need evidence of the exact circumstances in which pharmacists would make decisions based on these values, and what action these decisions result in.

2.3 Project aims

The research presented in this report was an investigation of the following empirical questions:

- What are the ethical dilemmas pharmacists encounter in their daily work?
- How often do these problems occur?
- What action do pharmacists take when faced with such dilemmas?
- What do pharmacists understand ethics to be?

3. METHODS

Both qualitative and quantitative research methods were used to seek answers to questions about how often pharmacists face certain ethical problems, which decisions pharmacists make about these problems, and what their understanding of ethics is. These empirical methods of research combined led to the delineation and better understanding of what the ethical issues are for pharmacy practice.

The methods used were: focus groups and a postal survey. All participants were either qualified pharmacists or preregistration trainees. The sectors included in the study were community, hospital and primary care practice. The number of respondents from primary care practice was too low (15) to make reliable inferences, and so the data from this sector are not reported here.

The study plan was given a favourable opinion by Keele University Research Ethics Committee and an NHS multi-centre research ethics committee.

3.1 Focus groups

Rationale

Focus groups were an appropriate method for simultaneously serving two purposes: informing the quantitative survey and developing an understanding of pharmacists' attitudes towards ethics in their practice.³⁹

³⁷ 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)

³⁸ Benson, A.; Cribb, A. & Barber, N. (2009) Understanding pharmacists' values: A qualitative study of ideals and dilemmas in UK pharmacy practice. *Social Science and Medicine* 68; 12: 2223-2230 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)

³⁹ For detailed discussion of the strengths and weaknesses of focus groups see Kidd, P.S. & Marshall, P. (2000). Getting the focus and the group: enhancing analytical rigor in focus group research. *Qualitative Health Research*. 10; 3: 293-308 and Webb, C. & Kevern, J.

Recruitment

Following a pilot focus group with four hospital pharmacists, three focus groups were run with preregistration trainees, community pharmacists and pharmacists undertaking a qualification to become supplementary prescribers, respectively.

Participants were recruited from postgraduate educational courses at Keele University and from a preregistration training study day in Birmingham. Participants were contacted by post and email via teaching and administration staff.

Format

Questions and vignettes were used to stimulate discussion in the focus groups.

All participants were given 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.

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

Data analysis

Qualitative data gathering and analysis were carried out by broadly the principles of grounded theory.⁴⁰ 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. Themes emerging from the data were identified and grouped.

3.2 Survey

Rationale

Quantitative data were gathered 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. Most questions in the survey were directly informed by the data from the focus group discussions.⁴¹

Format

Three types of questionnaire were distributed. Each was aimed at one of three specific sectors of pharmacy practice: community, hospital and primary care practice. Each questionnaire contained a set of demographic questions. The main parts of the three questionnaires were made up of scenario-based questions. 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.

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

Sampling strategy and recruitment

The sectors included in the study were community, hospital and primary care practice. All participants were qualified pharmacists.

(2001) Focus groups as a research method: A critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*. 33; 6: 798-805.

⁴⁰ 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)

⁴¹ For detailed discussion of the nature and designs of quantitative surveys see De Vaus, D. (2002) *Surveys in Social Science Research* (5th edition) (London: Routledge)

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.⁴² At the time of the distribution of the survey, the region contained approximately 684 registered practising pharmacists,⁴³ approximately 120 community pharmacies⁴⁴ and twenty-five hospitals.⁴⁵ The area encompassed one large conurbation (Stoke-on-Trent), rural areas and several small towns. The number of postal questionnaires sent was 522, sent to all registered pharmacists in the Shropshire and Staffordshire Strategic Health Authority.

Distribution process and handling of data

Two pilot questionnaires were run. For the main 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. The questionnaire was anonymous. Consent for use of data was assumed with the completion and return of the questionnaire. This was made clear in the covering letter sent to participants.

Response rate and representation

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. The response rate was 54%.

Community pharmacists were slightly under-represented and hospital pharmacists were slightly over-represented, but the proportions of respondents in each sector do not differ statistically from national figures.⁴⁶

Quantitative data analysis

The quantitative data analysis involved a combination of simple descriptive statistics and statistical analysis. Basic frequencies are presented in this report in the form of tables and text to address the main research questions:

- How often do particular problems occur in pharmacy practice?
- What decisions do pharmacists make when faced with these problems?
- Do pharmacists working in different sectors make different decisions regarding ethical problems?

4. FINDINGS

4.1 Focus group results

This subsection reports the findings from the focus groups, picking 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 under the following subtitles:

⁴² Based on the expert opinion of Professor Stephen Chapman and Professor Alison Blenkinsopp

⁴³ The number in the postal address list from the RPSGB of all registered pharmacists in the SSSHA.

⁴⁴ <http://www.yell.com>

⁴⁵ Shropshire and Staffordshire Health Authority (via email enquiry)

⁴⁶ Hassell, K. & Shann, P. (2003) 'Overview of the main census findings' *The Pharmaceutical Journal* 270: 314-315

- Pharmacists' understanding of what ethics is
- Rules
- Key ethical concepts

Each participant who was a qualified community pharmacist was given a unique label: Pharm1, Pharm2 and so on. Preregistration trainees were given the labels Pre-reg1, Pre-reg2 etc. The label 'unknown' is used to denote a participant of the Supplementary Prescribing group who could not be identified due to poor recording quality.

4.1.1. Pharmacists' understanding of what ethics is

Participants in the focus groups tended towards storytelling and giving examples. 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 or in the abstract. 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 (EHC) as a "grey area" (Pharm2).

