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**Royal
Pharmaceutical
Society**
of Great Britain

**Respect for medicines and
respect for people:
mapping pharmacist practitioners'
perceptions and experiences
of ethics and values.**

Dr Ailsa Benson, Professor Alan Cribb and Professor Nick Barber

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Foreword

Pharmacy practice is entering a new era. Not only will pharmacy professionals see their professional authority extended, and their legal standing reinforced, the Royal Pharmaceutical Society of Great Britain is currently reviewing its Code of Ethics. It is a characteristic of all professions that they are accountable to values and principles which reflect their role in society and which distinguish them from others. This adherence to ethical values is as central to the good and proper practice of pharmacy as it is to all healthcare professionals.

This timely report succinctly identifies two primary strands – respect for medicines and respecting the patient’s best interests – as key drivers in pharmacy practice. However, it also identifies the tendency of scientific rationality to eclipse or obscure the more personal, ethics-driven values which should inform best practice. Moreover, the report concludes that – again in common with some other healthcare professions – there is a tendency to paternalism, which will need to change to take account of the increased emphasis on patient autonomy and societal change.

This is a fascinating and balanced report, stressing the changing world in which we live and the need to respond accordingly. It presents a challenging account of pharmacy practice and makes powerful recommendations which can only enhance the reputation of this important strand of healthcare provision and its practitioners. The revision of the Code of Practice is heading to its final stages and it is to be hoped that it will assist pharmacists and pharmacy technicians to meet the challenges confronted by the exacting and demanding roles which they play in securing the health of the community in which they practice. Dr Benson and her colleagues are to be congratulated on this report which will hopefully inform educational and professional requirements in the future.

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1. SUMMARY

The findings suggest that the current values and ethics of pharmacy practitioners provide a solid base for practice, with pharmacy emerging from the study as a highly responsible and conscientious profession. The findings also suggest that greater ethical and values literacy would make an important contribution to the profession in two respects. First, it would directly support new and developing practice activities and responsibilities. Second, it would help the profession to maintain and develop its broader contribution to society including medicines and health-related policy making.

The research identified two core values - *respect for medicines* and *the patient's best interests* - as central to the way the ethical components within professional activities are managed and understood. The strong attachment to professional expertise, exemplified in *respect for medicines*, leads to a meticulous approach to work activities, and a conscientious acceptance of associated responsibilities and accountabilities in the achievement of a *patient's best interests*. At the same time certain styles of reasoning dominate, especially a reliance on a broadly scientific model of rationality, including the use of evidence in making assessments of harms and benefits. There is an associated tendency for pharmacists not to appreciate the role that personal constructs and value judgments can play in overtly neutral or 'scientific' reasoning. The scientific rationality model is sometimes extended, inappropriately, to situations that also have significant ethical components. Limiting pharmacists' contribution to the 'facts' of treatment may increasingly lead to their exclusion from shared care decision-making with other health care professionals.

Fidelity to the patient and sensitivities to the need for loyalty, trust and honesty in the range of relationships are very apparent. These broadly positive qualities also produce a tendency towards paternalism in the care of patients. Such paternalism can sideline consideration of two important ethical principles: respect for patient autonomy and justice. With regards to patient autonomy, there is sometimes inadequate provision of information, limited involvement of a patient in care decisions, or a failure to acknowledge patient values e.g. those arising from different cultural or religious perspectives. Any reluctance to engage with the values of patients may, over time, lead to a diminishing of trust and respect. Similarly, sensitivity to the values of other health care professionals may enhance the care of patients. The tendency to rely on professional judgments about what is in the interests of a patient has two adverse effects. First, it can allow preconceived notions about individual patients to introduce bias (e.g. partiality or favouritism). Second, it can lead to failures to consider the wider public good (e.g. when overriding rules or guidance designed to ensure fair distribution of resources).

Summary of findings:

- Two central and linked values: *Respect for medicines* and *the patient's best interests*;
- Confidence in professional expertise in medicines;
- Responsibility for patient's best interest;
- Meticulousness and conscientiousness;

- Scientific rationality approach to decision-making (use of evidence; harm/benefit assessments, bodily norms);
- Paternalistic and agent centred;
- Limited involvement of patient in own care;
- Personal accountability and agency linked with a willingness to break rules and other guidance;
- Justice considerations can be sidelined;
- Fidelity to a patient (altruism, care, compassion, partiality);
- Loyalty, trust, and honesty within relationships;
- Limited familiarity with ethical language and concepts (especially autonomy and justice);
- Minimal appreciation of the role of personal value judgments.

The central recommendation arising from the research is that the profession should aim to develop practitioners' ethical and values literacy so as to:

- Improve the identification and management of ethical and value components within day-to-day practice dilemmas and decisions;
- Strengthen the requisite skill set, for example, those relating to managing conflicts between professional and patient autonomy, or between professional responsibilities to the patient and to the wider public;
- Promote greater respect for the values of patients and other health care professionals; and
- Enhance the contribution pharmacists make to shared decision-making, whether in the care of an individual patient or in policy discussions.

More broadly we recommend that, over time, the core values of pharmacy practice should be slightly reoriented. We suggest that the values associated with *respect for medicines* should continue to be fostered and practiced, albeit with some refinements, but that there is a need to shift the emphasis somewhat from a concern with *the patient's best interests* towards the value of *respect for people*.

2. STRUCTURE OF REPORT

The report has seven further sections. Section 3 introduces the research background and research question. Section 4 contains a short description of the methodology. Sections 5 to 7 present the findings. Section 5 reports the key values identified in the research. The following two sections reveal how those values are bound up with the identification and perception of the nature of ethical dilemmas in professional practice (Section 6) and influence decision-making (Section 7). Section 8 reviews the implications for pharmacy practice, as it develops to meet both new professional opportunities and societal changes. The recommendations associated with those implications are presented in Section 9.

There are, inevitably, some repeating themes across the sections.

3. THE RESEARCH BACKGROUND

A discussion document, 'Developing pharmacy values: stimulating the debate', published by the RPSGB in 2000 (Cribb and Barber) set out the ways in which value judgments are inherent in every aspect of pharmacy. This document reflected the growing awareness of the importance of values and ethics in daily professional activities (Fulford, Dickenson and Murray, 2002; Wright, 1987). It concluded by recommending a benchmarking of the values and ethics of pharmacy practitioners. The authors suggested that such work would enable the identification of possible changes to professional practice necessary to support the profession's continuing development. The research informing this report was thus designed:

To explore and map the values and ethics of pharmacy practitioners through their self-reported day-to-day perceptions and experiences.

Defining ethics and values is not easy as both terms are used in a wide variety of ways. For the purposes of this report ethics can perhaps be most readily understood as being about the ways in which ideas of right/wrong and good/bad are understood, identified and managed. Life is however more complicated than such simple ethical polarities imply. Ideas about duties and responsibilities, considerations of consequences and the exercise of virtues are examples of the different dimensions of ethics (reflecting different theoretical traditions - deontology, consequentialism/utilitarianism, and virtue/care ethics respectively). The term 'values' is being used here in a much wider sense than the term 'ethics', and relates to the wide range of things that are valued by people. Some values have a clear ethical dimension: for example, the personal value someone attaches to the importance of honesty. Other values – e.g. the stress on the importance of evidence – are not about ethics in any obvious sense, but can strongly affect professional norms and the construction of professional ethics. The sources of values are complex and may relate to personal, institutional, vocational (i.e. relating to pharmacy) or general professional identities (Cribb and Barber, 2000). Some values may be hidden (including from ourselves), but still affect the way that a problem is perceived, the alternatives for action identified, the way a decision is rationalized (Wright, 1987) and the management of relationships (Griseri, 1998). Values, then, link into ethics in that they affect the way that right/wrong and good/bad in daily practice activities are identified, understood and managed. Conflicts between different values and competing ethical approaches occur within policy and practice activities, creating dilemmas, for example between obligations to patients and employers, or consequences for self or the patient. The ways in which such conflicts are resolved provide indications of the relative role and influence of different values. For example, personal value judgments can shape the interpretations of and/or adherence to vocational and institutional values.

