

**ETHICAL PROBLEMS AND THEIR RESOLUTION
AMONGST UK COMMUNITY PHARMACISTS: A
QUALITATIVE STUDY**

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ABSTRACT

This thesis explores what UK community pharmacists experience as ethical problems in their work, how they try to resolve such problems and how the community pharmacy setting may be of influence. Utilising existing normative ethical theories, but acknowledging the status of empirical ethics research and also the social context of ethical problems, semi-structured interviews were conducted with a purposive sample of twenty three community pharmacists from the north of England, UK. It was found that pharmacists encountered ethical problems in the routine minutiae of dispensing prescriptions and medicines sales. Ethical problems often involved legal and procedural concerns and could be distinguished from philosophical dilemmas and many pharmacists understood law and ethics synonymously. Ethical passivity emerged as a description of pharmacists who were ethically inattentive, displayed legalistic self-interest and failed to act ethically. Ethical reasoning was often incomplete and involved appeals to consequences, the golden rule, common sense and religious faith. Some pharmacists were ethically active and sensitive to ethical issues and experienced ethical doubt and uncertainty. The code of ethics and the advice of professional bodies were not considered helpful. The community pharmacy setting precipitated ethical problems and was inimical to ethical practice since pharmacists' relative isolation from others precluded ethical discussion and relationships; pharmacists' subordination to doctors precipitated problems and vitiated ethical responsibility; routinization of pharmacists' work meant difficult ethical situations could be avoided. The findings of this thesis raise questions as to how pharmacists can be effectively educated in

ethical issues at an under- and post-graduate level; how values can be adequately transmitted within the profession given the ineffectiveness of the code of ethics; whether pharmacists are ethically prepared for new primary care roles; and whether isolation and subordination may be ethically problematic in healthcare more generally.

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ABBREVIATIONS

ANA	American Nursing Association
BMA	British Medical Association
CAQDAS	.....	Computer Assisted Qualitative Data Analysis Software
CD	.....	Controlled Drug
CMD	.....	Cognitive Moral Development
DIT	.....	Defining Issues Test
EHC	.....	Emergency Hormonal Contraception
GP	.....	General Practitioner
GMC	.....	General Medical Council
MEP	.....	Medicines, Ethics and Practice. A Guide for Pharmacists
MUR	.....	Medicine Use Review
NHS	.....	National Health Service
NPA	.....	National Pharmacy (formerly Pharmaceutical) Association
OTC	.....	Over the Counter
P Medicine	.....	Pharmacy Medicine (only available for supply in pharmacies)
PAS	.....	Physician Assisted Suicide
PMR	.....	Patient Medication Record
POM	.....	Prescription Only Medicine
RPSGB or RPS	.....	Royal Pharmaceutical Society of Great Britain
PACT	.....	Prescribing Analysis and Cost Tabulation
PCT	.....	Primary Care Trust
UK	.....	United Kingdom

1 WHY STUDY ETHICAL ISSUES IN COMMUNITY PHARMACY?

1.1 INTRODUCTION

In this first chapter, I set out the reasons why a study of ethical issues in UK community pharmacy is necessary and provide an indication of the scope of the thesis. This introductory chapter will also explain why I became involved in the research and will offer a brief overview, chapter by chapter.

This study is intended to add to the literature on empirical ethics within healthcare – that is, research that uses the analytical tools of the social sciences to gain an understanding and increase our knowledge of ethical aspects of healthcare - but focusing upon the specific issues that arise within the community pharmacy setting for pharmacists. In particular, I am interested in what ethical issues arise and how pharmacists understand and describe such problems. A linked concern involves how pharmacists then attempt to resolve the ethical issues they identify and experience in their work. But as will become apparent, I am also interested in why such ethical issues arise and why pharmacists try to resolve them as they do in relation to the unique environment of UK community pharmacy.

Using empirical techniques to consider what have until recently been considered to be the sole preserve of moral philosophers is not an uncontested task and in this and the following chapter, an attempt will be made to sketch out the background to what appears to be an enduring debate about the place and value of empirical social

science research into ethical concerns in healthcare.

Setting aside this debate for the moment, a number of initial points should be noted that might inform and also orientate the reader as to why the present study of community pharmacists' ethical issues is necessary.

1.2 ETHICS IN COMMUNITY PHARMACY

Community pharmacists are engaged, both as members of society generally and also as members of a health care profession, in many activities that could be the subject of ethical enquiry. They go about their lives and work undertaking activities that may lead to questions as to whether what they do is appropriate, right, just or legal. In using such language, one can identify the normative claims that are made upon individual's activities and pharmacists are not exempt from such analyses. These claims arise in relation to the expectations of a number of parties – most obviously, perhaps, the patients and customers who use the services of pharmacies in the UK but also others who interact with pharmacists such as other health care professionals, pharmacists' own peers, pharmacy inspectors and, increasingly, pharmacists' employers. But it is also possible to think of ethical matters in community pharmacy from the perspective of the actual pharmacist and to reflect upon what ethical issues might mean to pharmacists and to consider the reasoning processes they use to deal with such problems. As will become apparent, one of the central aims of this thesis is to understand what ethical issues mean to pharmacists and to recognise the interpretative aspect of social phenomena like ethical issues

and ethical decision-making from the perspective of the pharmacist and as *they* understand these concerns.

In addition, such ethical claims must also be considered in the context of the pharmacy environment and in relation to community pharmacy's distinct place in the delivery of health care in what in the UK is referred to as primary care. The community pharmacy setting is a unique setting and can be distinguished from other areas of healthcare such as the secondary care environment of the hospital due to a number of reasons. It is a commercially-driven, retail environment, where, as one of the participants in this study noted, pharmacists may still be regarded as 'shopkeepers' but it is also one in which increasing corporate ownership of pharmacies is making different demands of pharmacists *qua* employees in larger organisations. Pharmacy has been identified as an occupation that may struggle to reconcile what have been argued to be the disparate aims of commercial profitability and professional altruism (Denzin and Metlin 1968, Kronus 1975) and hence *caveat emptor* may be incompatible with *credat emptor* – let the buyer beware and let the buyer trust, respectively (Hughes 1958).¹ Although sociology's relatively brief flirtation with pharmacy centred upon changing definitions of a profession and whether pharmacy was 'an incomplete profession' (Denzin and Metlin 1968) or 're-professionalised' (Birenbaum 1982, Holloway 1986), the attention stemmed from the particular place of pharmacy in relation to other areas of health care. Although other health care roles are involved with medicines,

pharmacy has been argued to be uniquely placed to undertake the symbolic transformation of chemical, technical drug into the patients' and consumers' medicine (Dingwall and Wilson 1995). Furthermore, the community setting is not usually involved in some of the more high profile ethical issues that arise in the medical ethics literature or that are reported in the popular press. A review of the recent popular press reveals ethical concerns about conjoined twins, face transplants and the pre-selection of embryos to eradicate genetic diseases and to select gender, for example, but community pharmacy remains largely untroubled by such concerns. As Brazier notes:

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 properly, we barely even notice its importance. (Brazier 2001 p. xxii)

This thesis attempts to consider pharmacists' ethical concerns in the light of such remarks and to reflect on what might be of ethical concern for pharmacists, even if they appear to be neglected in relation to more dramatic areas of healthcare such as medicine.

Until relatively recently, however, enquiries into the ethical conduct of individuals has proceeded normatively – that is, from philosophical debate about what might promote the most good, constitute right conduct, or result in the best way to live.

¹ A compelling visual image may be found in Edward Hopper's *Drug Store* (1927), for example, which plays with the contrast between the sober drapery and carboy displays and the advertisement for laxatives.

As the next chapter will consider, from early Hellenic thought, through to the Enlightenment and to the present day, philosophers have offered arguments that can be used to assess individuals' conduct and lives. But more recently, there has been a burgeoning interest in applied ethics and to enquiries about more specific activities, as opposed to meta-ethical and metaphysical debate in moral philosophy. Such applied fields have attempted to use philosophical analysis to inform and resolve ethical issues that arise in particular areas of society. Pharmacy has not been excluded from normative debate and a number of publications offer advice on how ethical issues within the pharmacy setting can be resolved and examples include Veatch and Haddad's *Case Studies in Pharmacy* (1999), *Ethical Issues in Pharmacy* edited by Weinstein (1996) and Appelbe, Wingfield and Taylor's *Practical Exercises in Pharmacy Law and Ethics* (2002). However, as noted above, it is increasingly being recognised that the empirical description and analysis of ethical issues may have considerable relevance and benefit, not only to practice but to philosophical debates, too. The relevance of empirical ethics research has even been championed as the saviour of traditional ethics and Hoffmaster (1992), for example, has argued that applied ethics has failed medicine in particular. Normative accounts of medical ethics are, according to Hoffmaster, too abstracted, beset by conflicting principles and may rely upon assumptions, such as definitions of life in the abortion debate, which are not addressable from within ethics. Furthermore, applied medical ethics neglects the situational aspect of actual problems and of how it is that some problems become ethical problems and some do not, for example. To these, Seigler (1991) adds that empirical ethics research could assist in framing

philosophical enquiry in terms of identifying areas of concern and posing possible questions for ethical analysis. And Holm (1997) also recognises the potential pedagogical benefit of empirical ethics enquiry and that such research may be important in how ethics is taught to health care professionals, as well as how useful regulations are.

The implication for a study of pharmacy ethics is that empirical research may provide a better understanding of the nature of ethical problems within community pharmacy and of how they are perceived and dealt with. As will become apparent, using an empirical approach, it is hoped that valuable insights and understanding into aspects of community pharmacists' ethical issues in their work can be obtained. Furthermore, it is hoped that these can complement the existing literature and be of benefit to normative ethical enquiry within pharmacy, to inform pharmacy practice in the UK and to offer insights that may have relevance to a broader audience, including other areas of health care, and to normative ethics, too. But before exploring these aims, a central task in this thesis is to be open and reflexive about the research that was undertaken and perhaps the most obvious point with which to illustrate this is by considering why I became interested in this area of study.

1.3 MY BACKGROUND AND RESEARCH INTERESTS

I became interested in ethical concerns in community pharmacy primarily because I have been, for the last fifteen years, a practicing community pharmacist in England.

Through initial managerial roles to later locum work, I have worked extensively in hundreds of community pharmacies in many areas of the UK. During this time, I have been aware of many aspects of pharmacy work that I felt were ethically problematic. Community pharmacy practice, for me, involves numerous ethical conflicts: some arise due to the commercial nature of pharmacy and involve what I understand to be possible conflicts between profitability and customer and patient welfare. The increasingly consumerist nature of community pharmacy and the commodification of medicines (Hibbert *et al* 2002) has led to my experiencing a number of conflicts in relation to autonomy and whether, for example, customers should expect to be given medicines even if pharmacists believe such sales are inappropriate. However, many other ethical issues, such as distributive justice, conflicts of rival professional autonomy, confidentiality and consent, have all arisen as concerns in my work.

Partly as a result of such concerns, I undertook further academic study and completed a qualifying law degree and also modules in jurisprudence and introductory ethics. I then studied for an M.A. in health care ethics and, as a result of these studies, gained an understanding of moral philosophy, ethics as applied to health care and also medical law and negligence. As part of my M.A. I undertook a number of projects and my dissertation focused upon the issue raised earlier – of competing customer and pharmacist claims to be given medicines, and whether the concept of autonomy could justify such decisions.