When ethics was discussed on an abstract level it was clear participants regarded ethics as subjective and/ or relative to cultural norms. These 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.

There were four main conceptualisations of ethics in the focus groups: as instrumental; akin to regulation; as relative or subjective; and as 'personal morality' and 'professional ethics'.

Ethics as instrumental

There were many instances in which ethics was seen as instrumental in justifying breaking the law or other rules. The following quotation presents a summary of this view:

"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 a tool for justifying breaking the rules as something that exists over and above the rules.

Ethics as regulation

Ethics was also occasionally perceived as almost synonymous with regulation:

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

Pharm4

There seems to be some confusion in using 'ethics' to mean something authoritative, something that might *allow* or *disallow* certain actions, rather than as a set of moral reasons for behaving in a particular way. The quick change from 'law' to 'ethics' may illustrate the close relationship 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*.

Ethics as subjective or relative to cultural norms

The participants' opinions about what they ought to do (which, it is assumed, includes what they ought to do morally) were varied, and this was something that became a topic for discussion. The participants attributed such diversity to differences in personality and upbringing, religion and professional standards, and understood judgement as being an 'individual thing'. Even so, participants discussed the value of consulting colleagues to get a second opinion on difficult matters.

In practice 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, could, among other things, lead to an inability to articulate the ethical values of the profession.⁴⁷

"[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

'Personal morality' and 'professional ethics'

In one of the 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. For example, when discussing the supply of EHC, one participant said,

"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

It is worth noting that this itself is an ethically motivated statement. 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 used negatively in the focus group.

⁴⁷ Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham p256-264

4.1.2. Rules

The theme 'rules' was prominent in the focus group discussions, with participants understanding an ethical problem as one in which ethics came into conflict with the law. Other studies provide further evidence that pharmacists are concerned about the rules of the profession and the law.⁴⁸

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; obeying rules to avoid getting into trouble; and breaking rules, which included discussion of how rule-breaking could be justified.

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. This is demonstrated in the following statement regarding supplying EHC outside the product licence:

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

Pharm1

Obeying rules to avoid getting into trouble

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, asking fellow participants:

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

Pharm2

In the context of supplying medication outside the product licence, the following reason was given for acting by the letter of the rules:

"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

Breaking rules

The data suggest participants were comfortable with rules, and were keen to act in accordance with them. However, 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

⁴⁸ 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)

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.

An example was given of breaking the rules to supply medication without a prescription to a patient who had run out of her medicine.⁴⁹

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

Pharm7

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

Justification for breaking the rules

Justifying breaking the rules was 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

This statement points to the relationship between rules and professionalism; participants expressed a tension between acting professionally by following the rules and knowing when to act independently of the rules in the name of professionalism.

4.1.3. Key ethical concepts

This section is a summary of 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.

Individual patients' interests

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 patient's best interest ranked as the highest principle, though there is evidence that 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."

(unknown)

The above quotation may be an expression of a *prima facie* principle that could exist without consideration of additional competing principles. Other reports from

⁴⁹ 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'.

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.

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

(unknown)

The patient's best interests extended to the long-term social interests of the patient. In this context, 'social interests' means the non-health interests of the patient, which include patient autonomy, social relationships, financial interests and general welfare. When discussing the supply of EHC, participants considered the broad social interests of the patient.

In some incidents in which the patient's interests came into conflict with the law pharmacists were prepared to act illegally. In fact, interests of the patient were the most common reasons participants gave for breaking the law, though it is important to note that sometimes the law was given greater priority.

"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

How highly a participant ranked patient interests varied between individuals. 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.

Public interests

Concern for public interests was a relatively minor theme in the focus group discussions, but the subject did arise in relation to National Health Service (NHS) resources. For example, when asked about a vignette in which a doctor was 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. The following quotation comes from a participant commenting on her own experience of a doctor self-prescribing medication the participant suspected she was addicted to.

"[If] she starts prescribing from hospitals she's actually using the hospital's facilities ... rather than going to her own GP for it, and after about three months ... 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 a vignette:

“If it was NHS I wouldn’t [dispense something self-prescribed], obviously, but if it’s private then, it’s private, ...[isn’t] it? ... I don’t see anything wrong with it ...[because the self-prescribing doctor is] paying for that.”

Pharm2

The factor influencing this decision seems to be that there are wider public interests tied up with the NHS that do not exist with private prescriptions, and participants felt a moral obligation to act in the interests of the public.

Confidentiality

Although the ethical dimensions of confidentiality were recognised by some participants, there were occasions when the moral dimensions of the notion were lost in favour of the regulatory demands for confidentiality, and there were incidences in which confidentiality was overlooked entirely despite it being a relevant feature.

Confidentiality was understood as a professional obligation, or an institutional rule to be followed. 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 an education programme) to respect patient confidentiality.

“We’re specifically told that you know you shouldn’t break [the] patient’s confidentiality.”

Pre-reg1

This motivation for respecting confidentiality is to act within the rules; respecting confidentiality does not seem to be a moral compulsion. 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 a scenario in which a customer asks the pharmacist to identify a tablet he has found in the bedroom of his daughter (a patient of the pharmacy practice), participants recognised that confidentiality was one of the main principles at stake. Although they decided they would not disclose the information themselves, despite knowing what the tablet was, some said they would instead direct the father to a source of information that would identify the medication for him. This falls short of the moral obligation to act in order to preserve the confidentiality of the patient, and in fact would cause the same effect on the patient as breaching confidentiality would. Whether it is appropriate to breach confidentiality in this case (for example to prevent harm to the daughter), was not discussed in the focus group. Rather, the discussion was about how to direct the enquiring father towards information without oneself being the one to divulge the information.