4. METHODOLOGY

This section summarises the methods used. A more extensive description is presented elsewhere (Benson, 2006).

4.1 Obtaining the data

Perceptions and experiences of ethics and values can be revealed through the telling of personal stories. The most effective way of accessing such stories is through the use of

loosely structured interviews, and this was the method adopted here. To facilitate the 'reporting' of stories, participants were encouraged to talk about:

- Personal ideas about what makes someone a good pharmacist;
- Work experiences that pricked the conscience or created feelings of discomfort; and
- Observations of/participation in situations where a compromise had been made and/or where there were alternative courses of action.

All interviews were taped and the recordings transcribed. The transcripts were analysed, using the principles of grounded theory.¹ This approach allows for themes to emerge, and for emergent themes to be challenged and clarified in subsequent interviews and analysis.

The interviews were held in six time clusters, between March 2003 and November 2004. The numbers of participants in each cluster varied.

March 2003 - Three interviews

May/June 2003 - Five interviews

November 2003 - Four interviews

February 2004 - Six interviews

July 2004 - Ten interviews

October/November 2004 - Ten interviews

The broad themes and conclusions that emerged from the data analysis are mapped out in sections 5, 6 and 7. These include extracts from the interviews. The names used are not those of the participants, but are appropriate to gender and ethnicity.

4.2 Selecting the participants

A small qualitative sample cannot be representative of the profession in a statistical sense, but the use of purposive sampling ensured that the participants reflected something of the variety of roles and persons who make up UK pharmacy practice.

The key variables used to construct the sample were practice situation and role, gender, ethnicity, age, and length of experience. Participants were drawn from practitioners working within conventional types of practice, together with some drawn from those working in more unusual roles. Such roles included those working as primary care trust pharmacists, academics, or in senior managerial and policy-making roles. Pharmacists working within pharmaceutical industry were excluded.

¹ Essentially, this enables the transcripts to be transformed into meaningful data through the generation of themes. Comparisons of themes both within and across interviews are made, allowing for the identification of regularities and irregularities within apparently similar data. Initial analysis is concurrent with each interview.

Summary of final sample: 38 pharmacists (19 male, 19 female), of which:

- 18 community
- 10 hospital
- 10 others

This sample also reflected:

- Some concurrent experience in one or more sectors;
- Some historic experience of one or more sectors;
- Variations in contextual setting (e.g. type of hospital, rural or urban community setting); employment status, and job responsibilities;
- Experience ranged from two years to over 25 years; and
- Geographical spread across UK.

All interviews followed appropriate research ethics considerations.² The assurances given of confidentiality through anonymising the data are adhered to within this report. The interviews varied in length from around forty minutes to over three hours, with the average interview lasting for around one hour.

4.3 Reliability, validity and generalisability

The nature of the data collection and analysis mean that the scientific tests of reliability and validity commonly associated with quantitative research are not pertinent here. Reproducibility of data in the pure scientific sense is not possible; the data collection is, to some extent, a product of the *interaction* of the interviewer and interviewee and the analysis is to some extent a product of the *interaction* between the analyst and the data.

The report presents what, in qualitative research, are sometimes called ‘theoretical generalisations’ (as opposed to statistical generalisations). That is to say the generalisations reported are based on the assumption that the ethics and values revealed across the 38 interviews might have some general relevance for the wider pharmacy community. Generalising therefore takes the form “*Given* that some UK pharmacists think like this, and others may share some of these characteristics *then ...*”.

Readers need also to be aware that the presence or absence of any particular data may to some extent be an artefact of the interviews. We are therefore not wanting to make bold assertions about the statistical generalisability of these findings to the profession as a whole. However, we also recognise that the report needs to be useful for the pharmacy profession, and not just an exercise in academic caution. The broad themes and significant conclusions from the analysis are thus presented below but should be read with these caveats in mind.

Anonymised extracts from the research interviews are used within the next three sections of the report to illustrate some of the matters raised. Of course, any one

² The guidelines drawn on included those of the BSA 2002, the ESRC 2003, and the Department of Health 2003.

narrative is unique to that specific individual and situation. However, themes illustrated were generally apparent within the research interviews, unless otherwise indicated.

The findings are now reported on in three sections: key values, values in ethical dilemmas and values and ethics within decision-making. The distinction between the last two sections is essentially one of pragmatic reporting: dilemmas occur within decision-making.

5. FINDINGS PART ONE - KEY VALUES

5.1 Introduction

The research suggests that the two key values currently structuring the work of pharmacists might best be visualized as a double helix in which the two strands are *respect for medicines* and the *patient's best interests*. The range of values linked to each strand is outlined below.

5.2 Respect for medicines

Respect for medicines provides the knowledge and technical skills, through which professional responsibilities and obligations directed at *the patient's best interests* can be achieved.

5.2.1 Scientific rationality

The strongly scientific base of the *respect for medicines* strand leads to a powerful vocational attachment to scientific rationality and an evidence based approach in work activities. Assessments about harm/benefits (whether about treatment, supply or non-medicine related activities) appeared, within the research, as a dominant feature of pharmacists' reasoning.

Len

Everything we do is around optimising therapy for the patient. Maximum benefit, minimum damage. So it's weighing up the factors and trying to reach a decision that you think is in the patient's best interests.

5.2.2 Professional expertise

The values associated with *respect for medicines* are thus those related to pharmacists' professional expertise with medicines, including their specialist and technical knowledge. These values mark the distinction between pharmacists and other health care professionals. Keeping such knowledge up to date was seen as important. The recognition by others of that expertise was valued, with it sometimes also providing the basis for the exercise of power in relationships with doctors and patients.

Fran

It is obvious that you have got to have the scientific and technical knowledge

Hal

[Keeping up to date] means we are continually having to change what we consider is best practice

Gwen

I think it's terrifically important [being knowledgeable] because that's the bit that was always the turning point for me in relationships with medical staff.

Ansana

There are times when we can't give [the customer] what they want. We have to tell them 'I think you need to go and see a doctor'.

5.2.3 Conscientiousness, meticulousness

Respect for medicines brings with it an acceptance of the need for conscientiousness, meticulousness and vigilance in the approach to work.

Jan

Pharmacists are a bit kind of pernickety; things have to be right. You can't have a dosage that's kind of, like, oh nearly right. So you have to think of a lot of things. You have to dot your i's and cross your t's. ... We become very conscious of every detail being correct.

Beth

If we can't hand out the right prescription according to what the doctor has written then the patient hasn't benefited from it whatsoever.

Strongly associated with such values is recognition of the importance in admitting errors.

Ken

If I've made a mistake, then the first thing you do is hold up your hand and say 'I'm awfully sorry, I got that wrong'. Then you do your best to put it right as quickly as possible and hopefully that person doesn't go away and report you. ... I put it right and make sure that no harm's come to them.

5.2.4 Adherence to sources of 'rules'

The participants respect for 'rules' relating to medicines - medicines law, the profession's Code of Ethics, institutional rules, professional guidance and standard operating procedures - also forms part of the *respect for medicines* strand. Knowledge of the Code of Ethics itself was limited, out of date, and appeared to be considered relevant to and by community pharmacists only. 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 judgment about harms/benefits in relation to *the patient's best interests*.