I began the present research in response to applications to study for a PhD in the area of pharmacy ethics at the University of Nottingham.

1.4 EXTANT LITERATURE

Although the next chapter will consider the extant empirical pharmacy ethics research literature in much more detail and consider the debate as to the place of empirical and social science contributions to ethics, it is nonetheless appropriate in this introductory chapter to frame the present research in terms of the existing literature. In comparison to medicine and nursing, relatively little research has considered ethical concerns in pharmacy and specifically community pharmacy (Cooper *et al* in press) and pharmacy, for example, lacks dedicated ethics journals, unlike medicine and nursing. Research dating back to the 1980's often involved American or Canadian pharmacists and, as the next chapter will indicate, often used pharmacy students as convenience samples or in one study, proxies for actual pharmacist's ethical views. These studies often involved postal questionnaires and focused upon specific concerns such as, for example, using a particular psychometric technique on pharmacists to test hypotheses about gender, socialization and employee status that will be explored in more detail in the next chapter. One small UK study (Hibbert *et al* 2000) and an Australian study (Chaar *et al* 2005) have indicated that ethical problems and reasoning may be varied but both studies' reliance upon a specific, if popular, theoretical approach to ethical reasoning and also changes in the pharmacy profession in the UK, means that further research is required to gain an understanding of what UK community pharmacists' presently experience as ethical issues and how they attempt to resolve them.

1.5 CURRENT ISSUES

As noted, community pharmacy in the UK is changing and a number of current concerns in pharmacy offer additional impetus for this thesis' investigation of empirical issues in community pharmacy. Firstly, there has been debate in the last year or so about a revised code of ethics for pharmacy (Royal Pharmaceutical Society 2006b) and this has highlighted concerns about the values that underpin pharmacy work and about value literacy amongst pharmacists more generally (Cribb and Barber 2000). Empirical research that can increase our understanding of the ethical concerns that are encountered by pharmacists and, importantly, how pharmacists attempt to resolve them can directly inform the debate about a revised code. It is hoped that the present study can offer insights into pharmacists' awareness of the code of ethics and whether it is used in resolving ethical issues in their work, especially since previous studies appeared to cast doubt on the relevance of a pharmacy code (Hibbert *et al* 2000, Chaar *et al* 2005). Secondly, the last decade has seen a number of high profile scandals in health care such as the Bristol and Alder Hey affairs, which relate to ethical issues and the reporting of health care professionals. But perhaps of most relevance to pharmacy was the Shipman affair and, in particular, the role of pharmacists in supplying medicines that may be used inappropriately (*The Shipman Inquiry Fourth Report. The Regulation of Controlled Drugs in the Community* Cm 6249, 2004). Ethical issues arise in relation to whether pharmacists are accountable for their role in supplying such medicines and, as a result of a subsequent enquiry into the affair, when and

how pharmacists should report poor standards amongst their health care peers. Thirdly, community pharmacy is changing in relation to a new NHS contract and also the increasing de-regulation of previously prescription-only medicines (POMs), which may lead to a number of ethical concerns. For example, pharmacist access to patients' medical records may become more routine and this may lead to concerns about confidentiality, pharmacist prescribing may involve pharmacists more in ethical issues of distributive justice in relation to medicine costs in the NHS and the recent availability of ethically sensitive medicines such as emergency hormonal contraception (EHC) may lead to concerns. Fourthly, a trend towards increasing corporate ownership of pharmacies (Blenkinsop *et al* 1999) may mean that pharmacists encounter new ethical concerns as more become employees in large organisations. Such changes offer not only the possibility of ethical assistance from an organisation and its employees (de George 1990) but also the potential challenges of a different culture (Trevino 1986) and organizational climate (Sims and Keon 1997).

Although not specific to pharmacy, it is also important to consider the more general place of ethics in a society that, as will be explored later, may be increasingly distancing individuals from ethical issues and hence there is a need to confront such issues and make ethical decisions. In contrast to what was described above as the normative traditions of philosophy, a number of recent accounts of ethics have recognised that the Enlightenment goal, in particular - of a rational, autonomous ethical agent - has not succeeded and that 'late modernity' should be understood in terms of increasing codification and legislation (Bauman 1993) and

increasing sequestration of moral experience (Giddens 1991).² This thesis, then, also aims to gain an understanding of community pharmacists' ethical issues in terms of a wider concern for ethics in late modernity which, in turn, raises the issue of how important are structure and agency in understanding individuals' ethical action – a concern that will be addressed in chapter six.

1.6 AUDIENCE

The overriding aim in this thesis is to gain an understanding of UK community pharmacists' ethical concerns, how they are resolved and what might influence these. However, it is recognised that in addition to making a meaningful contribution to the literature on ethics and pharmacy and increasing our knowledge of what is known and understood about ethical issues in community pharmacy, this thesis has other implications and may be relevant to a number of different audiences. As well as pharmacists and researchers, another significant audience are the policy-makers, both at a pharmacy level and also governmentally. The role of research in terms of shaping future policy and practice may, of course, originate in the direct commissioning of research for such purposes but it has also been argued by F. Smith (2002) that informing healthcare policy is a central aim of research conducted within the health care setting, including pharmacy and '[...] the

² The terms moral and ethics are used interchangeably in this thesis, although it is recognised that other writers use the terms separately to distinguish, like Bauman (1993) for example, between, formal and derivative ethical codification and more fundamental moral understanding. See, also, Beauchamp and Childress (1994 p.11) for a brief discussion of this point.

immediate goals of health service research are to provide background data and experimental evidence from which policy makers can make informed decisions' (F. Smith 2002 p. xiv). Cribb and Barber similarly note that pharmacy research can have a direct effect upon policies such as education, for example, and that this is no less the case for specific research concerns involving ethics and values, as this thesis covers. They note that:

Research is necessary if pharmacy values are to be understood and developed. Ideally any new initiative in professional education or policy would be underpinned by research because [...] it is vital to understand how these issues are experienced, understood and acted upon 'on the ground'. (Cribb and Barber 2000 p.31)

It is recognised that this thesis may be relevant to a number of audiences and the implications for specific issues in pharmacy practice and policy are returned to in the final chapter of this thesis, when education, the relevance of a code of ethics and additional roles are considered.

Before ending this section on the potential audiences of this thesis, I want to draw upon a literary analogy that was considered on several occasions during this research and which relates to the idea of representation and prospective audiences and which I hope is an example of the reflexive approach used in this research – a concern addressed in chapter three. In Conrad's *Heart of Darkness*, the narrator, Marlow, retells the story of a journey to find a fellow employee, Kurtz, who, although respected by Marlow as he came to know more about him, was ultimately flawed and corrupt (Conrad 1902). The novella is a powerful evocation of

colonialism, race and gender,³ but Conrad seems to be telling through the narrator, Marlow, a profoundly moral tale of a descent into darkness and of the discovery, in Kurtz, of a morally deficient character who he eventually witnesses dying in a strange and isolated environment. But it is also about understanding and belief and *Heart of Darkness* is about a search for what is thought to be a moral good only to find an ultimate vision of corruption and ‘the horror, the horror.’

The resonance of *Heart of Darkness* in the present thesis is that Conrad imbues the tale with a concern about values and especially a concern about the reputation of Kurtz. As the novella concludes, one of the most important scenes involves Marlow reporting the death of Kurtz to the bereaved fiancé and the telling of a lie – a lie that sought to protect the character of Kurtz but which agonized Marlow in terms of representation:

Nothing happened. The heavens do not fall for such a trifle. Would they have fallen, I wonder, if I had rendered Kurtz that justice which was his due? Hadn't he said he wanted only justice? But I couldn't. I could not tell her. It would have been too dark - too dark altogether. (Conrad 1902 p. 111)

The analogy to this thesis is that, in undertaking research into ethical issues and understanding amongst community pharmacists, should I, like Marlow, consider a reputation and of how to represent it? Like Marlow and Kurtz, the pharmacists in this thesis and I were connected through our occupation and, like Marlow, I was involved in telling a story – of research that would involve reporting on ethical concerns in community pharmacy and of community pharmacists. But although

³ See for example, Gilligan's discussion in *In a Different Voice* (1993)

several of the themes in *Heart of Darkness* are analogous to this thesis, my intention is not to protect a reputation or ultimately tell a lie and although my own values cannot be subtracted from the research process in a value-neutral sense (Weber 1949), I hope that my own background as a pharmacist does not imply that there would be a need to protect or lie about the profession of which I am part. As this thesis will indicate, the emergence of ethical passivity amongst many of the pharmacists in this study as a potentially negative attribute led me to reflect on many occasions about Marlow's lie but in referring to this analogy, I hope to illustrate that this research aims to be reflexive and that I was involved in an on-going assessment of my own values and concerns as a researcher but that a transparent approach to reporting this research will avoid Marlow's agonizing in the final scene about representation and audience.

In the final part of this introductory chapter, a summary and chapter outline is provided, which will hopefully act as a guide to this thesis.

1.7 THESIS OUTLINE

This thesis involved an empirical research project and the thesis is divided into, firstly, several background issues that are argued to be significant in not only framing the research but also informing how the research was undertaken; secondly, a description of the methodology and methods used in the research; thirdly, the presentation of the findings of the research, together with a discussion of them and, finally, a number of overall conclusions and implications for the

research.

In chapter two, *Normative and Empirical Ethics*, several key themes are developed that are argued to be relevant to this empirical research into UK community pharmacy ethics. Firstly, a number of ethical theories are described with the intention of identifying in these normative accounts of ethical reasoning, approaches to decision-making that may be of relevance to how community pharmacists deal with ethical problems. Secondly, the place of empirical research in relation to applied normative ethics is considered in more detail and an attempt is made to reflect on why this on-going debate may have arisen, how it may be challenged and why empirical ethics research can not only offer important contributions *sui generis* but also assist normative ethics, too. Thirdly, having offered so far what may be described as positive accounts of both normative and empirical ethics, these are then contrasted with a number of alternative, sociological accounts, that describe an increasingly marginalized place for ethics in society, as individuals seek the security of formal codes and laws and avoid ethically difficult problems. Fourthly, the extant literature on empirical ethics is described in relation to pharmacy and it is argued that this thesis can add to that literature and offer unique insights. Fifthly, ethical decision-making models from the business and healthcare ethics fields are considered and it is argued that using a model of ethical decision-making as a loose, analytical framework might further inform this research. The three central research questions of this thesis are then set-out, as informed by the range of theoretical insights set out above, the extant literature and also my own concerns: what do UK community pharmacists

understand by, and experience as, ethical concerns in their work, how do they try to resolve such ethical issues and how significant is the community pharmacy setting in relation to ethical issues and decision-making?

In chapter three, *Methodology*, the research strategy of this thesis is developed initially in terms of some general methodological issues. Then, the more specific question of why a qualitative approach, using semi-structured interviews, was chosen as the most appropriate strategy to answer the research questions is addressed. Issues relating to the sampling, recruitment and interviewing of the pharmacists who participated in this research are considered. The principles of constant comparison, deviant case analysis and theoretical saturation were utilised and, as noted, analysis was informed, in part, by the use of a decision-making model as an analytical framework but was also informed by the normative theories described in chapter two. In what is hoped is a reflexive approach, this chapter aims to be as transparent as possible about the research process and the decisions that were made in relation to sampling, recruitment, access, interviewing, transcription and analysis. Research ethics issues are considered as well as issues relating to the credibility of the research.