“[T]hey usually tell you to refer to a drugs information helpline, don’t they, ’cause they’re good at identifying [drugs].”

Pre-reg2

Conversely, participants at times took a very cautious approach to confidentiality, reporting to guard it closely, to the extent of suggesting that even saying that certain information was confidential might arouse suspicion and break confidentiality to an extent.

"[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

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

Competence of patient

Competence was seen by participants as measurable by common sense and by the Gillick competency test.⁵⁰ 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.

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. 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 ...[are] competent, but they're eighteen, so... and I've come across really young [girls] who've, you know, got their heads screwed on."

Pharm3

4.1.4. Sub-section summary

These findings show that participants' understanding of ethics in pharmacy is based largely on commonsense, with participants referring to ethics as subjective and relative to cultural norms. Expressing ethics in metaphorical terms may indicate a certain lack of fluency in discussing ethics, despite ethics being a feature of daily practice for pharmacists. 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 for breaking the rules.

The frequent reference to rules in the focus groups was striking, and an ethical dilemma was sometimes understood to be a conflict between moral and legal obligations, rather than a conflict between two moral obligations.

⁵⁰ 'Gillick competence' refers to the judgement that a person below sixteen years of age has sufficient understanding and intelligence to consent to medical treatment.

4.2 Survey results

The results presented here are from two types of questionnaires sent to community and hospital pharmacists. Data were gathered from pharmacists in community, hospital and primary care practice. Comparisons can be made between community and hospital pharmacists' responses but since the number of respondents from primary care practice was too low (15) to make reliable inferences, the data from primary care practice were not subject to statistical analysis.

Results are presented in such a way as to answer questions about the frequency of occurrence of certain ethical dilemmas, how pharmacists deal with these ethical problems, and whether there is any statistically significant association between the sector pharmacists work in, the decisions they make and how important they regard certain factors when faced with an ethical problem.

Results show general agreement in regard to what pharmacists would do in certain situations within and across sectors. 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.

The survey included scenario-based questions, which asked participants whether they had encountered certain situations in their work. They were asked how often the situation had occurred in the past year. Participants were then asked to indicate, from a selection of options, what action they had taken in those circumstances or, if they had not encountered the situation, what action they think they would take.

4.2.1 Frequency of occurrence of specific ethical problems

The following two tables detail the frequency of occurrence of specific ethical problems. Results show that 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.

It is worth noting that community pharmacists claimed to have encountered more of the presented scenarios than hospital pharmacists had. Pharmacists from both sectors have responded to scenarios they have not encountered, and as such there are many answers to hypothetical, rather than actual, situations.⁵¹

⁵¹ With thanks to an anonymous expert reviewer for this point.

Table 1. 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.

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
You are presented with a prescription for something like paracetamol. You see the prescription is not signed.	17 (10%)	57 (33%)	55 (32%)	23 (13%)	16 (9%)	4 (2%)	3	175
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.	1 (1%)	10 (6%)	34 (20%)	48 (28%)	56 (56%)	20 (12%)	5	175
You are asked to supply EHC over the counter.	13 (8%)	51 (30%)	54 (31%)	38 (22%)	11 (6%)	5 (3%)	3	175
A patient hands you a prescription. Ideally, you would receive further clarification/ information about the prescription from the prescriber.	17 (10%)	37 (21%)	56 (32%)	48 (27%)	12 (7%)	1 (1%)	4	175
A customer asks for an over-the-counter treatment. After talking to the patient you come to the conclusions/he does not really need the treatment, though it would do no harm for him/her to use it.	5 (3%)	22 (13%)	45 (26%)	65 (38%)	33 (19%)	3 (2%)	2	175
A 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
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.	0 (0%)	11 (6%)	51 (29%)	78 (45%)	35 (20%)	0 (0%)	0	175
A patient comes in for his/ her methadone treatment but it is the day after the date specified on the prescription.	2 (1%)	2 (1%)	22 (14%)	53 (34%)	60 (38%)	19 (12%)	17	175
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).	0 (0%)	5 (3%)	18 (11%)	73 (43%)	61 (36%)	13 (8%)	5	175
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.	0 (0%)	7 (4%)	25 (15%)	83 (49%)	48 (28%)	6 (4%)	6	175

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
The husband or wife, 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.	1 (0.6%)	0 (0%)	10 (5.7%)	33 (18.8%)	90 (51.1%)	37 (21.6%)	0	175
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.	0 (0%)	1 (1%)	4 (2%)	34 (20%)	103 (60%)	29 (17%)	4	175
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.	1 (1%)	1 (1%)	11 (7%)	19 (13%)	70 (42%)	66 (39%)	7	175
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.	0 (0%)	1 (1%)	4 (2%)	24 (14%)	62 (37%)	79 (47%)	5	175
You feel something a colleague has done is unethical.	1 (1%)	0 (0%)	3 (2%)	18 (10%)	81 (47%)	70 (41%)	2	175
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.	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/ daughter's treatment.	0 (0%)	1 (1%)	1 (1%)	9 (5%)	63 (36%)	100 (58%)	1	175
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.	0 (0%)	0 (0%)	3 (2%)	0 (0%)	30 (18%)	137 (81%)	5	175
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.	0 (0%)	0 (0%)	1 (1%)	0 (0%)	31 (18%)	139 (81%)	4	175
You suspect a child, who is one of your patients, may be subject to abuse at home.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	26 (15%)	146 (85%)	3	175
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).	0 (0%)	0 (0%)	0 (0%)	3 (2%)	15 (9%)	151 (89%)	6	175
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.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	4 (2%)	168 (98%)	3	175

Table 2. 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.