Dot

It's down to your professional judgement. So it's in ethical decision-making, there are different routes of action that you could go down. If you've got the right reason for doing it then you've got accountability for doing a certain decision, then that's the right decision. Whereas someone could come to a different decision using a totally different criteria. [It's about] justifying actions.

5.3 The patient's best interests

The use of the singular form of the term 'patient' reflects the value commonly attached to professional responsibility to and for the individual patient. It is this agenda that is more

often articulated rather than expressions that suggest patients are considered in groups or in general. Although the values associated with *the patient's best interests* are based on fidelity to the patient, the patient is not always the priority. Importantly the value attached to assessments of harm/benefit means that considerations about the consequences for others (including the individual pharmacist, other colleagues, the profession, and the employer) are taken into account and may sometimes take precedence over the patient. Illustrative examples appear within this and the next two report sections.

5.3.1 Altruism and self-interest

Altruism appeared as a value shared across the profession and was often expressed in relation to the needs of an individual patient.

Wendy

At three o'clock in the morning, I've had to come and dispense a diamorphine syringe driver to somebody to go home and die because they wanted to die at home. I mean, I couldn't live with myself if I didn't come in.

Ken

A ten-hour day, nine 'till seven in the evening, busy day, tired, somebody wanted an oxygen cylinder delivered. And there was a part of me that though, 'Oh no, I want to go home.' But I took it ... set up the oxygen for the gentleman. Went home, very late getting home.

However, altruism, when viewed from a different perspective, is not necessarily incompatible with self-interest, whether in terms of professional reputation or commercial benefit. The research suggests that community pharmacists see altruism as an important part of being professional. The following extracts provide examples of this but also begin to illustrate the potential for conflicts between a concern with patient welfare and other values.

Dilip

We have a relationship with our patients. We can't rip them off. Sure there is a commercial drive to run our business, but if they don't need [a product] why give it to them?

Mike

What is important? Not what's important for you the pharmacist, but what's important for that person, the patient.

Tom

Our pharmacists have always known ... our stance as a company. You do not sell something just to get the money in the till. ... When it comes to the professional decision about whether or not to sell somebody something, then you are at liberty and we would expect you to say no if they don't need it.

5.3.2 Care and compassion

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. Although most visible in situations where the patient was known, care and compassion were also exercised in situations where the patient was a stranger.

Ian

Caring for the patient's well being is obviously central to the whole thing. [Pharmacists] ... have to connect with helping the patient deal with the circumstances that they find themselves in, and that's particularly true in community pharmacy. I think in hospital pharmacy, some pharmacists can escape from that because ... there may be other people who can actually interact with a patient. Pharmacists doing their own rounds in a ward, patients in a bed – you don't have to speak to.

Nan

If it has gone from a lady who used to come in a couple of times a week, and you used to have a blather with them, to now, her husband coming in because she is dying. And then, finally she goes and you have to sort of ask awkward questions, like, 'How are you doing? How was the funeral?' Because you have known so much about them, it would be inhuman and insensitive if you didn't follow up. I think it is an important part of being a pharmacist.

Mary

[The patient started crying]. There was a big queue of people, ...[an abusive customer complaining] about waiting. ... I had to switch down, the [first] lady was important. ... I couldn't have sent her away. She wasn't herself ... She would have had to walk through the whole supermarket to the car park and then drive home.

5.3.3 Relationships – manners and virtues

Professional activities involve relationships, with patients, doctors and other health care professionals. There appeared to be many shared values about the way that such professional relationships should be conducted. Courteousness, politeness and respectfulness were habitually evident, if sometimes accompanied by deference to doctors. The need for trust and loyalty within relationships (with customers, patients, colleagues and doctors) was frequently identified as being important. The importance of the maintenance of the trust of the patient in the doctor and/or the profession, or that of a doctor in the profession was apparent in a number of examples.

Eric

I will say to the patient, 'Dr. so and so is of the opinion ... but [what I would suggest you consider] is ...'. What I've said to you is as near as you can get. Because you're not supposed to bring the doctor's judgment into jeopardy, that's part of our code.

Fred

The main incident I had in mind [when talking about the importance of trust between colleagues] was a piece of IT research/development where the senior pharmacist gave a presentation [to other pharmacy staff] without mentioning the person who had done the work successfully. Professionally this is wrong.

Tina

I felt it was divided loyalties. You were overruled when it wasn't really [my manager's] place to overrule. ... You shouldn't undermine what people are

trying to do and certainly you don't force people to go back on their word to someone else.

5.3.4 Confidentiality and privacy

Respecting both patient confidentiality and needs for privacy are important ethical principles that are part of attending to *the patient's best interests*. Such concerns were made more explicit within community pharmacy. Here, the situations where privacy was identified as being necessary included: for patients requesting EHC, the provision of methadone, and the taking of bodily measurements. There were also a few specific references both to the need for respect of cultural values and for caution in the management of privacy where the patient was of a different gender to the pharmacist. Within hospital pharmacy, those working within medical information acknowledged the need for confidentiality, but otherwise there were minimal references to the need for confidentiality and a seeming acceptance that privacy was not possible on wards. The provision of community pharmacist held information about a patient's medication to hospital pharmacists appeared to be regarded as a necessary breach of patient confidentiality.

Cath

My wards are very crowded. ... They have little curtains that they draw around the bed but everybody can still hear what's being said. ... From a pharmacy point of view it's [less of a problem] because you're just talking about the tablets most of the time, you're not talking about issues that they've got a problem. ... I suppose the only difference between community and hospital is, in the community, you're surrounded by probably quite healthy people and there'll be people overhearing that you've got a problem, whereas in hospital everybody's there because they're sick.

Roy

When you [in medical information] are doing queries for patients you have got to tread a lot more carefully. How do you know who you are speaking to? It could be somebody phoning up being nosy about somebody else's medication. It is an issue about confidentiality.

Wendy

[It's important to get an accurate picture] because something could be missed off. [A patient who came in today] said he is a diabetic and on insulin. [I] phoned the GP ... and he is not. ... We've had problems with some GP practices who don't want to give out that information. [Community pharmacists are] very helpful [in releasing information].

5.3.5 Paternalism

The strong attachment to a professional responsibility for *the patient's best interests* may reinforce the apparently broadly paternalistic approach to patients. The associated quite common reluctance to fully involve the patient in care decisions restricts the scope for both the respect for, and the building of, patient autonomy. A general focus on the individual patient also tends to sideline considerations about collective ends, including both justice and the public good. As a result, values related to the understanding of, and respect for, patient autonomy and justice considerations were seldom in evidence, appearing to be identified as important key values in three situations: -

- Respect for the lifestyle of a patient was strongly evidenced.

- Some acceptance of the need to provide information so as to support patient choice, albeit sometimes with an emphasis on 'telling'.
- Sensitivity to justice considerations was apparent in concerns about the cost of medicines and potential wastage by patients, sometimes creating a tension between respect for patient autonomy and professional responsibility for the cost effective use of medicines.

Dot

They have the right to knowledge [but if they don't want to know] then, based on what their answer was, I'd be able to respect their wishes. ... You've got to look at medicines, how expensive they are. ... look out for the form that the drug is in, so intravenous would be a lot more expensive than oral, so you think should the patient have this orally? As a pharmacist, you should be doing that.

Ivy

When you are putting their medicines from the [prescription] basket into the bag, you speak to the person; you tell them what you are putting in. That is an opportunity for them to say 'I've got one of those, I don't need it'. ... You can pick up waste ... that is important.

Hal

If you know somebody who's getting a very expensive medicine and regularly not taking it, you have to explore with them why they're not taking it. ... [A particular patient] doesn't take his warfarin ... and has to be given IV treatment. ... I've spent a lot of time with him ... [but he's not going to change his lifestyle] because that is the lifestyle he has chosen.