In the next three chapters, the results of the research and the emergent themes are described. Discussion of these findings and emergent themes is undertaken as the chapters progress, rather than as a separate part of this thesis and these three chapters reflect the three key research questions of this study. In providing a discussion of the emergent themes within each chapter rather than as a separate, formal discussion chapter, the intention is to help contextualise the research

findings and ground them in relevant theoretical insights. Such an approach also hopefully avoids the compartmentalisation of the empirical, research findings from any discussion and analysis – a separation that could perhaps encourage what chapter two identifies as the problem of the ‘gap’ between normative and empirical research.

In chapter four, *Ethical Problems in Community Pharmacy*, data are presented about the first research question relating to what community pharmacists understood by, and experienced as, ethical issues in their work. The pharmacists in this research often described ethical issues that related to the routine minutiae of their work and that these arose in two broad categories: in the dispensing of prescription medicines and in the selling of over the counter (OTC) medicines. A range of ethical issues were identified but two key themes emerged – firstly, the pharmacists in this study appeared to have a legalistic outlook and not only identified ethical concerns that were often partly legal in nature, but also extended this legalism to their very understanding of what ethics meant. Law and ethics appeared to be synonymous for many. Secondly, although pharmacists often talked about ethical ‘dilemmas’ in their work, these were not dilemmas as understood philosophically and the term ethical ‘problem’ is argued to be a more appropriate description. A third but smaller category of themes did emerge that related to issues that were more general in nature and issues relating to confidentiality, whistle-blowing and treatment refusal are described. Although the emergent ethical problems appeared to lack the drama of other areas of healthcare and are not dilemmas in the philosophical sense, they remained of importance for pharmacists

and were often a source of distress, anxiety and guilt in their work.

In chapter five, *Ethical Decision-making and Passivity*, how pharmacists tried to resolve the ethical problems they had described in chapter four is considered, and a four-stage model of ethical decision-making used as an initial analytical framework. However, although there was variation and some pharmacists appeared to be sensitive and thoughtful to ethical issues, many pharmacists were ethically inattentive, used limited ethical reasoning, often referred to legally defensive self-interest and, although recognising what was ethically required at times, did not act ethically. The concept of ethical passivity is developed as a description of these omissions in the stages of ethical decision-making. The use of consequences, the golden rule and common sense were identified as forms of ethical reasoning and religious faith was identified as an ethical influence for some. Formal and informal forms of ethical influence and assistance such as the code of ethics, the RPSGB and NPA ethics and information departments were not considered helpful by most pharmacists in resolving ethical problems.

In chapter six, *The Community Pharmacy Environment*, the focus shifts away slightly from the micro-social aspects of ethical problems and pharmacists' decision-making to broader, macro-social issues. In particular, the emergent concepts of isolation, subordination and routinization are developed as being significant but inimical to an ethical approach to community pharmacy work and that these also offer a greater understanding of how ethical problems might arise and why ethical passivity predominates. Ethical isolation is identified, not only as a physical separation of pharmacists from their peers but also, it is argued, from their

customers and patients. Psychologically, this isolation may inhibit ethical awareness but drawing upon the concept of proximity and ethical distance and the work of Bauman (1993), Levinas (1981) and Malone (1994), it is argued that pharmacists' ethical passivity may be more fully understood by such isolation. The ethical implications of isolation in terms of communication are also considered and following Habermas (1989) are argued to be ethically problematic.

Pharmacists' subordination to doctors is then developed as a further feature of the community setting that not only precipitated ethical problems but also allowed pharmacists to avoid ethical responsibility. The identification of atrocity stories and the example of EHC are used to support the claim that this feature of community pharmacy may be ethically relevant to passivity and to not only the incidence of ethical problems but also how they are dealt with by some pharmacists.

Finally, the routinization of many pharmacy tasks and problems, as identified in chapter four, is argued, following Giddens (1991), to offer pharmacists a sense of ontological security. This, in turn, means that pharmacists may be avoiding confrontations with ethical situations. Although EHC is again used as an example – of an opportunity to engage in ethically sensitive issues – it is further argued that, like Camus' retelling of the Sisyphus myth, in the routine tasks that pharmacists often described in this thesis, there is the opportunity to identify ethical issues of relevance.

In the final chapter, *Conclusions*, I argue that there are a number of implications of the findings of this research for pharmacy practice and health care more generally. Educational needs for ethics are considered at both an under-graduate

and continuing education level. The relevance of a code of ethics is challenged due to the findings of this thesis as, too, is community pharmacy's attempt to undertake additional roles. The implications of this study for healthcare and society are considered and concerns are raised about whether the emergent themes in this thesis, such as isolation and subordination in particular, may be problematic for the effective delivery of care in the primary care setting in the UK. The question of how values and ethical norms are transmitted and communicated in the pharmacy profession is considered as a more fundamental issue but I argue that pharmacists may be no different from other individuals in society in seeking the security of formal and legal rules rather than ethical uncertainty. The limitations of the thesis in terms of its timing are considered and areas for further research identified, including the influence of ethics teaching, the impact of corporatization and employee status for pharmacists and how ethical values and norms can be transmitted in the profession.

2 NORMATIVE AND EMPIRICAL ETHICS

2.1 INTRODUCTION

Having provided an introductory background to a number of general issues in relation to ethical concerns in community pharmacy in the last chapter and identified several initial reasons why this research should be undertaken, a number of important areas need be considered in more detail. These include concerns about how this thesis can both compliment but also build upon what is already known about empirical pharmacy ethics, about locating empirical ethics more generally in terms of its relationship to normative ethics and considering other relevant insights such as several sociological concerns about the marginalization of ethics and, finally, the relevance of practical models of ethical decision-making. This chapter begins with a broad overview of the normative ethics literature and it will be argued that an understanding of how moral philosophy has tried to resolve the enduring question of which acts are morally right, for example, can inform the empirical approach in this thesis. Key theories such as utilitarianism, Kantian deontology and the four principles of biomedical ethics, for example, are briefly considered as well as the role of casuistry, narratives, intuition and common sense intuition. It is argued that all of these approaches may have application to community pharmacy. The contribution of Kohlberg's and Gilligan's respective empirical research and subsequent theories is then considered in relation to the present study and it is argued that whilst their different theories of cognitive moral

development have an empirically grounded appeal, they may be variously challenged and should be considered as merely other possible ways of how ethical decisions occur in practice. The status of empirical ethics research is then explored in the context of the 'is-ought' debate and, despite traditional philosophical reluctance in accepting empirical data, research such as this thesis may have relevance not only in its own right but also in assisting in developing normative philosophical theories that are more sensitive and relevant to practical ethical problems in healthcare fields such as pharmacy. The broader place of ethics in what has been described as late modernity is then considered and it is argued that in the work of Giddens (1991) and Bauman (1993) , an awareness of the marginalization of ethics in society provides an important counter-point to the optimistic claims in, for example, the normative accounts in this chapter and the ethics literature more generally. (These contributions are further developed in chapter six, in relation to more macro-social concerns about pharmacy). A review of the existing empirical pharmacy ethics literature is then provided, to identify what is already known about this subject area. It is argued that there are limitations and omissions in the extant empirical pharmacy ethics literature due to the use of pharmacy student and often American or Canadian sample cohorts, and the use of specific ethical theories to inform analysis. Whilst these are not problematic as individual pieces of research, it is argued that much remains to be explored in this subject area and that the research questions identified in this thesis will offer important and original contributions. The development of ethical decision-making models are then considered – both as they arise in the context of resolving ethical problems in healthcare and also more

generally in fields such as business and organizational ethics – and are argued to be a useful analytical template for considering how ethical problems are resolved in practice.

2.2 NORMATIVE GENERAL ETHICAL THEORIES

Although this thesis is about how ethical issues arise and how they are resolved from an *empirical* perspective, as understood by community pharmacists, an understanding of the various claims to moral authority advanced by philosophers over the centuries is still important. However, the intention is not to describe the various ethical theories that have been advanced either comprehensively or in great detail. The aim is rather to ground the reader in what are recognised as some of the most significant ethical approaches developed and to consider how these may be relevant to empirical research. In particular, being sensitive to existing ethical approaches may be important in understanding what community pharmacists mean when they talk about their decision-making and reasoning processes. As the next chapter will develop in more detail, interviews were chosen as a method to explore and answer the research questions in this thesis and although an attempt is made to see ethical issues, and to understand how ethical decisions are made, as pharmacists do, the use of existing theory is not argued to compromise these aims. Indeed, it is hoped that it may allow for a more comprehensive account of the range and variety of pharmacists' reasoning although the intention is not to compare or rate pharmacists in relation to philosophical reasoning. As will be seen, the present

research may be contrasted sharply with the aims of empirical ethics research in pharmacy such as Latif's, in which moral reasoning is treated as an operational concept and assessed using a psychometric test that leads to statistical scores of principles reasoning that can be used to compare individuals (Latif and Berger 1997). The intention in this thesis is not only to utilize existing theories in the analysis of interviews – albeit in a broad, sensitising way rather than a testing or exact way – but also to indicate possible *differences* between normative approaches as advanced philosophically and empirical approaches as understood in the community pharmacy setting but without inviting invidious comparison.

In the following section, a brief account of several influential general ethical theories is offered: utilitarianism and deontological theories, the popular four principles of biomedical ethics, casuistry, narratives and, finally, the role of intuition. As noted, the descriptions offered are not intended to be detailed or critical appraisals of the ethical theories but the relevance of identifying them is to simply indicate their presence and general approach so that, in exploring how pharmacists make ethical decisions, existing approaches can offer a theoretical starting-point or basis for analysis.

But what are we to make of this range of possible ethical justification? Does it imply that the individual community pharmacist can pick and choose the most appropriate theory according to the situation or does it imply that such theories are rival and incompatible and that to support one is to repudiate another philosophically? Seedhouse, in defending his inclusion of general ethical theories in his account of health care ethics, considers Emmet's (1979) metaphor of a prism

of ethics and that:

The point of describing and discussing the theories of ethics [...] is to display the richness of moral reasoning. Moral reasoning has been described as a prism which can shine different light onto issues. Which light is shone depends upon the person who is to reason, and the more theories of ethics that are understood the more options there are about which light to shine. The point of describing so many theories is to make it utterly clear that it is inadequate to select one theory and apply it consistently to every problem or dilemma. It can be argued that simply adhering single-mindedly to one theory is not what it is to be moral at all [...] It is clear that there are no specific rules that can always be applied to best effect in all situations. (Seedhouse 1988 pp. 90-91)

For Seedhouse, a pluralistic relationship between ethical theory and ethical reasoning is both possible and desirable. But contrary to this claim that using a single theory is inadequate, such approaches have, in fact, been advocated within moral philosophy and are referred to as *deductivist* methods of moral reasoning or, commonly, ‘top down’ methods and it is to perhaps the two most influential of these that this section now turns.