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 patient hands you a prescription. Ideally, you would receive further clarification/ information about the prescription from the prescriber.	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
The husband or wife, 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.	0 (0%)	0 (0%)	4 (6%)	10 (16%)	24 (39%)	23 (38%)	3	64
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.	0 (0%)	0 (0%)	1 (2%)	13 (21%)	28 (46%)	19 (31%)	3	64
You feel something a colleague has done is unethical.	0 (0%)	0 (0%)	1 (2%)	3 (5%)	27 (46%)	28 (47%)	5	64
A paediatric consultant has asked you to dispense, for a child, a dose of medicine that is outside the SPC limits, but is still not at toxic level. You speak with the consultant about it who confirms these are his/her wishes.	1 (2%)	7 (11%)	6 (10%)	29 (47%)	14 (23%)	5 (8%)	2	64
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.	0 (0%)	0 (0%)	9 (15%)	20 (33%)	20 (33%)	12 (20%)	3	64
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.	0 (0%)	2 (3%)	1 (2%)	5 (8%)	19 (32%)	33 (55%)	4	64

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
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.	0 (0%)	0 (0%)	0 (0%)	1 (2%)	10 (16%)	51 (82%)	2	64
The mother or father of a patient asks for confidential information about his/her fifteen-year-old son/ daughter's treatment.	0 (0%)	0 (0%)	0 (0%)	3 (5%)	14 (22%)	46 (73%)	1	64
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 Accident and Emergency (A&E) is extremely long.	0 (0%)	0 (0%)	3 (4.7%)	4 (6.3%)	15 (23.4%)	41 (64.1%)	1	64
You suspect a child, who is one of your patients, may be subject to abuse at home.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (3%)	59 (92%)	3	64
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).	0 (0%)	0 (0%)	0 (0%)	0 (0%)	9 (15%)	53 (86%)	2	64
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.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	62 (100%)	2	64
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.	0 (0%)	0 (0%)	1 (2%)	7 (11%)	17 (27%)	37 (60%)	2	64

4.2.2 How pharmacists deal with specific ethical problems

Using scenario-based questions, participants were asked to report what they had usually done when they had found themselves in specific ethically-problematic situations at work. One of the features of these scenario-based questions was that, if participants had answered that they had never in fact been in that situation, they were asked what they *would* have done in that particular situation. Percentages have been rounded to the nearest 1% and exclude missing values and those who answered 'don't know' or 'N/A'.

4.2.2.1 Opinion within sectors

Community pharmacy

The following results have arisen from scenario-based questions that applied to community pharmacists only, and exclude void answers. Community pharmacists were mostly in agreement over how to resolve most situations (divisions of opinion in ratios between 8:2 and 10:0 are considered to be 'mostly in agreement'). Consensus was reached on whether to supply or not supply methadone to a patient who has come in for his/her methadone the day after the date specified on the prescription (98% refused to supply, and 2% agreed to supply). Pharmacists were mostly in agreement over whether to dispense for an unsigned prescription for something like paracetamol (80% would dispense; 20% would refuse to dispense) and whether to dispense from an unsigned prescription for something like an opioid analgesic (81% would refuse to dispense; 19% would dispense). Pharmacists were mostly in agreement over whether to sell medication over the counter to a patient who does not really need it (and who would also not be harmed by it) (13% would sell the medication; 87% would advise against the sale) and whether to sell medication over the counter to a customer who may be abusing the medicine (14% would sell the product; 86% would refuse to sell it). When asked whether their personal beliefs affect whether they would supply EHC over the counter 6% pharmacists reported that their personal beliefs affect their decision to supply; for 94%, their decision is not affected by personal beliefs. Pharmacists were mostly in agreement about what to do if they suspected a doctor was abusing medication from NHS and private scripts. In the scenario given, the doctor had not responded to verbal intervention from the pharmacist. There were almost identical results from the scenarios relating to abuse of NHS and private prescriptions; 80% would report the doctor abusing medication using NHS scripts, 81% would report him/her for abusing medication using private scripts; 20% would not report the doctor abusing medication using NHS scripts and 19% would not report the doctor for abusing medication using private scripts.

There was slightly more pronounced division of opinion over whether to dispense clinically equivalent medication when the pharmacy is out of stock of the brand named on the prescription (71% would not dispense; 29% would dispense the equivalent). Opinion was split over whether to supply medication to a patient who has made it known s/he will use the medication against guidelines (e.g. hydrocortisone cream being used for the face), with 59% of the opinion the supply should be refused, and 41% of the opinion the medication should be supplied. Over the matter of a girl who appears under sixteen years of age requesting EHC in an area where no PGD (patient group direction) is in place, opinion was divided over whether to supply EHC or not, with making the supply, and refusing to do so. Locum community pharmacists were divided over how to resolve the following problem: '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'. Opinion was divided with 21% operating as normal for that pharmacy, and 79% refusing to work that way.

Hospital pharmacy

The following results have arisen from scenario-based questions that applied to hospital pharmacists only, and exclude void answers. All respondents agreed that medication should be dispensed as requested if a paediatric consultant were to ask for medication that is outside SPC (Summary of Product Characteristics) guidelines. There was also strong agreement over what should be done in the following situation: '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.' The majority (93%) would refuse the supply, while 7% would supply the medication. On the matter of knowing a patient who has a condition that may affect him/her while driving has not informed the DVLA (Driving and Vehicle Licensing Authority), 8% would report the patient to the DVLA, 37% would talk to the patient, knowing s/he is unlikely to inform the DVLA him/herself, and 55% would inform a medical consultant.