6. FINDINGS PART TWO - ETHICAL DILEMMAS

6.1 Introduction

Thinking about values and ethics necessarily means consciously acknowledging that professional life can involve conflicts between competing values, goals and commitments. In this section we will review some of the 'ethical dilemmas' associated with this fact. However it is important to note straight away that not everything reviewed here is necessarily recognised or labelled as a 'dilemma' by the practitioners themselves.

Ethical dilemmas arise for a range of commonly identified reasons; for example:

- When there are conflicts between obligations to different parties (for example, employer, patient or colleague) – how do you decide which obligation to put first?
- The weighing of consequences for these different parties – how do you decide which consequences matter and matter most?
- Conflicts arising from official constraints on actions (imposed, for example, by the law) – how do you decide between what is 'permitted' and what you personally believe to be right?

Another important source of dilemmas is:

- fundamental conflicts between competing values, whether personal, vocational, professional, or institutional.

For example, the commitment to the professional value of responsibility in relation to medicines can conflict with respect for patient autonomy. These fundamental value conflicts were not always identified or presented as 'dilemmas', or indeed as being about ethics. The ability to identify ethical dilemmas and to recognise the pervasive presence of value choices, even in routine situations, is itself evidence of ethical and values literacy skills. Such skills were not particularly evident in the data set.

Ethical dilemmas can become obscured in several ways:

- Routine working habits;
- Unthinking reliance on phrases or ideas (such as *the patient's best interests*);
- Limited appreciation of ethical concepts; and
- The insidious role of unacknowledged personal value judgments.

Different roles and working contexts additionally affect the nature of dilemmas that present within practice.

The remainder of this section considers dilemmas in three different groupings. Dilemmas appearing in all contexts are considered first. More context specific dilemmas are then considered, first in relation to community pharmacy and then in relation to hospital pharmacy.

It is important to appreciate that these are dilemmas current at the time of the research. Changing roles and responsibilities, especially through the growth in prescribing, suggest some contextual differences will diminish over time. Changing roles and responsibilities will, of course, also create new dilemmas.

6.2 Ethical dilemmas that appear across contexts

6.2.1 Owing up to medication errors

How and when to 'own up' to errors was identified as a dilemma but with the acknowledgement that their admission was normally important, whether or not there might be repercussions for the individual. The nature and severity of the harm (see also second extract in 7.2), or perhaps concerns that the consequences may be worse (for the pharmacist) if someone else identifies the error, suggests a general inclination towards 'admission now'.

Hazel

I had to make a decision about a mistake that had been made. ... a chart had been transcribed, but on the new chart the dose was different to the old chart, and I hadn't picked it up for about a week, I think. And it was at that point that I felt really uncomfortable because I had to admit that I had been in that role and I hadn't picked it up, and that involved telling the consultant. Yes, that was an uncomfortable time.

Ken

If I've made a mistake, then the first thing you do is hold up your hand and say 'I'm awfully sorry, I got that wrong'. Then you do your best to put it right as quickly as possible and hopefully that person doesn't go away and report you. ... I put it right and make sure that no harm's come to them.

6.2.2 Allocation of resources to practice activities

Although only formally identified by one participant, any decision about how to allocate time between competing responsibilities and practice activities is an example of a day-to-day dilemma. Participants commonly referred to the pressure on time, suggesting that this may well be unrecognised as constituting a dilemma, the resolution of which may draw on unreflective use of personal values in determining priorities. For example, in deciding which patients need to be spoken to about their prescription. Those participants involved in policy making or policy implementation faced dilemmas over the allocation of resources. In such contexts, the vocational and professional value attached to the individual patient may need to be adapted to reflect (greater) considerations about the interests of the wider public.

Guy

[Some] wards get a very casual, quick service and I'm thinking possibly some elderly care wards and things like this, where they only get two or three visits a week.

Kay

You have to [balance an individual's rights against] population rights. That's something that the pharmaceutical advisor job is very much based on. Because you're actually looking at population rights against individual rights.

6.2.3 Conflicts between personal religious or cultural values and professional obligations

Cultural and religious diversity within UK society is increasing and requires sensitivity to, and knowledge about, religious and cultural values, whether in relation to the individual practitioner, the patient, or other health care professionals. Very few of the participants identified dilemmas in this area. Respecting the values of patients in such matters is, of course, one potential opportunity for demonstrating (or failing to demonstrate) a respect for patients and patient autonomy.

Respect for a patient's cultural values may sometimes conflict with professional assessments of, and responsibilities for, maximising patient benefit. Contraception and abortion were two examples where conflicts between pharmacists own personal religious/cultural values and their vocational responsibilities were identified by a few participants. In one instance, strongly held personal values relating to the importance of preventing teenage pregnancies significantly reduced adherence to the guidelines for EHC provision. A few community pharmacists referred to specific cultural factors and gender differences between pharmacist and patient that affected the management of confidentiality and privacy (see also 5.3.4).

Len

Ethical issues [relating to drug administration] are the ones most overlooked. For example, you may have a patient who doesn't agree with animal products. And a lot of drugs are animal derived. If you think a drug is in the best interests of a

patient but it happens to contravene their deeply held belief, should you be giving it or not? ... there comes a point where if I really think that a drug is in the patient's best interests, yet it contravenes perhaps what they would have wanted should they be competent ... then, on occasion, I may feel, actually, I think it is probably best to give this drug. ...

Roshan

I don't [ask the age of girls requesting EHC]. ... if I didn't sell it, ... what would be the consequences? ... I say [to the girl] I will sell it to you because it's really important for me. ... If this girl has an unwanted pregnancy, what will her future be?

6.2.4 Dilemmas within relationships

Conflicts about trust, loyalty and honesty across working relationships create a range of ethical dilemmas (see also examples in 5.3.3). Resolving any conflicts about to whom loyalty and trust are primarily due may sometimes also raise dilemmas about the extent of honesty.

Will

An example might be you tell the little white lie to protect either yourself or a colleague who had forgotten to order a prescription item. ... There are times when to actually not be honest would not be a position that you could maintain.

As also exemplified earlier (see example in 5.3.5), a conflict arises where there are concerns about the lifestyle of a patient. The extent of respect for the patient's lifestyle frequently appeared to be regarded as providing a constraint on professional action, rather than an opportunity for health education. There were some attempts to check the need of a patient for each NHS funded medicine being dispensed, or to encourage prescriber use of the cheapest formulation. However, there appears to be an acceptance of a patient's lifestyle when associated with a lack of adherence to a treatment regime that may subsequently require additional NHS funded treatment. (See also example in 5.3.5).

Ansana

You can only tell the patients so much. I know the government wants the pharmacist to take care of lifestyle changes for the patient. I feel that every individual must take hold of their own life.

6.2.5 Competency concerns about colleagues

Within health care there is a growing awareness of the responsibility of health care professionals to raise concerns about a colleague's (doctors or nurses as well as pharmacists) inappropriate standards of practice and/or conduct. There were a few examples provided of such situations. The associated dilemmas include conflicts about the extent of loyalty to colleagues, the maintenance of the trust of the patient in the professional, and the well being of the patient.

Nat

The dilemma for me was, "Do I actually say anything? Have I got any grounds to say anything, to express concerns [about my colleague's competence]?" Then again, I suppose the nervousness in thinking, "How will this be perceived?"

6.2.6 Conflicts between professional responsibility for a patient's best interests and laws/rules/code of ethics/standard operating procedures.