2.2.1 Utilitarianism and Deontology

The modernist aims of the Enlightenment period in the late 17th and 18th centuries – of reason and rationality as the basis for scientific and philosophical advancement – are no more evident than in the theories of utilitarianism (or consequentialism) and deontology (especially as understood by Kant). They are also two theories that illustrate markedly different approaches to the resolution of ethical problems. For utilitarianism, a calculation of overall utility and justification is based entirely upon

the consequence of an action as opposed to any consideration of the nature of the act itself. For John Stuart Mill (1992), this involved happiness as the only measure of ethical utility and, according to this form of utilitarianism, acts were right only in so far as they promoted the greatest overall happiness. Key aspects of the theory are that it is aggregative and it requires a calculation to consider all potential individuals' happiness as the result of a putative ethical act.

In contrast, deontology refers to 'duty based' ethical theories and the most influential of these, by Immanuel Kant (1989), involves a duty to always act in accordance with the Categorical Imperative and several of its famous formulations: treat individuals not as means but ends in themselves and act only in a way that could be otherwise made a universalizable act. This may be seen to contrast, paradigmatically, with a consequentialist theory of ethical action that values not the act itself but only a measure of utility or outcome. For Kant, some acts were always wrong such as lying, deception or suicide.

Such influential but distinct approaches to ethical reasoning may lead to different types of justification and hence outcomes in pharmacy practice. For example, a duty never to treat a patient as a means to an end would be problematic if there were, for example, a further paternalistic concern for their welfare when involving, say, the pharmacist deceiving the patient such as when a placebo was given. In such an example, the duty to act in accordance with the Categorical Imperative as formulated by the particular maxim not to treat another without respect would mean not lying or deceiving the patient with the consequence that the patient may, in fact, suffer clinically. This example could, similarly, be applied to the use of

utilitarianism and that for the community pharmacist to apply such an ethical theory, only the consequence and, specifically, the maximum utility (expressed as happiness or welfare) of all concerned must be considered. In this example, a duty-based approach would lead to a difficult choice for the pharmacist whereas a utilitarian approach would not and deceiving the patient would not be ethically prohibited. In other cases, however, problems may arise with utilitarianism since such a theory is silent as to the actual acts of individuals and that, for example, acts of infanticide or euthanasia could be ethically justified if the overall amount of happiness were maximised – such as less suffering for a terminal cancer patient or severely disabled newborn or their respective families (Singer 1987). This ethical reasoning could clearly lead to the justification of acts that would not be allowed using a Kantian approach that values human life intrinsically.

2.2.2 The Four Principles of Biomedical Ethics

Having sketched very briefly the dominant ethical theories of utilitarianism and Kantian deontology as the high water mark of the modernist ethical tradition and considered how they could be applied in community pharmacy, another influential approach to ethical reasoning will be advanced. This is the ‘four principles approach’ and has been developed within the field of bioethics and health care by Beauchamp and Childress in their work, *Principles of Biomedical Ethics* (1994). It has been widely accepted within health care (Gillon 1994) and the principles espoused by the theory are repeated in numerous ethical and general texts and

health care research – often with reference only to the principles themselves and to the exclusion of the underlying method of balancing and choosing those principles. Central to the theory is the claim that there are four principles and that these are sufficient to apply to any of the ethical problems that arise within health care. Importantly, these are argued to originate in the common morality and medical tradition of health care but are, as the authors concede, merely considered judgements that rest upon an assumption of their primacy and validity that is not subject to an argued defence (Beauchamp and Childress 1994 p.37). The four principles defended are respect for the autonomy of the individual, non-maleficence (avoiding harm), beneficence (providing benefits and welfare) and, finally, justice (the fair distribution of benefits, risks and costs). Just as important as the principled content of the theory, however, is the method of applying these principles as it will be obvious that the four principles listed may, in fact, conflict at times and require some system of adjudication. This mirrors the concern raised previously about the place of conflicting general ethical theories and of whether they can be considered as *choices* or *absolutes*. The same potential problem occurs within the four principles approach but that must reject an absolutist approach or else undermine the central tenet of the approach – that the four valid principles all have merit and value. The solution to the problem of these competing principles for Beauchamp and Childress is to use a coherentist approach that allows specification and balancing of the principles. It avoids the problems identified previously with deductive methods and, instead, relies upon considered judgements that seek to ground a particular principle in relation to other beliefs and also the more general

ethical theories. Such an approach is often attributed to the work of Rawls (1979) and his concept of reflective equilibrium and that considered (pre-reflective) beliefs should be accounted for by appeals to more formal rules or general ethical principles and then tested to exclude inconsistency or incoherence. Equilibrium in an ethical sense is achieved when the iterative process of re-evaluation and reference to theory and belief lead to a coherent combination. However, such a process relies upon principles being accommodated within the plurality of individuals' beliefs and this concern will be addressed later as regards ethical intuition. Beauchamp and Childress refine the way in which principles are selected in individual cases by a process of balancing that borrows from Ross's (1930) *prima facie* ethics that attempts to overcome the problem of diverse individual beliefs.

As has been argued, no attempt is made to evaluate a particular normative approach to ethical justification. The purpose is, rather, to illustrate the existence and manifestation of possible ethical theories in order that the empirical study of community pharmacists in this thesis may be informed by such approaches. As such, the four principles approach may be identified, primarily, in terms of the championing of autonomy, beneficence, non-maleficence and justice and of the process of balancing these potentially competing principles to resolve ethical problems. Research involving pharmacist's ethical awareness in terms of the four principles approach has, in fact, been undertaken and is considered later in this chapter (Hibbert *et al* 2000, Chaar *et al* 2005). In these studies, the mere utterance by pharmacists of one of the four principles (or using language that may be

interpreted as such) was considered to be sufficient to justify ethical understanding according to the four principles approach. Whether this fully reflects Beauchamp and Childress' theory or, indeed, how pharmacists reason or understand ethical concepts is considered later in this chapter in a more detailed review of the empirical pharmacy ethics literature.

So far, a deductive approach (that applies a monistic ethical theory to a particular problem) and a version of a coherentist approach (using a comparative approach to theory and other beliefs) have been considered. A further ethical method involves the opposite approach to deduction and seeks to justify ethical reasoning in terms of induction and is exemplified in the use of casuistry.

2.2.3 Casuistry

In contrast to ethical approaches that begin with a single, universal ethical theory and seek to apply these to particular examples, casuistry proceeds in the opposite direction, inductively, and grounds ethical justification in a given ethical problem from a comparison of the particularities of this problem to other examples. Central to such an approach is the existence of paradigm cases that represent settled, ethically unambiguous examples and that may be used for comparative purposes. The approach originated in a religious context but underwent a resurgence following the work of Jonsen and Toulmin (1988). As noted, casuistry centralises particular examples or cases as being important and is a 'bottom up' method that derives ethical justification from the particularities of specific cases. As Jonsen and

Toulmin note, casuistry places central value upon '[...] the outcomes of previous experience, carrying over the procedures used to resolve earlier problems and re-applying them in new problematic situations' (Jonsen and Toulmin 1988 p.35) The casuistic process involves a search for paradigm cases that may be of relevance and eschews abstracted, general ethical theories and principles but does, however, require the development of maxims or generalised statements from such paradigm cases. These maxims are helpful summaries of earlier cases and allow comparisons to be made more easily. As regards the use of this approach in the present research, community pharmacists would use casuistry to resolve ethical problems in their work by making reference to previous cases and comparing them to the present problem. The cases referred to would, ideally, be paradigm examples that provided ethical justification for applying that case and its outcomes to the present ethical problem.

2.2.4 Narratives

Unlike the normative theories considered so far in this section, an alternative approach is to base ethical reasoning upon a broader interpretation of a given situation and this is exemplified in the development of narrative approaches. Central to such approaches is the understanding that ethical decision-making involves perception as opposed to rational deductive application of abstract, ethical theory. Ethical problems are not simply holes that must be made to fit the shape of an ethical theory but, rather, multi-faceted situations that it is important to

understand as being shaped, instead, by social, cultural and personal factors. Narratives, furthermore, provide the skills upon which informed decisions can be made. However, narratives have also been used in addition to more general ethical principles and have been regarded as instrumental to ethical justification. For example, Schultz and Ornes advocate a narrative approach for pharmacy ethics that requires narratives as well as the theoretical application of existing ethical theory and ‘[...] it is the process through which the patient and pharmacist join together in writing and interpreting the story of [the patient’s] medication needs and desires’ (Schultz and Ornes 1996 p.108). They illustrate their point with the problem of a patient who may require additional counselling about her medicines and which, they argue, can only be properly resolved by considering the patient’s unique perspective in terms of culture and predicament. They argue that:

Inasmuch as narrating and interpreting these needs and desires [of the patient] comprises application in pharmacy ethics, this activity or process, we think, should become the primary focus or task of pharmacy ethics. It is primary because how the story of this patient’s medication needs and desires is told and interpreted shapes the significance of ethical principles and rules and thus, constitutes the meaning of the pharmacist’s obligations and duties in specific cases. (Schultz and Ornes 1996 p.108)

Such an approach, be it one that replaces normative ethics or one, like Shultz and Ornes advocate for pharmacy, that helps apply and shape other ethical principles, may be seen empirically in the existence of stories or narratives by community pharmacists. Hence in the present research, evidence of ethical reasoning and justification may be based upon a broader consideration of an ethical problem in terms of the relevant background to the parties affected by the problem and also by

a wider concern for social and cultural factors. Of course, these may also be seen in other theories such as utilitarianism, for example, where a potentially limitless concern for maximum aggregate welfare or happiness must be considered and evaluated. However, a narrative approach is not limited only to calculation of utility but can embrace any number of relevant personal and social factors and hence give a much more contextual basis to resolving ethical problems. Stories also appear in casuistic ethical theories but require the identification of previous, paradigm cases and maxims as opposed to a narrative's more simple aim of contextualising an ethical problem in the various social and personal aspects that appertain to the problem.

So far, consideration has been given to two major general ethical theories, to a popular principle-based approach to health care ethics, to casuistry and also to narrative approaches. These are neither intended to be comprehensive nor exhaustive of the ethical approaches that may be used but are included because of their influence and relevance to health care and, potentially, community pharmacy. One final approach that warrants inclusion but is somewhat distinct from the approaches considered so far centres more particularly around the individual community pharmacist. The foregoing ethical approaches have all provided an *external* justification for ethical action but it is also recognised that individuals have many pre-existing values and make ethical judgements in the absence of any substantive ethical theory or approach. Such a consideration relates to Wingfield's remark about how ethical problems in pharmacy may be resolved, when she states

that ‘many pharmacists appear to tackle such situations pragmatically, using prior experience and common sense’ (Wingfield 2004 p. 2394). Such concerns have also been raised in the empirical pharmacy ethics literature and Hibbert *et al* (2000), for example, concluded that community pharmacists may use a common sense approach as one of a number of forms of ethical understanding.

In the present empirical work on community pharmacist’s ethical reasoning, it may be most relevant to consider these pragmatic, common sense strategies for resolving ethical problems since they represent what community pharmacists believe to be appropriate justification for resolving problems. In addition, appeals to common sense or intuition may be justified on a more substantive philosophical basis and this will now be considered.