4.2.2.2 Opinion between sectors

Data from a total of eighteen scenarios that could occur in either a community or pharmacy setting were analysed. Within these eighteen, there was mostly agreement within sectors and between sectors about how they would resolve each ethical problem presented. There were only two exceptions to this, which will be detailed towards the end of this sub-section.

There was general agreement over the following: if further information was needed about a prescription, most would contact the prescriber (97% community; 98% hospital). If a patient returned unopened, unused, in-date medication, most would dispose of it (87% community; 95% hospital). If a colleague was taking prescription medicine from the controlled drugs cabinet, most would report the colleague (96% community; 98% hospital). If there was reason to suspect a child patient was subject to abuse at home, most pharmacists would know what procedure to take and would go through the appropriate channels (89% community; 92% hospital). If the pharmacist believed the patient would be more compliant with important treatment if s/he was misled about some information, most would not withhold the truth but would talk frankly to the patient (82% community; 90% hospital). If a colleague was behaving unethically, most pharmacists would talk to their colleague rather than take no action at all (94% community; 81% hospital). If that colleague continued to behave unethically after the pharmacist had spoken to him/her, most would then report the colleague (82% community; 92% hospital).

If a close family member of an adult patient requested confidential information about that patient, most would not pass the information on (92% community; 94% hospital). However, opinion was divided in both community and hospital sectors over whether to pass on confidential information to a parent of a fifteen-year-old child, with 34% community and 42% hospital of the opinion that the information should be passed on, and 66% community and 58% hospital of the opinion the information should remain confidential. Divide was greater again over the question of whether a pharmacist should inform a member of the public of the identity of a tablet that did not belong to them. Figures 1 and 2 below show these last two sets of results in cluster bar graphs.

Of all the results detailed in this subsection, none showed any association between the answers given and the sector the pharmacist works in.

Figure 1 Clustered bar graph showing percentages of hospital pharmacists (n=53) and community pharmacists (n=164) 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.

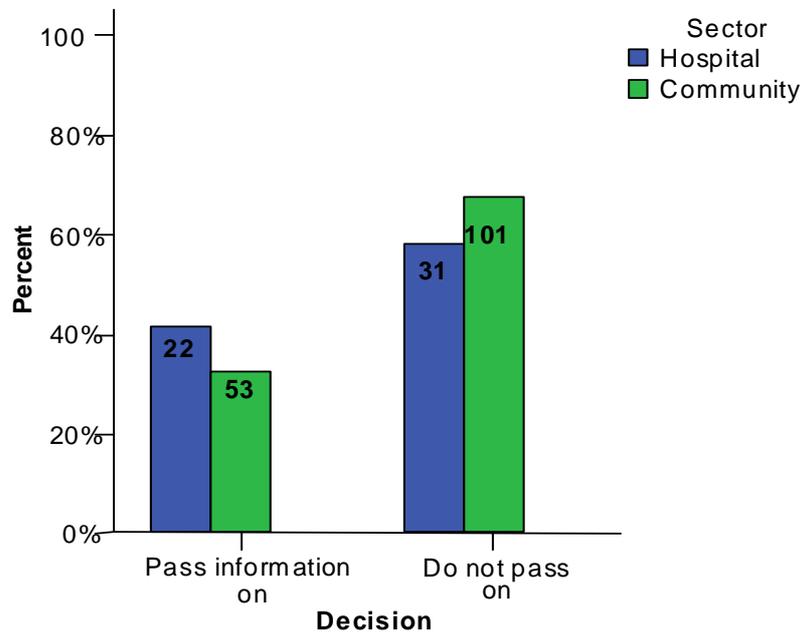
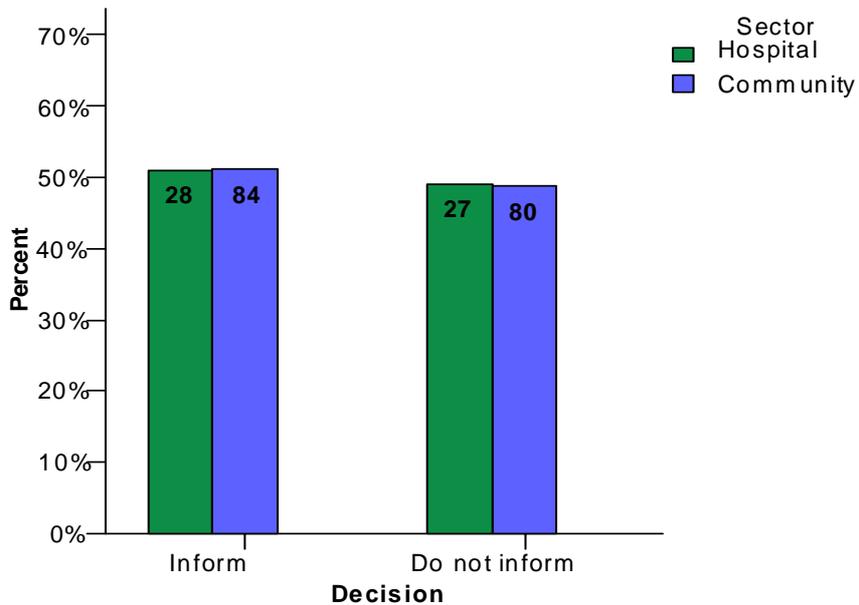


Figure 2 Clustered bar graph showing percentage of hospital pharmacists (n=55) and community pharmacists (n=164) who would inform or not inform someone of the identification of a tablet that did not belong to them if the pharmacist was able to identify the tablet. Frequencies are shown in the bars.