The law, the professional code of ethics and practice guidance, rules (for example those provided by the employer), and standard operating procedures all provide guidance about the conduct of professional activities. There is then the potential for conflict between the feeling of professional responsibility for a patient and adherence to any such 'rules'. For example, the pressure to supply medicines against 'rules', whether in community or hospital pharmacy, creates a dilemma. Only community pharmacist participants raised concerns about being reported to the RPSGB where 'rules' had been broken, especially for infringements of the law and/or professional code of ethics; although some hospital pharmacists referred to the potential for litigation.

Eve

I've given emergency supplies of controlled drugs. ... This was a regular customer. I didn't want him to be without his painkillers overnight. ... You've got the Misuse of Drugs Act, but you've also got your Code of Ethics, what is it says? 'The pharmacist ... the welfare of patients'. So I decided in this that I was to take more notice of the Code of Ethics.

Fred

It seems some [hospital] sites, some pharmacists, operate on the basis that the only important thing is the supply to the patient. ... But what they seem to forget ... is the [official] standards around the compounding, for the sake of getting something out.

6.3 Ethical dilemmas within community pharmacy

Community pharmacy operates, commonly, within a retail environment, creating the potential for dilemmas where there are conflicts between commercial and professional responsibilities and values. There is a range of dilemmas relating to decisions concerning the supply of medicines (across the different legal classifications of medicines) in the treatment of patients. Examples include situations where the prescription may be incorrect or considered inappropriate in some way, or there may be a need to make an emergency supply. Over-the-counter sales provide the potential for conflicts between professional autonomy and patient (consumer) autonomy, as well as between profit-generating expectations of owners (corporate or individual) and patient interests. Generally, if a sale was refused, an explanation to the patient about the reason was provided, or an alternative course of action recommended, such as going to the doctor if the condition was considered serious. Stemming from *respect for medicines*, there was an acceptance of the need to be aware of the potential for patient misuse of medicinal products.

Mary

[My employers] have said that we have to push the bigger pack [of painkillers] and I won't because I personally don't think it is right. ... We are also told to give the branded product if someone asks for it. We're not to let them know there is a cheaper generic. I don't think that is right. ... So if someone asks me for the branded product, I'll say 'we've got our own version and it's exactly the same and it's half the price. It's up to you'.

Tom

If somebody is abusing a medicine, and you know they are, and you also know that if you refuse the sale, they'll just go down the road and get it at another pharmacy. So some people will say 'why don't you sell it, it will put money in your till?'. No. You cannot take responsibility for what the other person does but you are responsible for what you do. Therefore 'No, I'm not selling to you because I don't think you need them and think it is dangerous for your health.'

6.4 Ethical dilemmas within hospital pharmacy

Hospital pharmacists, (as well as those working with primary care trusts) may have to make decisions about which patient/s should be allowed access to treatment. Protocols may identify which patients can have which treatments. Patients in hospital may be sedated, mentally or terminally ill, or in other ways regarded as non-autonomous. Thus, quality and value of life related ethical considerations are likely to be more apparent dilemmas within hospital pharmacy. However, within the research the identification of such dilemmas as being about 'ethics' was unusual.

Wendy

There was a patient with chronic schizophrenia who was refusing her drugs. ... she was having to be pinned to the floor and given a syringe ... it's a lot easier to give people an injection against their will if it's an injection. ... Me and the medics were on one side, and the nurses were on the other side. ... Well, the [patient] is on a section, she ain't got no rights. ... This was being cruel to be kind; ... this drug is the only drug that has got a chance of helping this lady, who lived in a chronic psychotic state.

Len

We often get into discussions about whether that drug is appropriate to give to a particular patient if they have quality of life issues, or if they're not expected to survive beyond the next – well, where do you draw the line?

7. FINDINGS PART THREE - DECISION-MAKING

7.1 Introduction

Some common approaches to reasoning and decision-making are apparent. An emphasis on a broadly scientific model of rationality, or what is sometimes called a 'technical-rational' approach, predominates in explicit accounts of decision-making (although in practice this approach is mediated through sometimes unreflectively held personal value judgments – see below). Such an explicit emphasis on a 'rational' approach can obscure the way that value judgments and ethics are embedded in decisions and, more particularly can lead to the sidelining of considerations of patient autonomy, the public interest and social justice. As well as producing a tendency towards paternalism this emphasis on professional agency, judgment and responsibility can, on occasions, lead to practitioners' personal value judgments overriding sources of guidance.

7.2 Fundamental approach

The most common approach, irrespective of whether the decision related directly to some aspect of treatment or some more general policy or practice choice, is one that relies on the assembling of evidence, through the collation of facts, and a broadly scientific rationality. (See also 5.2.1.)

Scientific, or technical rationality, is loosely associated with utilitarian assessments about the consequences of actions. These are, in turn, frequently associated with the methodology of science and its attachment to 'hard' knowledge and facts. 'Calculations' about harms/benefits become key considerations. However, personal values may play an especially important role in resolving how to balance conflicting harms/benefits considerations: scientifically the solution is not always simple and clear cut. The associated concept of the patient is primarily as a physiological body, rather than as a person whose autonomy should be respected.

Within the practitioners' accounts the dominant focus was on assessments about the harms/benefits of courses of action, whether or not the decision was directly concerned with the use of medicines. Considerations about the patient as a person and consequences to the wider society appeared only to a very limited degree, the latter predominantly in connection with concerns about patient wastage of medicines (see examples in 5.3.5).

Professional decisions may need to be justified, for example to the professional body, employers, or other health care professionals. A view that very often prevailed is that accountability for decisions was related to justifications about the patient's best interests. The emphasis on the practitioner's assessments about the patient's best interests, commonly related to the safe and effective use of medicines, may explain the relatively low emphasis placed on patient autonomy and thus the often-apparent paternalism. The acceptance of professional responsibility for the patient led to the exercise of professional agency in breaking rules, where that was considered appropriate.

The gathering of evidence is an important component of the technical-rational approach to decision-making. Such a desire to gather evidence before making professional judgments was apparent in a range of situations: from decisions about medicines to considerations about reporting concerns about the competence of colleagues. Potential sources for 'the evidence' or 'the facts' include specialist reference sources, colleagues, experience and the patient. The first three of these sources for 'the facts' were often cited within the research. However, the patient as a source of evidence was rare in the hospital pharmacists' interviews, although a little more visible within the community pharmacist interviews. Maintaining the profession's reputation in front of other health care professionals was also an important consideration referred to, and one which led to careful preparation to ensure confidence in the quality of any evidence used.

Len

When I'm up on the wards I've already made those decisions [on the basis of evidence] behind the scenes and I don't need to think about them again. That bit is done and out of the way. And ... if I am asked 'Why are you recommending this particular ...' [by the consultant] I'd say 'Well, I can present this little bit of evidence, blah blah', which I think is actually compelling and I've got a case to support it with.

Paul

It is appropriate that if the therapeutic risk is low, you haven't to make too much fuss even though the mistake might be quite vast.

7.3 Considerations relating to the patient

The most common focus, in treatment contexts, appears to be on the patient as a body, and associated ideas about norms of bodily functions. That is, the workings of bodily functions, whether measured against known physiological measurements or pharmacological parameters. The patient as a direct resource for decision-making, for example through their experiences of treatment or specific requirements, was rarely evident. The approach suggests a limited respect for (or understanding about) patient autonomy as a formal consideration within decision-making, and opens up the potential to fail to identify, ignore or override patient's personal perspectives or cultural or religious requirements. (See example in 6.2.3.)

7.3.1 Pharmacist constructions about the patient

Some patient-specific considerations were apparent within the research. Assessments about the patient's condition, for example, the severity of pain, and temporal effects in delaying treatment are two considerations. However such constructions and judgments about particular patients can be mixed in with much less 'scientific' considerations. These include assessments about the patient's own responsibility for their position, with, for example, some suggestion that 'lazy' patients may be treated less favourably on occasions. Personal preferences for patients may clearly conflict with justice concerns, for example, in relation to the impartial allocation of resources, including time. Liking a patient may in turn lead to greater tolerance, better care, or a willingness to take a bigger professional risk.