2.2.5 Ethical Intuition

Seedhouse, in his text concerning the application of ethics to health care, *Ethics: The Heart of Healthcare* (1988), argues for an awareness of several ethical theories but also claims that:

It is apparent that a reliance on intuition is not sufficient. However well educated and well intentioned a person is there is no guarantee that she will automatically, on every occasion, be able to intuit what is right. (Seedhouse 1988 p. 91)

However, appeals to intuitive or common sense reasoning have been supported as justification for ethical reasoning and it may be premature to accept Seedhouse’s assertion that they are insufficient. The idea of an individual having an ethical

intuition rests upon the recognition of certain pre-reflective or pre-theoretical beliefs. These are the gut feelings or responses that are elicited in relation to an ethical problem. They are what Williams has described as:

Spontaneous convictions, moderately reflective but not yet theorized, about the answer to some ethical question, usually hypothetical and couched in general terms. They are often questions about what to do. (Williams 1985 pp 94-95)

However, do they carry a similar weight to the normative ethical theories considered so far in this section and, as regards the present empirical research, would they constitute a form of ethical reasoning if used by community pharmacists? Intuitionism within ethics gained much popularity at the start of the last century and was defended as an ethical approach that considered an individual's intuitive feeling or understanding as the epistemological basis for further ethical theory (Ross 1930). However, such theories were criticised for their ultimate inability to adequately justify why certain intuitions should be accepted. It may also be argued that different individuals may have different intuitive feelings or responses to a situation and so an element of relativism may arise and justification would tend to rest, unhelpfully, upon potentially numerous personal beliefs. However, the use of intuition still has currency within moral philosophy and is used in the previously described coherentist approach to balancing ethical choices that is favoured by Beauchamp and Childress. Drawing upon Rawls' idea of reflective equilibrium, intuition finds its place in terms of the need to consider the acceptability of more general ethical principles in the light of the individual's

intuitive response. In this respect, intuitions are not given ethical superiority but instrumental value in relation to other ethical concepts. Elliott (1992) developed this theme and argued that individuals often do not use general ethical theories but, instead, draw upon their own ethical beliefs and intuitions that are, in turn, dependant upon cultural and social forces. He does not claim that ethical theories are redundant but argues that the present state of competing ethical pluralism results in further pressures: pressure upon intuitions that must adjudicate between theories and also upon the ethical theories, themselves, that must allow for acceptable outcomes. He notes that:

As there are no shortage of ethical theories, one must be able to adjudicate among rival theories to decide which to apply to any given ethical problem. This can be difficult, especially when intuition does not incline us in a particular direction. When we do have strong moral intuitions, they are usually concerned with a particular case, and not with a theory. Moreover, theories are tested not only against moral intuitions; they are also tested against other theories [...] it is not at all plain why we should expect a moral theory to measure up to such tests when our own moral beliefs are often genuinely unclear, uneconomical, non-comprehensive and incoherent. (Elliott 1992 p.30)

According to this approach, the use of common sense, intuitive ethical reasoning by community pharmacists may be relevant but not in an independent way. Evidence of 'unclear, uneconomical, non-comprehensive or incoherent' reasoning by community pharmacists should not be discounted but conversely, may be a necessary but not sufficient form of reasoning. It is a more complex interdependency that appears to exist, according to Elliott, and in relation to this research, intuition may complement other substantive forms of reasoning.

The ethical theories identified so far do not offer a comprehensive account of how individuals may make ethical decisions and in the next section, theories that have emerged from empirical research in psychology are explored as further potential approaches to dealing with ethical problems, and of relevance to how pharmacists may make ethical decisions.

2.2.6 Kohlberg

So far in this chapter, a number of influential normative ethical theories have been identified and described in order that they may be used in this thesis as sensitizing concepts in analysing how pharmacists appear to deal with ethical situations and what reasoning process, if any, they apply. They are part of a philosophical tradition that dates back thousands of years and have been extremely influential. However, debate about moral reasoning took a new turn in the middle part of the last century when attention was focused upon the expanding field of psychology and, in particular, the concept of cognitive moral development (CMD). Central to this approach to ethical reasoning and understanding was the claim that, like overall psychological development in, for example, attaining social skills, language and cognitive and abstract reasoning abilities, individuals also gain moral ability progressively. CMD was radical in that it made comparisons between morality and psychology and it also assumed to a certain extent that moral development was independent of any substantive content (Thomas 1991). Furthermore, one of the

most important aspects of CMD, as developed by Kohlberg, was that moral reasoning progressed in a number of distinct and unidirectional levels and stages. This theory was, however, *empirically* grounded and was based upon a single, longitudinal study of 84 adolescent American boys over an eventual period of more than twenty years (Kohlberg 1984). Kohlberg identified three levels of moral development (and two sub-stages of each level) that related to reasoning that could be distinguished as: firstly, pre-conventional and involving reasoning related to external punishment (stage one) or egoistic self-interest (stage two); secondly, conventional and appealing to reasoning that considers one's immediate peers (stage three) and then broader social implications and laws (stage four); thirdly, post-conventional and applying principled reasoning that recognises the social contract (stage five) and finally, universal ethical principles (stage six). This final stage involved reasoning that was manifestly justice based and, according to Kohlberg, may have been influenced by a neo-Kantian approach to universal reasoning. This is re-iterated clearly by Rest, who subsequently developed CMD and produced a psychometric test called the defining issues test (DIT), when he noted that:

Contrary to some philosophers who use 'moral' to include concepts of the good or worthwhile life, the use of 'moral' in this account [of CMD] is restricted to concepts of justice and fairness. (Rest 1979 p.20)

At this point it might be reasonably asked, why should CMD not be used in the present study as an underlying theory that might inform how community pharmacists reason? It would appear not only to be empirically grounded but also

to have a significant body of subsequent empirical research, including much within healthcare, to support it (Sheehan 1980, Rest 1984). As will be indicated in the following section, CMD has been used in empirical pharmacy ethics research but there a number of significant concerns about CMD that are argued to undermine its relevance to the present study and a convenient starting point involves the work of Carol Gilligan (1993).

2.2.7 Gilligan and an Ethic of Care

Carol Gilligan initially worked as a researcher with Kohlberg but increasingly distanced herself from his theoretical approach and, indeed, became critical of it. Central to Gilligan's criticism of Kohlberg and CMD was that the empirical origins of his theory involved only boys and that this male cohort may have distorted his findings. Gilligan supported this claim in her own early work involving women, rather than boys or men, and identified an alternative ethic of *care*, as opposed to justice (Gilligan 1993). For Gilligan, many of the problems faced by individuals and especially the women in her early study, could be considered in terms of relationships and responsibilities, rather than an impartial justice-based approach. But it was not only Kohlberg's all male cohort that led him to incorrectly formulate his CMD theory in terms of justice, according to Gilligan, but the type of hypothetical dilemmas used in his research and in the subsequent DIT as developed by Rest and other workers. According to Gilligan, these scenarios were constructed so as to consider issues that involved, and could be resolved by, a consideration of

social justice. But for Gilligan and her interviewees, this represented only one type of possible ethical situation and she recalled how Amy, an eleven year old girl, interpreted Kohlberg's famous Heinz dilemma – in which respondents are asked about a husband's decision to steal a drug that would save his wife's life because it was too expensive to buy from a chemist - in a different way to Kohlberg:

The world she knows is a different world from that refracted by Kohlberg's construction of Heinz's dilemma. Her world is a world of relationships and psychological truths where an awareness of the connection between people gives rise to a recognition of responsibility for one another, a perception of the need for response. (Gilligan 1993 p. 30)

Kohlberg's CMD theory is inherently normative and is based upon a highest, sixth stage of post-conventional reasoning that prioritises a '*deontological justice*' that also aspires to universality (Kohlberg 1984 p.248). Unfortunately, the empirical basis for this stage appears to have been largely absent but Kohlberg maintained that this stage was fundamental and that only by considering this highest, justice-based stage could all of the other stages be understood and explained (Puka 1990). What is apparent in this aspect of the theory is that CMD ultimately represents yet another normative account of how individuals *should* act and although the empirical basis of the theory is appealing given this thesis' concern about empirical ethics, CMD may not reflect how different individuals make ethical decisions. As Gilligan's research indicated, alternative approaches are possible and the aim in this study is to remain sensitive to existing theory but to consider how pharmacists might, uniquely, understand ethical problems and ethical decision-making. As such, Gilligan's work offers additional insights that may have relevance to how

pharmacists deal with ethical issues in their work. Furthermore, these empirical psychological studies indicate that the *type* of ethical issue itself could affect how a decision is made. Walker *et al* (1987), for example, noted that personal moral issues – ones that the individual had actually experienced and of a type often cited by women in Gilligan's research, for example - tended to involve appeals to care and relationships but that more impersonal or hypothetical scenarios resulted in less care-orientated reasoning.

The aim in this section has been to present a range of influential ethical theories that have guided moral debate but that may also offer a basis from which to consider how pharmacists may attempt to resolve their ethical issues at work.

Another important aim in this chapter is to review the existing research that has been undertaken involving pharmacy ethics but to do this, it is important to explore the relationship between normative ethics and empirical research in ethics. The reason for this rests upon on-going debates about the apparent incommensurability of normative and empirical accounts of ethics but in the next section it is argued that both approaches to ethics can be used to mutual benefit.

2.3 THE STATUS OF EMPIRICAL AND NORMATIVE ETHICS

Until relatively recently, ethics was understood as the sole preserve of the moral philosopher and the influential theories identified in the preceding section such as utilitarianism and deontology reflect the rationalist, Enlightenment goals of developing normative ethics theories which would serve as comprehensive guides

to ethical action or an ethical life. This was increasingly challenged, however, by a number of concerns and, as the previous section indicated, the development of psychology as a science led to an interest in ethical reasoning as a cognitive process. It is also possible to see the development of other fields such as sociology as being contributory to a broadening interest in what are understood by ethical concerns and to increased recognition of the status of empirically derived ethics data. The aim in this section is to sketch out the debate between empirical and normative accounts of ethics, using health care and medicine in particular, but to indicate that empirical research such as this thesis may be regarded as significant in not only informing more normative accounts of the ‘facts’ but in contributing to a deeper understanding of not only how ethical problems arise in particular situations but also how individuals understand and experience them, too. Amongst the key early, sociological thinkers, both Weber and Durkheim made contributions to ethics. For Weber (1949), this involved not only an internal consideration of how values and ethics might relate to the developing field of sociology but also an external, pessimistic concern about how society had developed an ethical approach that was guided by scientific progress and formal legal mechanisms. For Durkheim (1984), morality was a feature of society that was amenable to scientific study and was to be viewed as a fact, like other social facts. But despite this early sociological interest in ethics and values, divisions between the social sciences and philosophy continued and this has led to rival concerns about the respective status of both empirical ethical research and also normative ethical claims. One of the most problematic and enduring issues concerns the meta-ethical issue that is referred to

as the naturalistic fallacy or Hume's law or more commonly, the is-ought divide (Hume 1978). The division between fact and value has been argued to perpetuate a lack of integration or even mutual understanding between empirical and philosophical accounts of ethics (Davydova and Sharrock 2003). Although having little to do with Hume's overall emotivist approach to philosophy, the reference in *Treatise of Human Nature* is frequently cited to explain the position that philosophical prescriptions cannot be obtained from facts or 'no ought from is.' Unfortunately, Hume was only making a logical point but the statement has been subsequently used in many ethical arguments that assert that just because something *is* the case does not mean that it *should* be the case. Empirical data in relation to ethics has not been entirely rejected by normative accounts and Beauchamp and Childress (1994), for example, recognise the place of what they term 'descriptive ethics' but as Hoffmaster (2000) noted, the first edition of Beauchamp and Childress's *Principles of Biomedical Ethics* claimed that descriptive accounts were, in fact, secondary to normative approaches. This changing account, and perhaps recognition of empirical ethics, is indicative of a trend that has seen increasing claims from the social sciences that philosophers and moral theory can benefit from empirical insights. Although it has been argued that the rapidly developing field of medicine and healthcare more generally have provided a fertile ground for philosophical debate (Toulmin 1982), there were increasing claims that moral philosophy could not assist with such ethical situations (Hoffmaster 1992, 1994). Central to these criticisms were concerns that ethics was too abstracted, 'general and vague' and that attempts to deductively apply theories