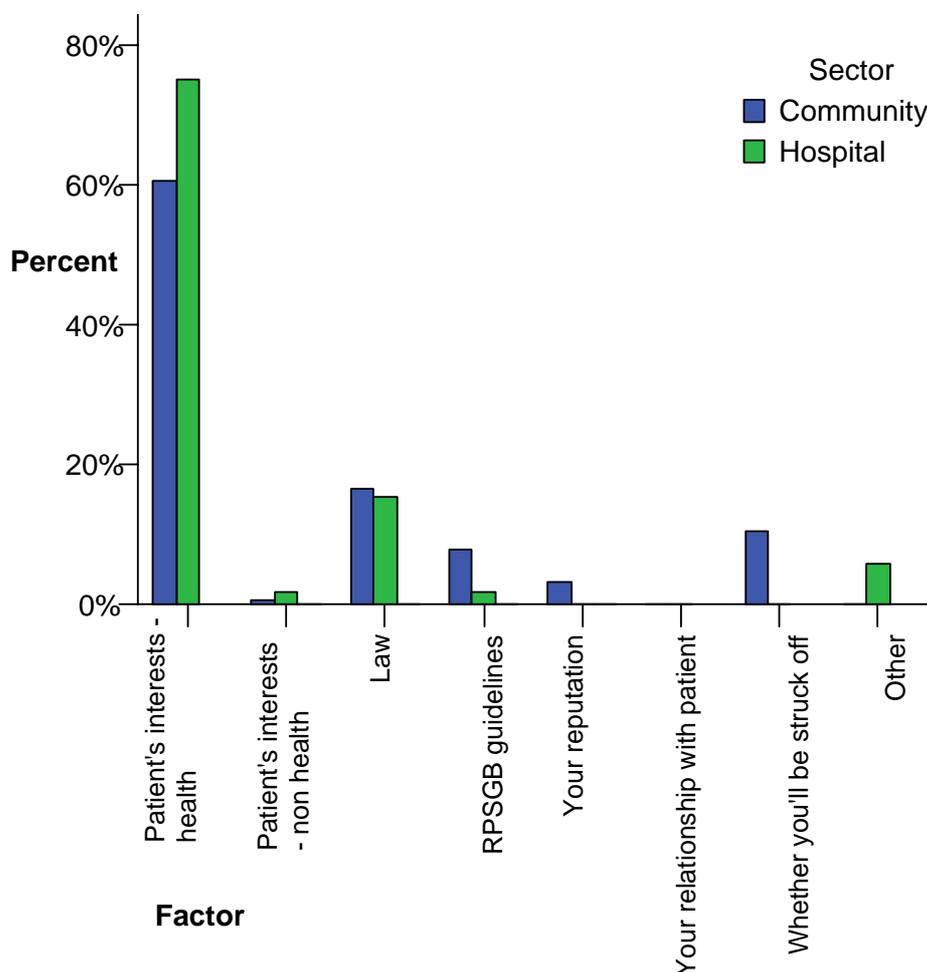
4.2.3 How important certain factors are in making ethical decisions

Pharmacists were asked how much importance they gave to certain factors when making decisions about situations such as those presented in the questionnaire. The most marked of these was the consensus, both within each sector and across sectors, that the patient's health interests should be given a great deal of consideration (the mean score across sectors was 89%). It is also worth noting that across sectors pharmacists gave a great deal of consideration to keeping within the law (the mean score across sectors was 67%). Pharmacists across sectors also gave a great deal of consideration to whether they would be struck off (the mean score across sectors was 52%), to keeping within the guidelines of the RPSGB⁵² (the mean score across sectors was 50%), and to their reputation (the mean score across sectors was 31%). Factors that were given 'quite a lot of consideration' were the pharmacist's relationship with the patient (the mean score across sectors was 41%) and the pharmacist's relationship with the prescriber (the mean score across sectors was 37%). 'Some consideration' was given to the financial interests of the company/trust/ hospital (the mean score across sectors was 47%), the patient's non-health interests (the mean score across sectors was 46%), and participant's relationships with pharmacy colleagues.

An association was found between the sector pharmacists worked in and how much consideration they gave to their own financial interests ($U=3634.5$; $n_1=175$; $n_2=64$; $p=.003$), with community pharmacists considering their own financial interests more than hospital pharmacists did. 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 they work for ($U=3609.5$; $n_1=175$; $n_2=64$; $p<.0005$), with community pharmacists less concerned with this than hospital pharmacists were. 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.

⁵² Note the questionnaire was conducted before the RPSGB introduced a new, principle-based, Code of Ethics in 2007 and prior to the demerger of the RPSGB into a pharmacy regulator (The General Pharmaceutical Council) and Professional Leadership Body (The Royal Pharmaceutical Society).

Figure 3 Cluster bar graph showing which factor community pharmacists (n=150) and hospital pharmacists (n=51) considered the most important when making ethical decisions.



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'.

5. DISCUSSION

There is general agreement across sectors about how frequently certain ethical problems arise in practice. Within sectors there was a lot of agreement about what ought to be done, and no statistically significant difference was found between the answers community and hospital pharmacists gave in response to questions concerning what the appropriate action would be in each situation.

The data from both the survey results and the focus groups suggest pharmacists consider the patient's health interests to be a very important factor in ethical decision-making. It is worth noting that the patient's health interests were ranked more highly in the survey than any other factor, but that the patient's *non-health* interests were not ranked very highly. Many of the scenario-based questions asked in the survey

would have included an element of the patient's health interests, for example the scenario in which the pharmacist would ideally have more information about the prescription. It is arguably in the patient's best interests that the pharmacist dispenses only on full information, and most (97%) community and most (98%) hospital pharmacists reported that they would request further information from the prescriber in such a situation.