Eve

[I wouldn't dispense an emergency CD prescription] if I thought they had been a bit lazy ... or a bit lax. ... A patient that I know, I know there is a need for it.

7.3.2 The patient's life

Other areas where personal values can become entangled with more scientific reasoning include assessments about the patient's lifestyle, quality of life, and value of life. It seems that pharmacy practitioners are reluctant to directly intervene in matters relating to patient lifestyle (see example in 5.3.5 and in 6.2.4). There are likely to be institutional rules (if not legal constraints) about matters relating to assessment of capacity and competence in patients. But judgments about mental capacity, quality of life and value of life also have an ethical dimension (Beauchamp and Childress, 2001) and the implications of this dimension, and the role of personal values about such matters, were not always recognised.

Jan

It's a hard one [providing lifestyle advice]. Because you know, for their overall benefit they'd do a whole lot better if they weren't drinking that much alcohol, but, at the end of the day, that's a whole lifestyle choice and whole lifestyle change. ... I think if there's any type of mental damage, or a significant amount of mental impairment, then for me, I can say that's not a great quality [of life].

7.3.3 The patient's involvement

The use of the patient as a source for information and the patient's involvement in decision-making appears relatively limited across all contexts. One exception was apparent within community pharmacy. Here, concerns about a patient's prescription could lead to 'checking with the patient' before deciding whether or not the prescriber needed to be contacted with a prescription query. A number of informants spoke about providing information to the patient, and this may be the most frequent manner in which patient autonomy is both understood and respected.

Eve

A lot of the time you can resolve the problem with the customer ... rather than jumping straight on the phone to the doctor.

Hal

On the wards, the pharmacists will have a profile of the patient, look at what the patient's condition is, look at the medication therapy they are on, see if it is appropriate medication ... look to see if there any drug handling issues that means the treatment needs changing.

Dot

They have the right to knowledge [but if they don't want to know] then, based on what their answer was I'd be able to respect their wishes and say 'Well, that's fine, I won't throw all these information leaflets at you then'.

7.4 Other factors in decision-making

7.4.1 'Rules' (see also 6.2.6 above)

The report has already highlighted several issues relating to the use of rules within practice activities. Rules, where the term is used broadly to include sources such as the law, professional codes and institutional protocols, provide a potential source for guidance. Rules are generally designed to meet one or more objectives; for example, in the context of health care to manage health care effectively, safely and fairly. The research suggests that the practitioners disregarded 'rules' when they were considered to be working against professional responsibilities to act in a patient's best interests. Detailed knowledge of the professional Code of Ethics was limited, dated, and appeared to be considered relevant only to community pharmacists. (See also the first example in 5.3.3)

Jan

So, I'm working to a protocol, yet I'm working on my own. I suppose I feel quite autonomous in that. I haven't got a medical team to vet my decisions, my decisions stand. I suppose I have to run them by the patient.

Len

First do no harm is an ethical principle and nowhere will you find that written in any code of conduct. At least, I don't think it is in our code of conduct, yet it is a principle we all adhere too.

7.4.2 Experience

Competence in decision-making is commonly linked with experience, and a number of participants identified experience as a valuable aid to decision-making. However,

experience frequently leads to the creation of personal and habitual rules, which in turn may preclude the identification of situations requiring a different resolution.

Eve

What I think what helped me – it's one of those things where a few years being qualified kind of gives you the confidence to make [that kind of] decision.

Jan

A number of times I deviate from my protocol but that is based on my experience.

7.4.3 Discussions with colleagues

Working within a team, whether only of other pharmacist colleagues, or a team of health care professionals, can modify the emphasis on sole decision-making. Hospital pharmacists acknowledged the value of being in a team, providing the opportunity to discuss decision-making situations with other pharmacist colleagues; some community pharmacists commented that their isolation from other colleagues was a problem in complex situations.

There was a general sensitivity to the power of doctors and their responsibilities as prescribers were sometimes regarded as a constraint on pharmacist accountability. As a result, concerns about any prescription that required referral back to the doctor, were approached with great caution. Typically, the assessment of the extent of harm to the patient was the deciding factor. The presentation of evidence, for example about the options for medicines usage, to a prescriber appeared often to be based on an assumption that the 'facts' would speak for themselves (see example in 7.2).

Dot

When I first came into hospital, I was a bit kind of cautious about, 'Can I do this? Can I change that?' ... And now I'm a bit more confident about actually doing things that I've seen other pharmacists do and I'm happy to do. ... whenever I have changed something for the first time I've always gone to another pharmacist and said, 'Do you think it's OK for me to do this?' And they've gone, 'Yep, that's fine, we always do that,' and then I know that I can do that, so I don't do it off my own bat, I always make sure it is one of the polices, or other pharmacies have been doing it, it's standard practise.

Roshan

... difficult decisions have to be made in a manner where you are convinced what you're doing is right. And in those situations it is helpful to have someone to talk it over with.

Hazel

Although as a pharmacist you can put forward your opinion, it is always the clinician that has the final say. It is only on their final say that medication is started or discontinued.

Will

I go against the prescriber [where I think the dose is wrong and the prescriber is insistent] and rely on the patient, as it may seem more appropriate. I suppose that is betraying his trust [but I do it] for self-preservation ... litigation.

7.4.4 Professional versus commercial values (see also examples in 5.3.1 and 6.3)

A community pharmacy is normally also a retail business and hence is a commercial environment as well as a professional one. Decisions may then require balancing conflicts between professional or commercial values and organisational rules. The research suggests a general preference for professionalism over unmediated commercialism (see example in 6.3), which may be driven by considerations about the maintenance of both customer loyalty and trust. Another area of concern here may be the perceptions of GPs about the commercial nature of community pharmacy. GPs sometimes place pharmacists in difficult situations by, for example expecting proprietary prescription items to be dispensed against generic prescriptions, whether for themselves or patients. 'Face saving' by community pharmacists may then be an important consideration, even if it carries an adverse financial cost.

Ansana

Just to keep the peace with that particular doctor, I have [dispensed proprietary items against a generic prescription] actually done it for him. Where do you stand? I don't know. Because I draw my prescriptions from that particular surgery.

7.4.5 Communication strategies

The use of carefully considered communication strategies is an important tool in decision-making, for example to help to minimise any potential loss of trust and loyalty. Examples of such strategies that appeared within the research included: careful choice of words, cautious disclosure, writing on patient ward notes, sharing information, remaining silent, withholding information, 'fobbing off', and lying (see also examples in 5.3.3 and in 6.2.4).

Roy

I'm giving advice to the patient if they ask me the appropriate questions. I'm giving advice to the doctor if he asks me something. I'm not going to say to the patient, 'this doctor's told you something wrong'. I'm not going to say the doctor is wrong. I'd tell the doctor he's wrong. I wouldn't tell the patient the doctor is wrong. ... I might say 'I think there might be a problem about dose or side effects of this medicine.'

7.5 Decisions to report on the poor performance of colleagues (doctor, nurse or pharmacist) (see also 6.2.5)

Where a prescriber's actions are considered to be harmful to a patient, then considerations about loyalty (to the prescriber) and maintenance of patient trust (in the prescriber) will both take a secondary place. Additional considerations that were identified related to concerns about wastage of taxpayers money, the reputation of the profession, employer reputation, experience and sufficient evidence, or as a part of responsibility for clinical governance. Similar considerations apply where the concern is with the competence of another health care professional, including pharmacists.

Nat

Things were going on that weren't right. And it was using taxpayer's money.