such as utilitarianism or Kantian deontological duties to increasingly complex medical situations was failing. The declining fortunes of moral philosophy have been charted by sociologists such as Fox (1989) and Borry (2005) but criticism was typified by Hoffmaster's (1992 p. 1429) reference to a contentious quote by Hare (1977) that 'if the moral philosopher cannot help with the problems of medical ethics, he ought to shut up shop' (Hare 1977 p.49). Hoffmaster has been particularly critical of the existing approaches in philosophy but makes it clear that moral philosophy's present inadequacies are not fatal and that it is a problem of applicability and, he argues 'the principal problem [is] the gap that exists between the general concepts and categories of moral norms and the particularities of actual moral situations' (Hoffmaster 1994 p.1156). The enduring gap between empirical fact and prescriptive statements is therefore seen to be used in reverse and it is an epistemic gap and that ethical theory should become more attentive to the complexity and variety of actual ethical problems in practice. However, it is not just applied philosophy's apparent lack of insight into specific problems that may be problematic but also, as Hedgecoe (2004) notes, an unsupported reliance upon empirical data. Hedgecoe uses the example of Beauchamp and Childress' four principles theory to illustrate a failed opportunity to utilize relevant empirical data and he notes that in describing a deductive ethical theory, they claim such a approach 'conforms to the way virtually all persons learn to think morally' (Beauchamp and Childress 1994 p.16). However, they do not attempt to support this assertion with any of the ample research or empirical evidence that has been undertaken in psychology and the social sciences generally. Such a point reflects

one of Holm's aims in that empirical research may offer insights into existing theories that relate to 'unalterable aspects of human psychology' (Holm 1997 p.25).

The status of both ethical theory and empirical accounts appears to have been contested but there is recognition, not just within bioethics and sociology, but also in other fields such as business ethics, for example, that more integrative and less antagonistic approaches to normative and empirical ethics are possible. Trevino and Weaver (1994), for example, argue that three possible scenarios are possible:

- Parallelism – in which the incommensurability of normative and empirical ethical approaches are accepted and kept separate,
- Symbiosis – in which a more collaborative approach is possible which recognizes mutual benefits and involves communication,
- Hybridization – the most difficult and extreme form of integration, in which a new kind of theory could emerge.

The authors note, however, that it is the second of these possible relationships that is most likely to occur and, as Trevino notes in another article:

A more collaborative relationship is possible [between normative and empirical ethics] in which scholars from the two perspectives communicate with each other, recognizing the potential relevance of each other's work for their own. (Trevino 2002 p. 219)

Hence, the status of empirical ethics may be viewed not simply as what Haiman has described as 'the over-simplistic division between normative and descriptive ethics (that assigns the social sciences the 'handmaiden' role of simply providing the facts)' (Haiman 2002 p.89)

To summarise, the aim of this foregoing debate about the status of empirical and normative ethics has been partly to indicate the potential tensions between the respective claims in what appears to be an on-going debate. However, the intention has also been to consider how empirical ethics research can do more than play a handmaiden role in merely describing social phenomena that are ethical in nature. Furthermore, that it can, in questioning the authority of normative accounts, illustrate that empirical ethics research has the potential to offer unique insights that could even challenge how normative philosophy is understood.

2.4 LATE MODERN AND POST-MODERN ACCOUNTS OF ETHICS

Although scholars such as Hoffmaster have been highly critical of areas of moral philosophy such as the applied field of medical ethics, there has been concern that ethics more generally – whether normative or empirical - has become increasingly marginalized in society. Although related in some respects to the previous section's concern about the place and value of ethics in relation to empirical data and as a means of resolving ethical problems, the aim in this section is to consider several accounts of ethics that are altogether more bleak, although it is argued that such insights still have much relevance to this thesis. Although the pessimism of Weber was identified earlier in relation to ethics, several accounts of what have been described as 'late modernity' or 'post-modernity' have challenged the idea that ethics or morality has the relevance and importance it once had. In the work of Bauman (1993) and also Giddens (1991), for example, it is possible to identify

distinct concerns about how modernity has bracketed-out moral thought and responsibility by variously seeking reliance upon social apparatus such as expert systems or codification. For Giddens, the present time of late modernity is one of increasing pace and technology – what he terms riding the ‘juggernaut’ – but also a concomitant need for a sense of ontological security in individuals’ lives. This desire for security has come at the expense of engaging with ethical issues and amounts to a ‘sequestration of experience’ and leads to a sense of meaninglessness. Giddens argues that this phenomenon needs to be understood:

In terms of a repression of moral questions which day-to-day life poses, but which are denied answers. ‘Existential’ isolation is not so much a separation of individuals from others as a separation from the moral resources necessary to live a full and satisfying life. (Giddens 1991 p.9)

Giddens’, though, is ultimately optimistic about a ‘re-moralization’ of society and identifies a number of areas that herald the return of certain repressed societal groups and the promise of proper moral experience and discourse.

For Bauman, however, there is rather less enthusiasm about the ability of moral discourse to gain its proper place in society. Echoing the concern about isolation in the above quotation by Giddens, Bauman argues that individuals are increasingly morally distant from each other, despite their physical proximity. A multitude of supposed freedoms have led to a concern amongst individuals as to what to do and this sense of helplessness has led to increasing codification and legislation.

Bauman, contrary to this thesis, distinguishes between what is moral and what is ethical and the latter is, for him, a pejorative term that he uses to indicate a failed attempt at universal goals and it is only by radically changing our understanding of

what our responsibilities are, that we can hope to become true moral individuals. The relevance of accounts such as Giddens' and Bauman's to this thesis is that they draw upon sociological, philosophical and psychological insights to offer an alternative understanding of the place of ethics – whether it be normative or empirical – but one that is bound up in the complexity and difficulties of modern society. It is not simply a question of the internecine meta-ethical debate of the is-ought issue or the specific ability of applied ethics to resolve ethical problems in, for example, healthcare but instead a more widespread moral malaise of late modernity that can be located in very individualistic concerns about self-identity, security and responsibility (C. Smith 2002).

Although this discussion seems much broader in scope than the specific aims of this thesis - to understand what pharmacists experience as ethically problematic in their work and to understand how they resolve such issues - it is argued that such insights may be relevant to community pharmacy. The influence of ethical codes such as that produced by the RPSGB, may be an example of what Bauman argues are mechanisms of control and may lead to pharmacists not understanding their responsibility towards others. Similarly, legal structures represent societal forms of codification and, again, perhaps pharmacists' use of law and legislation may come at the expense of more thorough ethical understanding. Indeed, although not considered so far in this thesis, the role of law may be significant in relation to ethics, and as chapters four and five of this thesis will illustrate, law emerged as a significant concern for pharmacists. Such a legalistic concern may be problematic, however, and Habermas (1987) in particular identifies the influence of ever more

complex and multifarious laws and regulations - juridification (verrechtlichung) - as being a consequence of increasing state involvement in individuals' personal and ethical activities. This colonization of the lifeworld, as Habermas refers to it, is inimical to individuals' ability to make ethical decisions and may inhibit the communication of values and ethical debate. Using such theoretical insights admits of the possibility that the pharmacists in this research may be no different from other societal members in being increasingly regulated by, and ultimately reliant upon, legal and procedural systems.

Before concluding this section, one further aspect of both Giddens' and Bauman's accounts of ethics has relevance to this research and this concerns their claims that making moral decisions is an inherently difficult task (aporetic even, according to Bauman) and this is why social codification and the sequestration of moral experience are attractive mechanisms for removing this burden from individuals. The theoretical accounts offered earlier in this chapter were conspicuous by the absence of such potential revelations as to the practical consequences and difficulties of making ethical decisions and so by considering not only the broader social location of ethics but also these quite different interpretations, a more complete but also complex account hopefully emerges of ethics. The aim, once again, in this thesis is to be sensitive to these additional accounts and, as will become apparent in chapter six especially, in considering emergent themes related to the community pharmacy environment – to isolation, subordination and routinization – the insights offered by these less optimistic accounts are argued to

be most relevant and can assist in understanding how ethical issues not only arise but are also dealt with. Similarly, the influence of law for pharmacists will be shown in chapters four and five to be an important theme and the interrelationship between law and ethics, as understood by Habermas, Bauman and others, will be further explored as an issue.

Now that an account has been provided of several influential normative approaches to ethics, how empirical ethic research may be of relevance not only to normative philosophical approaches but also of significance *sui generis* and also to how ethics can be located in terms of broader social accounts in late modernity, it is possible to consider the empirical ethics research that relates to pharmacy. Such a review of the extant literature is relevant not only in identifying whether there are under-researched aspects of pharmacy ethics that this thesis can address but also whether relevant methodological and theoretical insights might be used to develop this thesis.

2.5 EMPIRICAL PHARMACY ETHICS LITERATURE

In a recent review of the scope of the international pharmacy ethics literature, Wingfield *et al* (2004) identified a number of concerns and omissions including a preponderance of scenario based studies from pharmacy practice and a paucity of substantive literature on ethics and values within pharmacy. Wingfield *et al* did provide an example of empirical ethics research but because of specific search

dates, omitted other relevant empirical studies. An aim in this section is to review the extant empirical pharmacy ethics literature, heeding Marx's advice that:

We are not only creators of new knowledge, but protectors and transmitters of old knowledge [...] Seek an appropriate balance between appreciation and advancement of the literature' (Marx 1987)

But an aim is also to identify areas of empirical pharmacy ethics that the present thesis can shed light upon. Three key areas emerge from the existing literature on empirical pharmacy ethics research. Firstly, earlier studies typically used questionnaire-based quantitative methods but more recently, qualitative approaches have been adopted using focus groups and semi-structured interviews. Secondly, the use of theory is explored in relation to studies that are based upon the four principles of biomedical ethics and also CMD. Thirdly, samples appear to have often involved students and Anglophone, especially American, pharmacists. A summary of the available empirical pharmacy ethics literature is shown in table one.

The number of *distinct* studies appears to be similar to other relatively under-researched areas of health care such as general medical practice, for example, where one literature review identified only nine relevant empirical studies (Rogers 1997). It should be noted that the relatively prolific output of Latif involved the repeated use of one data set, reported on in many publications.