However, many of the scenarios in the questionnaire demanded the participant consider his/her relationship with the prescriber, the patient and the public, and many included a dimension of the social interests of the patient. It is worth noting that when asked to rank the level of consideration they gave to certain factors when considering an ethical problem, although the patient's health interests take priority, regulation seems to play a very important part in moral decision-making among pharmacists. Pharmacists ranked their consideration of the law, RPSGB guidelines, their reputation and the risk of being struck off more highly than the patient's non-health interests.

Concern for regulatory constraints is echoed in the findings from the focus groups, which showed that sometimes pharmacists were prepared to break the rules in the interests of the patient, but in some cases pharmacists acted in accordance with the rules even if this was not necessarily in the best interests of the patient. The findings from the focus groups showed that deferment to regulation occurred for at least two reasons: out of respect for the rationale behind the rules, and because of fear of getting into trouble.

Where the community and hospital sectors differed in their approach to ethical problems was in consideration of the financial aspects of pharmacy. Community pharmacists are under commercial pressure in a way that pharmacists in other sectors are not, and given this it is perhaps not surprising that community pharmacists were more concerned about their own financial interests than hospital pharmacists were. Many (24%) community pharmacists give 'some consideration' to their own financial interests. Findings from the focus group indicated that the pharmacist's own financial interests were not of great importance, though one participant did note "We're pharmacists, but we're also businessmen" [Pharm1]. 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".⁵³ Hospital pharmacists are exposed to different financial pressures, which is shown in the fact that community pharmacists are less concerned about the financial interests of the company they work for than hospital pharmacists were concerned about the financial interests of the trust or hospital they work for.

However, since the scenario-based questions did not have scope for explanations for the answer given, it is impossible to tell which factors influenced pharmacists' decision-making in each scenario given. For example, the 80% community pharmacists 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 against the product guidelines may have been motivated by financial gain, or may alternatively have been more concerned about the patient's interests and the patient's autonomy.

⁵³ Hibbert, D., Rees, J. A. & Smith, I. (2000) 'Ethical awareness of community pharmacists' *The International Journal of Pharmacy Practice* 8: 82-87 p85

It is worth noting that while most (79%) community pharmacists were willing to dispense from an unsigned prescription for something like paracetamol, most (71%) would not dispense a clinically equivalent medicine if out of stock of the brand named on the prescription. Not dispensing the clinically equivalent brand is not in the patient's best interests, since it makes no clinical difference, and it would have no financial impact on the pharmacists. Compared with dispensing from an unsigned prescription, this is a minor breach of rules, and so it is possible another factor is at play. Pharmacists across sectors reported to give 'quite a lot of consideration' to their relationship with the prescriber (the mean score across sectors was 36%). Cooper suggests community pharmacists suffer subordination under doctors,⁵⁴ which may account for any reluctance for community pharmacists to go against the request of a prescriber in such a situation.

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. 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: "Pharmacists should be aware that information about services provided to adolescents should not normally be disclosed to their parents."⁵⁵

Opinion about confidentiality was divided 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. 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 an illegal substance, what it is usually used for, where the person asking about it got it from, and so on. 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. This is a complex scenario for

⁵⁴ Cooper, R. (2006) PhD Thesis 'Ethical problems and their resolution amongst UK community pharmacists: A qualitative study' University of Nottingham, p273-279

⁵⁵ 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.

other reasons too, for example, it is arguable that the enquirer has a right to know what the tablet is, since its identity is a publicly knowable fact.

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 explicable 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. 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 empirical research.

5. IMPLICATIONS OF FINDINGS

The findings of this research are important for providing evidence that ethical problem-solving is an important part of the 'job description' of pharmacists. While it is already clear that ethics plays a significant role in the consciousness of the professional body and regulator (RPSGB), there is evidence that ethics is also a prominent feature at the practice level. As pharmacy has become increasingly people-orientated, rather than medicine-orientated, practising pharmacy means not only applying technical knowledge about medicines and physiology, but also using skills to understand and work with patients as persons. Having discovered from this research that pharmacists seem to take a commonsense and patchwork approach to ethics, a natural line of investigation to pursue would be to determine the extent of pharmacists' awareness, knowledge and understanding of ethics.

In addition, the findings from this research invite a combination of philosophical and empirical questions to determine how well ethical problems are being managed by pharmacists, what implications this might have on the ability of the profession to carry out its role in society and how well educated individual pharmacists are to carry out this moral role. The three key questions to be asked are:

- 1) Are pharmacists right in the way they deal with ethical problems?
- 2) To what extent is it important that pharmacists make the right ethical decisions?
- 3) How should pharmacists be educated in ethics?

This penultimate section unpacks these questions.

- 1) *Are pharmacists right in the way they deal with ethical problems?*

This research, along with Benson's findings on the values of the profession,⁵⁶ offers some insight into the rationale behind the decisions being made by pharmacists. It is clear that on many matters pharmacists are largely in agreement about what ought to be done in certain situations, which may be derived from the pharmacy culture, or may be a representative 'slice' of the cultural values of a wider community.

⁵⁶ Benson, A.; Cribb, A. & Barber, N. (2009) Understanding pharmacists' values: A qualitative study of ideals and dilemmas in UK pharmacy practice. *Social Science and Medicine* 68; 12: 2223-2230

The answer to this question of whether pharmacists are dealing appropriately with ethical problems will be complex, hotly contested and possibly indeterminable. Even so, some matters are worth exploring, for example particularly contentious issues, those deemed to be of great moral magnitude, or ethical questions emerging from new technology or practice.