Tom

[I report them] because the reputation of the profession is important.

Roy

Unless I'd seen something absolutely dreadful, I don't think I would have had grounds to report them without giving them a fair crack of the whip. ... I would probably bring it up with management before I reported them. ... Patient care [would need to be] severely compromised, resulting in possible injury.

7.6 Ethical and values literacy

The stress on scientific rationality and reliance on evidence appears to largely restrict ethics to a consideration of harms and benefits, set within a scientific/technical-rational framework. There is an associated tendency to exclude the patient from involvement in his/her own care, a sidelining of the identification of professional responsibilities to wider society, and an inappropriate attachment to harm/benefit assessments in relation to quality/value of life and patient competence decisions. As a result, ethical decision-making becomes blurred with treatment decision-making.

For those involved in resource allocation decisions (policy formation or implementation), a limited grasp of the many complex concepts related to the public good and justice considerations may reduce ethical decisions about resource allocations to cost/benefit analysis.

Nat

How do we define what services someone needs? You've actually got to say 'well, yes, I can see there's a benefit there but actually it's too much money'. ... You've got to say 'What's the evidence?'

8. IMPLICATIONS

8.1 Introduction

Pharmacy practice is not static; policy change, along with wider social change, shapes the range and manner of practice activities. Changes in policy provide for the development of new clinical roles, including greater responsibility for prescribing, and extended roles within public health through the provision of lifestyle guidance. The form of health care delivery itself is changing; with, for example, more emphasis on inter-professional shared care and the extension of community-based health care delivery. The numbers of kinds of accountability within certain practice activities is increasing. Broader social changes include a lessening in the acceptance of authority (including even in the certainty of science), the growth of patient choice and autonomy, and increasing cultural diversity (of both patients and health care practitioners). The growing use of technology, for example in electronic prescribing and the proposals for a centralised database of all NHS patient records, bring additional dilemmas, which may be obscured by the technology itself.

Impact of policy and societal changes:

- Growth in clinical roles.
- Nature of accountability becoming more complex.
- Membership of a multi-disciplinary team and shared care.
- Increasing patient expectations for involvement in own care.

- Cultural and religious diversity.
- Wider responsibilities to society for equitable, efficient and economic use of resources.

The changes in day-to-day practices increasingly faced by pharmacists create new situations that require complex trade-offs between differing sets of values. A more sophisticated literacy about ethics, ethical concepts, and a greater sensitivity to the pervasiveness of value judgements would strengthen professional practice. Pharmacists' reasoning and decision-making might then include a more explicit and deliberative handling of ethical considerations, as well as a more reflective appreciation of the role of values in practice.

Greater ethical and value literacy could also further develop the respect of other health care professions in the pharmacy profession, helping to foster the co-operative spirit needed for shared care. Moreover, those members of the pharmacy profession contributing to either health care policy formation and/or its implementation could do so with a broader range of expertise and articulacy.

Most obvious is the need for: -

- greater attention to the ethical concepts of patient autonomy and distributive justice; and
- greater familiarity with ethical concepts and debates related to quality or value of life.

Through this means, for example, pharmacists would become better able to make distinctions between the harms/benefits attached to alternative courses of treatment and the broader ethical and value components of decision-making.

Implications for professional development:

Improved ethical and values literacy to support the following: -

- Appreciation of the role of values in framing problems, identifying options, and making choices;
- Identification of ethical dimensions within day-to-day practice;
- Reduction in the tendency towards paternalism and the greater involvement of patients in own care;
- Respect for cultural and religious values;
- Broader understanding of key ethical concepts including beneficence, non-maleficence, autonomy, and justice;
- Shared care with other health care professionals; and
- Policy development and implementation e.g. in relation to resource allocation.

Development of communication skills enabling the elicitation of the perspectives and values of others and leading to decision-making that is: -

- More reflective and draws on a wider base of considerations
- More sensitive to the role of value judgements, acknowledges the problems in use of habitual rules, and the complexities arising from partiality to patients
- Appreciates pharmacy's responsibilities to the wider society

8.2 Clinical roles

8.2.1 Professional judgements

The increasing recognition by the wider health care community of the central role of values and value judgements in decision-making (Fulford, Dickenson, Murray, 2002), suggests that the existing approach to decision-making, framed currently by an emphasis on evidence, scientific rationality and associated assessments of harm/benefit, needs to be broadened.

The reported use of individual professional agency to 'break' rules needs to be set in a wider context that considers, in addition to the harm/benefit for a patient, the effect on rules that have been designed for broader ends (such as distributive fairness in the allocation of resources). Shared care is likely to lead to an increase in the presence of protocols and standard operating procedures. Decisions to break any such 'rules' will need an account justifying such actions that is more complex than paternalistic assessments about the patient's best interests. The personalisation of 'rules' risks undermining universalisability, and may create difficulties where other pharmacists interpret the rule differently. Personal rules may also lead to habitual use, encouraging a personal framework for decision-making, and increasing the potential for unwarranted partiality to specific patients.

The research also suggests that the Code of Ethics (at the time) was regarded as primarily relevant by and to community pharmacists, who in turn had limited and dated knowledge of the contents.³ Three other gaps between the stated aspirations of the Code (at the time) and practitioner narratives were apparent. These were: -

- the principle of involving patients in decisions about their own care;
- the need to consider the public good; and
- partnerships with other health care professionals.

The current comparatively limited engagement with the patient as a person (rather than the patient as a body) needs to be reframed to encourage the greater involvement of patients in decisions relating to their care. In this process the identification of patient perspectives and values becomes ever more important.

8.2.2 Prescribing and health education roles

Community pharmacists especially have long had a role in over-the-counter prescribing, but both hospital and community pharmacists have increasing roles in the prescribing of prescription medicines. Regarding such a role as only a technical-rational activity marginalises other important considerations. Prescribing is more complex. It does of course involve technical expertise, but this expertise should be seen in the context of the sometimes conflicting demands arising from the wants and needs of a patient on the one hand and the collective good on the other (Cribb and Barber, 1997).

The potential contribution that pharmacists (in both community and hospital) can make to health education has been identified for some years. It remains a role with which many pharmacists seem reluctant to engage. Health care professionals have a

³ Proposals for a revised Code of Ethics include the statement that pharmacists 'must abide by its principles irrespective of the job you do' (Pharmaceutical Journal, 11 November 2006 Vol. 277, No. 7426 page S3).

professional responsibility to share their expertise and to manage the effective and efficient use of health care resources, and the provision of health education may help to support more appropriate use by patients of their medicines, or provide a greater understanding of specific health issues. It is possible that there is limited understanding of the opportunities and requirements of such a role. The reluctance to engage in health education activities, commonly argued on the basis of respect for patient autonomy, would seem to indicate a specific developmental need, if such a role is to be accepted. A greater understanding of the distinction between, and relationships between, 'creating autonomy' and 'respecting autonomy' may help to support such activities.

8.2.3 Shared care

Shared care requires the engagement with, and understanding of, the objectives/values of a team and its individual members. Personal constructs and value judgements help to determine individual perceptions about appropriate outcomes for the patient. So, sensitivity to one's own individual and professional values and the ability to identify and understand the values of other health care professionals is very important. In some cases doctors and nurses may have greater familiarity with ethical language and explicitly draw on ethical considerations in patient care. Any lack of ethical literacy and sensitivity will inhibit participation in team discussions and decisions, potentially reducing the effectiveness of pharmacist contributions.

Increases in the number of health care professionals in the care loop, (and the inevitable changes in membership of that care team) make it ever more important that actions and reasons are documented, probably a marked practice change for many community pharmacists. The sharing of care thus has increased implications for confidentiality. For example, in the way patient requests for confidentiality should be managed when information provided has implications for the care of the patient by the wider health team. Increasing ethical challenges about such situations, which may well justify breaches, will arise and will require formal ethical consideration.