STUDY	SAMPLE	DESIGN	AIMS/RESULTS
Lowenthal, Klein, Overton (1986, 1988)	55 US Pharmacists, 165 US Pharmacy students	Questionnaire	Document pharmacy students' attitudes to ethical dilemmas and compare with pharmacists. Both have high level of ethical behaviour.
Dolinsky and Gottlieb (1986)	170 US Pharmacy Students	Questionnaire	To identify pharmacy students' descriptions of moral dilemmas and use of moral development theory.
Haddad (1991)	869 Practicing US Pharmacists	Postal Questionnaire	Compare incidence and difficulty of ethical problems and influencing variables.
Latif and Berger (1997)	113 US pharmacists 92 US students	DIT psychometric test	Pharmacy students scored higher on moral reasoning than community pharmacists.
Latif <i>et al</i> (1998a)	114 US Community pharmacists	DIT psychometric test	Community pharmacists' moral reasoning and components of clinical performance.
Latif (1998b)	113 US community pharmacists	DIT	Ethical cognition, organisational reward systems and patient-focused care.
Latif (1998c)	114 US community pharmacists, 34 covertly	DIT, covert observation	Pharmacists' moral reasoning was significantly positively linked to their medicine warning advice but negatively to social desirability.
Latif (2000a)	113 US community pharmacists	DIT	Ethical cognition and selection-socialization in retail pharmacy
Latif (2000b)	114 US Pharmacists	DIT	Link between moral reasoning and patient care.
Latif (2000c)	Not stated	DIT	A comparison of chain and independent pharmacists' moral reasoning
Hibbert, Rees, Smith (1999, 2000)	6 UK Community pharmacists	Semi-structured interviews	4 principles and practical ethical reasoning found. Legal, business, organisational concerns present. Range of dilemmas identified.
Latif (2001)	113 US community pharmacists	DIT Psychometric Test (postal)	Influence of pharmacists' tenure upon moral reasoning. Older pharmacists scored lower.
Latif (2002)	69 Canadian & 73 US students	DIT psychometric test	Assess moral reasoning of pharmacy students. Unexplained national variation.
Elwell and Bailie (2003)	112 US pharmacy students	Questionnaire (3 point scale)	Influence of class and clinical experience on ethical decisions was not significant for 5 ethical scenarios.
Wingfield <i>et al</i> (2003)	40 UK pharmacy students	Focus group	Perceptions of ethics amongst pharmacy students.
Latif (2004)	1564 US pharmacy students	DIT psychometric test	To measure and compare ethical reasoning of 1 st and 3 rd year pharmacy students and geographical differences.
Wingfield <i>et al</i> (2004)	11 UK community Pharmacists (5 for focus group)	Focus group and Semi-structured Interviews	Influence of company policy on ethical decision-making. Policy created concern but also guided ethical thinking.
Kalvemark <i>et al</i> (2004)	5-7 Swedish hospital pharmacists, dispensers	Focus group	Assess extent of moral distress in hospital doctors, nurses and pharmacists. Time/recourse constraints, rule breaking, professional conflict cause pharmacy distress.
Deans (2005)	11 UK community pharmacists	Semi-structured interviews	Pharmacists experienced many problems but have incomplete awareness of ethics and do not fully engage with ethical problems.
Chaar, Brien, Krass (2005)	25 Australian pharmacists	Semi-structured interviews	Common sense reasoning and best interests of patient identified as central. Legal and business dilemmas in community common.

Table 1 Summary of Empirical Pharmacy Ethics Studies

2.5.1 Methodology and Methods

A chronological change in research approach and method was apparent over the nineteen-year period of identified empirical ethics studies. Many of the earlier studies utilized a questionnaire instrument which contained hypothetical ethical scenarios from which respondents selected options. This allowed statistical analysis of pharmacists' ethical problems and reasoning, whilst latter studies almost all adopted interview or focus group methods. Typical of the former approach was the earliest identified empirical ethics study, by Lowenthal *et al* (1986), that concerned the attitudes of practicing and student pharmacists to ethical dilemmas, with the aim of developing more appropriate undergraduate ethics teaching. A postal questionnaire was used and included questions that required a simple yes or no response to a variety of hypothetical dilemmas - the dilemmas originating from either the authors' experiences or from the normative literature. The study concluded that there was broad attitudinal agreement amongst students and pharmacists in relation to many of the dilemmas posed but some disagreements did occur. The choice of relevant vignettes or scenarios for questionnaires in empirical ethics research has been identified as a concern in the business and medical ethics fields and was also apparent in several of the pharmacy studies identified. Haddad (1991), for example, argued that this was due to the lack of available empirical examples of ethical problems and, using a questionnaire adapted from previous work on nursing ethics, included nineteen dilemmas which were selected on the basis of their frequency in the normative pharmacy ethics literature, rather than

from practice. A free response section was included for pharmacists to provide their own examples but the study did not indicate whether this section was used. Despite quantitative studies being particularly suited to statistical analysis of variables such as the frequency of ethical dilemmas, the study by Haddad was the only one to investigate this. It was reported that fifty eight percent of pharmacist respondents had encountered an ethical dilemma within the last year but a third of pharmacists simply could not recall when they were last involved in an ethical dilemma.

Unfortunately, quantitative and qualitative approaches have traditionally been considered to occupy distinct and separate epistemological territory, with one privileged over the other but as the next chapter will explore in more detail, the choice and relative merit of a particular research approach should be determined by many possible factors, not least, by the type of question being asked. The quantitative studies identified in this review, for example, often focused upon specific questions or sought to test hypotheses whereas the qualitative studies are more concerned with understanding and exploring issues in depth or contextually. The chronological variation in research approach is nonetheless apparent and appears to have precluded study designs that triangulate and combine methods. More recent research has tended to utilize qualitative approaches such as semi-structured interviews or focus groups. In the earliest identified study of this type, by Hibbert *et al* (2000), the authors used interviews to identify and explore the types of dilemma encountered by community pharmacists and to gain an understanding of pharmacists' ethical awareness. The study found a diversity of ethical influences upon pharmacists including business values, ethical codes, organisational values

and ethical reasoning that corresponded to a number of ethical principles and also common sense. As well as semi-structured interview methods, some later qualitative studies adopted focus group methods, with the advantage of allowing data to be gathered quickly and easily and utilising the interactive aspects common to focus group studies.

2.5.2 Ethical Theory

In addition to methodological differences between the studies identified, a number of distinct theoretical approaches were also found in relation to ethics. For example, whilst the study by Hibbert *et al* (2000) sought to explore the diversity of ethical understanding, the subsequent analysis of interview data involved comparison of pharmacists' reasoning to the four principles of biomedical ethics. Although other values were considered, the study focused upon examples of each principle – of autonomy, beneficence, non-maleficence and justice - although the authors recognised the implied nature of such inferences and noted that pharmacists did not mention these principles explicitly. The study offered no support for the assumption that the four principles approach should be *the* approach for ethical judgement except by reference to secondary texts (Campbell *et al* 1996). A similar approach was favoured by Chaar *et al* (2005) who again, despite recognising the range of available ethical theories, gave primacy to the four principles. In this study, no evidence of justice or non-maleficence was reported but patients' best interests were identified as being influential. Although based upon the principles of

biomedical ethics, neither study considered one of the central aspects of the theory - the process of specification and balancing of the principles. As noted earlier, it is not simply the recitation of the principles, *per se*, but rather the coherentist reasoning in selecting a principle in a particular health care situation which characterises their theory, in a manner similar to Rawls' reflective equilibrium (Rawls 1979). Both studies found, however, that a range of value sets and common sense appeared to be ethically influential for pharmacists.

In contrast to the normative ethical four principles theory used by Hibbert *et al* (2000), the psychological CMD theory was employed in the empirical pharmacy ethics studies of Dolinsky and Gottlieb (1986) and also Latif. As noted earlier, CMD theory has been extremely popular and has been used extensively within many health care settings and is claimed to have validity in relation to predicting better clinical or professional behaviour (Rest 1994, Sheehan *et al* 1980). The attraction of the theory for empirical pharmacy research according to Latif is that CMD may be regarded as a conceptual tool or skill and that 'individuals with more advanced moral reasoning skills are often better able to make sense of and resolve difficult moral and social dilemmas' (Latif and Berger 1997 p.167). However, Dolinsky and Gottlieb argue that CMD may also be useful in clarifying and developing moral understanding and the authors use CMD in differing ways: for Dolinsky and Gottlieb, CMD is primarily an analytical tool - to ascribe developmental stages to the responses that pharmacy students provided about ethical dilemmas in a similar way to that used by Kohlberg (who developed a moral judgement interview that required participants to provide reasoned but open

responses to hypothetical questions which were subsequently stage coded); for Latif, CMD theory is used in a psychometric form called the defining issues test (DIT) developed by Rest (1990). Using a self-completion questionnaire format, Rest sought to make identifying moral reasoning both easier and faster to administer and to provide less potential researcher bias by having non-interpretative, pre-coded responses to the dilemmas posed. The DIT is manifestly quantitative in nature and often uses a calculation that assesses the percentage of principled responses chosen over six (but possibly three) hypothetical dilemmas – what is called the P% score. In contrast to Kohlberg's claim that individuals reason progressively higher, Rest allows for reasoning across stages and is concerned with *recognition* and rating of pre-coded reasoning as opposed to Kohlberg's focus upon *self-generated responses*. However, Latif makes no mention of such theoretical differences.

The substantive content of Latif's work has been covered in some detail by Wingfield *et al* but across several publications he uses CMD and specifically the DIT instrument to explore the community pharmacy environment and consider what may be responsible for what he describes as the relatively low levels of moral reasoning of practising pharmacists. Following this initial finding, a number of subsequent hypotheses were considered in further publications including whether community pharmacists' level of moral reasoning would be, variously, positively correlated to their clinical skills, related to owner or employee status and number of years practiced. The study by Dolinsky and Gottlieb appeared to offer evidence of principled, stage six reasoning although the lack of empirical data to support such a

stage has raised concerns about this aspect of Kohlberg's theory, as noted earlier in this chapter (Puka 1990). Latif does recognise several challenges to CMD and in particular he identifies Gilligan's criticism of Kohlberg's theory that justice-based reasoning neglects alternative moral approaches such as, in particular, an ethics of care. Latif explored evidence of specific gender differences and found that female pharmacists obtained 'higher' DIT scores although Gilligan (1993) has subsequently argued that an ethics of care represents simply a different and not necessarily *female*, voice. Latif also identifies several implications of CMD in his work: firstly, an economic saving could be made if pharmacists develop more advanced moral reasoning skills; secondly, that moral reasoning be tested in the pharmacist recruitment process of organisations and, thirdly, that litigation against pharmacists may decrease in relation to the level of moral reasoning.

2.5.3 Samples

Having identified methodological and theoretical differences in the empirical pharmacy ethics literature, another significant theme was the types of respondents or samples used in the various studies. As table one indicates, differences in the samples relating to nationality and student cohorts are apparent. Many of the studies identified used American pharmacists and despite more recent studies including UK, Swedish and Australian pharmacists, there is under-representation in many areas of the world which may limit the scope of our comprehension of empirical ethical issues across different health care systems and cultures. In

addition, few studies focused specifically upon the hospital pharmacy setting and although Haddad and Chaar *et al* sampled pharmacists from all areas of pharmacy practice, including academia, only the study by Kalvemmark *et al* (2004) focused upon the hospital environment. It was also the only study to involve pharmacy dispensers and assistants.