2) *To what extent is it important that pharmacists make the right ethical decisions?*

There are two key points to address in order to answer this question. The first is irreducible to any other research question, and it concerns the moral conduct of pharmacists, regardless of any measurable impact this might have on patients or the profession. There is an intrinsic, basic value to ethics, such that it is simply important to do the morally right thing; the profession is on a very basic level obliged to ensure its members are acting ethically.

On another level, we need to ask what *impact* decision-making has on patients and the public. It has already been established that a patient's needs are not just physiological and that ethics is an element that runs through pharmacy's daily practice. Now we must ask, what is the impact of this on the service that is delivered to patients? Further, does it matter *how* these decisions are made?

The findings from both the focus groups and the survey bring our attention to the strong presence of regulation in pharmacy decision-making. While the patient's health interests were considered the most important factor when making ethical decisions, the law and the RPSGB guidelines were also given 'a great deal of consideration', and the patient's non-health interests were only given 'some consideration'. This suggests that while pharmacists encounter ethical problems in their daily work, their decisions are based primarily on concerns for the physiological needs of the patient, and a duty to act within the regulations.

Intuitively, there seems to be an important moral difference between the pharmacist who acts in accordance with the rules because she is afraid of getting into trouble if she does not, and the pharmacist who agrees with the fundamental principles behind the rules, or respects the process by which the rules have been set. Importantly, in cases in which both the autonomous professional's actions and the less autonomous individual's actions are compatible with the rules, the difference between the two is very subtle, so much so that in most instances it is unlikely to have any measurable impact on the patient or on the profession's ability to deliver an excellent public service.

In reality, pharmacists often find themselves in situations for which there are no clear guiding rules. The autonomous professional with sound moral judgement will usually handle such situations appropriately and ethically. It would be tempting to try to put in place further regulation to guide any less autonomous individuals, or anyone who may be mistaken in their moral judgements.

However, aside from the impracticalities of anticipating and regulating every possible eventuality, there is an important distinction to be made between the pharmacist who follows the rules habitually or for fear of the possible repercussions of breaking them, and the pharmacist who occasionally breaks the rules for considered moral reasons. The former may sometimes result in wrong action, while, if the judgement is right, the latter will result in the morally right action. It is important to note that any breach of a rule for moral reasons must be for the *right* moral reasons, and usually with the right results; arguably, integrity is only ever any good when the moral agent gets it right.

3) *How should pharmacists be educated in ethics?*

Depending on the answers to questions 1 and 2 above, the profession may wish to assess the formal ethics education pharmacists receive (during and/ or beyond the MPharm). The broad aims of formal ethics education in vocational subjects tend to be to raise awareness of ethical issues and the guidelines of the profession, and to provide a structure to assessing ethical problems and making appropriate, justifiable decisions.

Pharmacy schools now commonly include ethics as part of their educational programmes, and ethics appears as part of the RPSGB's Indicative Syllabus.⁵⁷ Pharmacy ethics education differs from other ethics education in its content, but the basic educational challenges are the same across other professional accreditation programmes. There are many pedagogic questions that are generic to ethics education, including what the purpose of ethics education is, how best ethics is learned, and how ethical competency can be assessed and measured.

Recent graduates have, on the whole, received more formal ethics education than previous generations of pharmacists, but ethical sensitivity and judgement are sometimes regarded as wisdom that develops with experience. It would be interesting to investigate the impact of formal education on pharmacists' awareness, attitudes and behaviour. Likewise, it would be interesting to investigate the impact of experience, or a combination of experience and recent training (for example when formal ethics education forms part of a later qualification). It would be worthwhile investigating whether pharmacists' approach to ethics in their work is influenced by certain factors (e.g. age, number of years practising since graduation, extent of formal ethics education).

6. CONCLUDING COMMENTS

The empirical research findings presented here form one level of investigation into pharmacy practice ethics. Although not statistically representative of the pharmacy population in the UK, the findings provide preliminary evidence of some of the ethical problems pharmacists face and detail frequencies of occurrence of these problems. The findings provide insight into what pharmacists understand ethics to be, what their priorities are when dealing with ethical dilemmas, and how they resolve specific problems.

The findings clearly indicate that ethics is an integral part of pharmacy practice, that pharmacists approach ethics in a fairly commonsense way, often giving the patient's interests priority, and often influenced by regulation. The profession, and in particular the RPSGB, must now consider exactly what it regards ethical conduct to be and whether the decisions pharmacists make are in line with the ethical principles of the profession. The newly revised Code of Ethics makes a significant contribution to addressing this. In addition, an important question for the pharmacy profession is, to what extent professional autonomy is a component for achieving its aims. All professional codes of ethics are limited in their capacity to guide ethical behaviour,⁵⁸ not least because a code of ethics may be regarded as a form of regulation. Formal

⁵⁷ <http://www.rpsgb.org/pdfs/edmpharmindicsyllabus.pdf> (visited 17/01/10)

⁵⁸ Dawson, A. (1994) 'Professional codes of practice and ethical conduct' *Society for Applied Philosophy* 11; 2: 145-153 and Deans, Z. & Dawson, A. (2005) 'Why the royal pharmaceutical society's code of ethics is due for review' *Pharmaceutical Journal* 275: 445-446

ethics education may help further equip pharmacists with the ethical awareness, knowledge and understanding needed to effectively manage the moral dimensions of the profession.

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