8.2.4 Accountability

The growing involvement of both community and hospital pharmacists in clinical activities, such as prescribing and medicines use reviews, enlarges the range and number of accountabilities. This balancing of accountabilities (e.g. between the individual patient and other stakeholders) increases the likelihood of ethical dilemmas and of decisions relating to conflicts in loyalties. Personal, vocational, professional and institutional values all influence how those accountabilities are perceived and prioritised.

Accountability within a team affects the way decisions about care are agreed, and justified. A focus on unmediated individual professional agency (or independence) becomes increasingly insufficient.

There are increasing pressures on health care resources. Some of the new clinical roles increase the 'double agent' role (i.e. the tension between professional responsibilities to a patient and responsibilities as a gatekeeper of resources) through activities such as monitoring compliance and other factors relating to a patient's use/misuse of health care resources. The current existing sense of responsibility and loyalty to an individual patient needs increasingly to be set in the context of professional responsibilities at the population level (Cribb, 2005).

8.3 Changes in society

Increasing cultural and religious diversity within society, combined with the greater emphasis on patient rights and choice, brings a requirement to identify, respect, reflect on, and manage value conflicts. Greater respect for the patient, through their active and informed involvement in their own care, requires engagement and familiarity with, and respect for, patient perspectives and values (cultural and religious). The current apparent tendency towards paternalism will need readdressing in two (sometimes conflicting) ways. First, by the need to involve the patient. Second by increasing the acceptance of professional responsibilities for the effective use of resources. Decision-making will thus need to consciously include the management of what are sometimes conflicts between professional autonomy, patient autonomy, and professional responsibility to the wider society.

The reliance on harm/benefit assessments for patients identified as being non-autonomous, or related assessments about quality and value of life need to be moderated. Practitioners should be able to identify such situations as having significant ethical components where harm/benefit assessments have a role but are only one consideration.

The changing cultural and ethnic mix of society is reflected amongst health care professionals themselves. The need for sensitivity to, and understanding of, potentially differing cultural perspectives has a role in contributing to effective team working.

9. RECOMMENDATIONS

9.1 Introduction

The research identifies much strength within pharmacy practice, but also identifies the need for further developments of the profession. If the profession is to respond to new challenges, it needs to grow so that it can continue to make effective contributions to health care in the 21st century. Our prime recommendation is the need for the profession as a whole to acquire greater literacy in ethics and values.

The repeating of key themes across the individual sections of the report, especially 5, 6, and 7 suggest that some key modifications have the potential to have a wide impact on professional practice. For example, an understanding of the limits of scientific or technical rationality and the sometimes unacknowledged but pervasive influence of personal constructs and values, will enhance the quality of decision-making. A wider grasp both of ethical concepts and of what is involved in ethical deliberation will both aid the identification of ethical dilemmas and lower the risk of them being reduced to purely technical questions. A wider understanding of the concept of justice, especially distributive justice, would support the need for the professional to acknowledge his or her 'double-agent role', and the need to balance loyalty to a patient with responsibilities to the wider society.

9.2 Developing *respect for medicines*

In terms of the identity of the profession, the substantive values associated with *respect for medicines* remain important in maintaining the identity of the profession, but some broadening is required. In particular there is a need to: -

- Accept that the application of a scientific or technical-rational approach is not always appropriate.
- Grasp the considerable extent to which values act as the hidden interpreter of the 'facts', including in assessments of harm and benefit.
- Appreciate that the sources of such values include personal, vocational (i.e. relating to pharmacy), general professional, and contextual (i.e. of the employer and institution).

9.3 From *the patient's best interests* to *respect for people*

The reliance on ideas or phrases such as *the patient's best interest* may encourage sometimes unjustified paternalism. Also, as is widely understood, and is reflected in the Code of Ethics and in this research, the patient is not the sole, and sometimes not the central, consideration. The use of the idea of *the patient's best interest* thus risks obscuring and minimising reflective awareness of the range and nature of 'people' who need consideration. Encouraging the profession to move away from the use of the idea of *the patient's best interests* to the richer idea of *respect for people* could play an effective role in helping to change the prevailing way of thinking.

Encouraging the profession to think more in terms of *respect for people* would support broader moves towards:

- Acknowledging the right for a patient to be involved in his/her own care.
- Providing respect for cultural and religious diversity.
- Acknowledging professional responsibilities for the wider society.
- Enhancing sensitivity to the values of other team members.

9.4 Educational and training initiatives

Educational and training initiatives are critical for supporting the development of the necessary ethical and values literacy.

9.4.1 Ethical and values literacy

An appreciation of the need for such developments and the ability to manage them, needs to be founded on a greater values and ethical literacy. Improving familiarity with ethical concepts is essential in: -

- extending the range of considerations in decision-making;
- reducing the reliance on harm/benefits when confronting ethical issues; and
- improving the identification of ethical dilemmas.

Such literacy would: -

- Improve the identification and management of ethical and value components within day-to-day practice dilemmas and decisions.
- Strengthen the requisite skill set, for example, those relating to managing conflicts between professional and patient autonomy, or between professional responsibilities to the patient and to the wider public.

- Promote greater respect for the values of patients and other health care professionals.
- Enhance the contribution pharmacists make to shared decision-making, whether in the care of an individual patient or in policy discussions.

The development of such literacy needs to be set in the context of professional practice. At undergraduate level this should be included as part of professional decision-making and communication skills development.

9.4.2 Literature references to educational initiatives

A brief review of some educational initiatives is provided elsewhere (Benson, 2006). Such initiatives will need to have a wide target audience, from the policy makers within the RPSGB, to those responsible for undergraduate and postgraduate education and continuing professional development as well as within specific job functions. The authors acknowledge the existing pressure on the undergraduate syllabus, but suggest that failures to support ethical and values literacy may lead to marginalising the profession from other health care professionals.

9.4.3 The four principles of bio-medical ethics

Within health care, the four principles (beneficence, non-maleficence, autonomy, justice) have gained much credibility. The research indicates that ideas connected to these four principles are drawn on by those participating in the research, but typically in an uninformed and ad hoc manner (especially when compared to the complex possibilities reviewed in the key source book, *Principles of Bio-medical Ethics* by Beauchamp and Childress, 2001). Greater familiarity with the range of ideas connected to each of the principles would provide a gateway to broader thought and debate (Cribb and Barber, 2000), and support literacy development.

9.5 Concluding comments

Pharmacists make an essential contribution to health care. These recommendations are made with the intention of supporting that contribution; so ensuring pharmacy practice develops to meet current needs and opportunities. It is essential that pharmacists maintain their place within health care, and that they have the facility to engage with the inevitable ethical and values dimensions of health care.

Responsibility for the management of these recommendations lies predominantly with the professional body, the RPSGB, as it is the regulatory body with the responsibility for ensuring its members practice legally, ethically, and competently. The combined phrase *respect for medicines and respect for people* may help provide a theme, and a vision, which, when supported by educational initiatives in ethical and values literacy, would strengthen the conceptual framework within which pharmacy practice develops. The Council and staff members have the opportunity to lead by example, through their continued commitment to reflection on pharmacy values and engagement with pharmacy ethics, as well as by their working to build greater understanding and expertise within the profession as a whole. The research suggests that the professional Code of Ethics is not valued as a guide for professional standards and behaviour, with current knowledge of it limited and applicability primarily a concern for community pharmacists. Although the proposed new Code of Ethics (see footnote 3) specifies its applicability to all registered pharmacists, effort will be needed to ensure that this becomes the accepted practice.

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