More apparent was the use of student cohorts in the studies identified - either solely or in comparison with practising pharmacist. This may be explained by the fact that many studies set out to inform the teaching of ethics at undergraduate level. Indeed, even studies that sought to explore practicing pharmacists' understanding of ethics, such as the study by Hibbert *et al* (2000), also aimed to be of use in the undergraduate pharmacy curriculum (Derek Hibbert 2004 personal communication). Whilst most studies valued the ethical views of students by virtue of their not being practising pharmacists, students in the study by Dolinsky and Gottlieb appeared to be used as proxies in relation to ethical dilemmas. Students were asked to describe two dilemmas that involved altruism and self-interest but these could be confusingly drawn from either first person experience or what students recalled about the dilemmas of other pharmacists. The authors concede that:

The inferred reasons for actions probably tells us more about the pharmacy student doing the inferring than about the level of moral judgment of the pharmacist. (Dolinsky and Gottlieb 1986 p.57)

In contrast and more transparently, the aim of the study by Wingfield *et al* (2003) involving pharmacy students was simply to determine their perceptions of

pharmacy ethics and concluded that exposure to practice (as students progress through the four year UK course) led to an increased awareness and understanding of ethical issues. Despite the direct pedagogical aims of some studies, it may also be argued that student cohorts are used, in part, because they represent an easier research group to recruit and investigate and are, in effect, a convenience sample. They are usually logistically, financially and temporally easier since they may be closer to the researcher on campus, require less remuneration (if any) for participating and also have perhaps more time to spare in comparison to practicing pharmacists.

2.5.4 Dilemmas and Themes

Having so far offered a critical review of the empirical pharmacy ethics literature in terms of methodology, theory and sampling, the actual results of these studies and advances in knowledge that they have generated must not be ignored. What was evident from many of the studies was that the pharmacy *environment* appeared to be significant in terms of shaping the types of ethical dilemmas or problems encountered and also relevant in terms of influencing the ethical reasoning of the pharmacist. This appeared to be especially important for community pharmacy and Chaar *et al* noted that problems occurred more often in the community setting than in other areas of pharmacy practice and Haddad similarly identified more ethical problems in the community setting but also found that actual work experience shaped pharmacists' ethically. By contrast, Latif's work repeatedly suggested that

the community pharmacy environment was detrimental to moral reasoning - pharmacists who had remained in practice longer tended to have lower moral reasoning scores and there were also some differences between scores for independent pharmacists and those who were employees, and pharmacy students, who had not been exposed to the community pharmacy environment, also scored higher. However, the qualitative studies in this literature review provide a more complex picture of ethical influence and, for example, Wingfield *et al* (2004) found that whilst business and commercial values led to ethical issues such as controlling profit and customer pressure, company and organisational policies were also helpful in terms of dealing with ethically problematic issues and in 'guiding their thinking in difficult areas such as supply of emergency hormonal contraception.' The pharmacists interviewed by Hibbert *et al* (2000) appeared to be even more variously influenced - by self-interest, commercial and organisational values and also legal concerns. The study also offered a considerable number of pharmacist generated ethical concerns that provide a wealth of information about UK community pharmacy and that, for example: pharmacists often have to deal with patient representatives and encounter confidentiality issues; regulations relating to emergency supplies and controlled drugs led to conflicts between benefiting the patient and complying with legal requirements; supplying syringes to addicts to prevent health risks must be balanced by a concern about theft from the pharmacy; the code of ethics was not often referred to. In the study by Kalvemark *et al* (2004), Swedish pharmacists appeared to suffer moral stress from issues that were related to time pressures in a hospital dispensary and to staff shortages. Similar concerns

emerged in the study by Hibbert *et al* (2000) in that pharmacists expressed concern about challenging prescribing doctors because of the perception of professional hierarchy and also having to balance breaking a regulation to benefit a patient.

It would appear that this is still a relatively under-researched area of health care ethics and many questions remain. For example, the dominance of CMD (and justice-based reasoning) and the ‘four principles’ approach to ethical theory in the studies identified may be explained by their popularity but do these adequately reflect how pharmacists make ethical decisions? The importance of other ethical theories such as narratives and casuistry have been identified already in the chapter and have been identified amongst other health care professionals (Braunack-Mayer 2001, 2005) but, because quite specific theoretical approaches have often been used in existing studies, this has not been explored amongst pharmacists. Hence, one of the key questions that emerges in this thesis is how ethical decisions are made, given the plurality of possible approaches? What was also apparent was that hypothetical ethical dilemmas were often used to gain an understanding of how pharmacists reasoned ethically. Whilst this is not criticized as a research approach, it leaves unanswered the question of how pharmacists actually resolve the actual problems that they experience in practice and one of the intentions of this thesis is to consider how pharmacists resolve such practical, rather than hypothetical problems.

A related point is that only one UK peer-reviewed study has considered what ethical issues are experienced by community pharmacists but many changes to

practice have occurred since the publication (and indeed even earlier sampling) of this small study. Hence, the question of what ethical issues are encountered by UK community pharmacists is an important question that this thesis will attempt to explore.

In identifying these important but hitherto unanswered or partly answered questions, it is hoped that this thesis can try to answer them and also offer unique insights into empirical pharmacy ethics. But before concluding this chapter, attention is focused upon one final insight into how ethical practical accounts of how ethical decisions are or could be made in practice and to the use of decision-making models.

2.6 ETHICAL DECISION-MAKING MODELS

The focus so far in this chapter has been upon different approaches to ethical reasoning – whether these be normatively or empirically grounded – and to a consideration of the type of empirical research undertaken in pharmacy. Although the empirical pharmacy ethics literature has considered various practical aspects of pharmacist's ethical issues and the reasoning used, the theoretical bases for these studies have often been located in normative theory (such as the four principles of biomedical ethics or Kohlberg's CMD) What none of the identified studies have considered, however, is what process of practical decision-making occurs amongst pharmacists in their work. Although ethical reasoning has been considered as the basis for how ethical decision-making and 'ethical understanding' (Hibbert *et al*

2000) can be considered, these still represent a theoretical account and there remains a question as to what is involved, practically, in how individuals actually go about making decisions. Similarly, although the work of both Kohlberg and Gilligan involved an empirical perspective, the focus was still upon reasoning as a cognitive process. A significant body of literature, however, has developed in relation to other aspects of how ethical decision are made and in this section, the development of a number of models of ethical decision-making are considered and it is argued that these may offer valuable insights into how pharmacists try to resolve ethical problems and hence could be of use as an analytical framework in this thesis.

Two main forms of decision-making model appear to have developed, reflecting different concerns in practical ethics. Firstly, a considerable number of pragmatic but prescriptive models have emerged, often related to particular fields of practice. Such models are also referred to as frameworks, guides and methods of ethical decision-making but they all share the aim of offering practical and pragmatic assistance to practitioners in a particular field as to how to deal with ethical concerns in their work. Secondly, a number of models have emerged that attempt to explain or predict ethical behaviour in terms of the process of decision-making. These latter types often emerged in the fields of business, organisational or marketing ethics where there has been a growing interest in developing theories that try to accommodate not only the stages of making an ethical decision but also factors relating to the individual and also their environment (Ford and Richardson

1994). Table two includes a selection of some of the available models and includes both practical models that relate to health care and pharmacy and several that have been developed as more theoretical explanatory models (identified with an *).

What is apparent is the difference in complexity of these models but also the fact that they all leave open the question of what ethical reasoning should be used. In this respect, the models are formalistic and require the individual to apply some form of ethical reasoning themselves.

Despite the popularity and number of such models, there is a surprising lack of justification for the models. In the field of business and organisational ethics, this may have resulted, in part, from a hypothetico-deductive approach, which according to Loe and Ferrell (2000) means that:

Studies addressing the ethical decision making process in business can be categorised into two distinct pursuits: 1) studies that directly examine the hypotheses set forth by decision making models, and 2) studies identifying the moderators of ethical decision making within the organisation. (Loe and Ferrell 2000 p.187)

In relation to the pragmatic prescriptive models, these are sometimes simply advanced as the correct way of resolving ethical issues in practitioners' work. However, there appears to be some degree of tacit acknowledgment that these models and methods have worked in practice, especially in relation to ethical education in pharmacy (Joy Wingfield 2006 personal correspondence) and medicine (Mike Parker, University of Oxford 2006 personal correspondence).

Model /Author

Distinct Stages in Individual Models

Weinstein (1996) Wingfield (1997)	Gather facts: law, codes, professional knowledge	Consider who is involved and their values	Generate options	Make decision				
Veatch, Haddad (1999)	Consider where situation is ethical problem:	a) Distinguish facts from evaluative statements	b) Distinguish moral and non-moral evaluations	c) Determine who should decide	Consider the range of ethical theories.	What other rules might apply?		
Parker Adapted from Pellegrino method.	What are relevant facts	Define who should act and when	List possible options	Identify morally significant parts of options	What does law say	Identify pros and cons of moral arguments	Choose option based on consistency, concepts and logic	Find best counterargument. If you can rebut it, decide.
Rest (1986) Jones (1991)	Identify ethical problem	Apply ethical reasoning	Establish moral intent	Act Ethically				
Schneider and Snell (2000)	What are my core beliefs	How have I acted in past	What are Reasoned opinions of others	What is experience of others in similar situations				
BMA (2004)	Recognise ethical situation	Break down dilemma into parts	Seek information from patient and others	Identify relevant legal & professional guidance	If no solution found, apply critical ethical analysis	Justify decisions with sound arguments		
Jonsen, Seigler and Winslade (1992)	Establish medical facts	Identify patient's preferences	Consider quality of life	Think about religious, legal and cultural factors				
Holm (1997)	What personal experience tells us	Ethical perception	Ethical Reasoning	Ethical decision	Consideration of practical possibilities	Final Decision	Implementation	

Table 2 Examples of ethical decision-making models

Furthermore, some methods appear to have been adopted from others and, for example, Wingfield's four stage approach (1997) bears similarity to that of Weinstein (1996) and Parker notes that his preferred approach to ethical decision-making is influenced by the work of Edmund Pellegrino (Parker 2006 personal correspondence). Similarly, Holm (1997) developed a model to explain how a sample of hospital doctors and nurses made ethical decisions that were influenced by the four-component model developed by Rest (1986), which originated in the psychological field of CMD and which was also used by Jones (1991) in his synthesized model of decision-making in the field of business ethics. Unfortunately, Holm did not explain his choice of Rest's model and merely noted that his research was 'influenced' (Holm 1997 p.80) by it, although he appeared to have developed a model that was explicitly based upon the four key stages of Rest's original model.

What these various models appear to indicate is that ethical decision-making might involve more than simply using ethical reasoning and that, in practice, the question of what motivates or leads individual ethical agents to act can be more comprehensively understood by including a number of additional, practical concerns. This is illustrated, for example, in the explanatory model advanced by Rest, and subsequently adopted by Jones and also used by Holm, in that it requires not only the identification of an ethical problem and the application of some form of ethical reasoning but also the perspicacity to set aside any self-motivated interests and also the conviction to act upon what one has decided is ethically correct. Although not included in table two, Jones' model also includes a number of additional components that appear to offer a very comprehensive account of the empirical issues that may be involved in an individual's ethical

decision-making (figure one). It requires a consideration of the differences between individuals and the particularity of ethical situations and also the influence of the environment in which both the individual works and lives and in which the ethical issue arises. Coupled with these factors is the influence of what Jones describes as ‘moral intensity’ – specific aspects of an ethical issue such as the urgency of the ethical issue and the magnitude and proximity of any resultant harm.

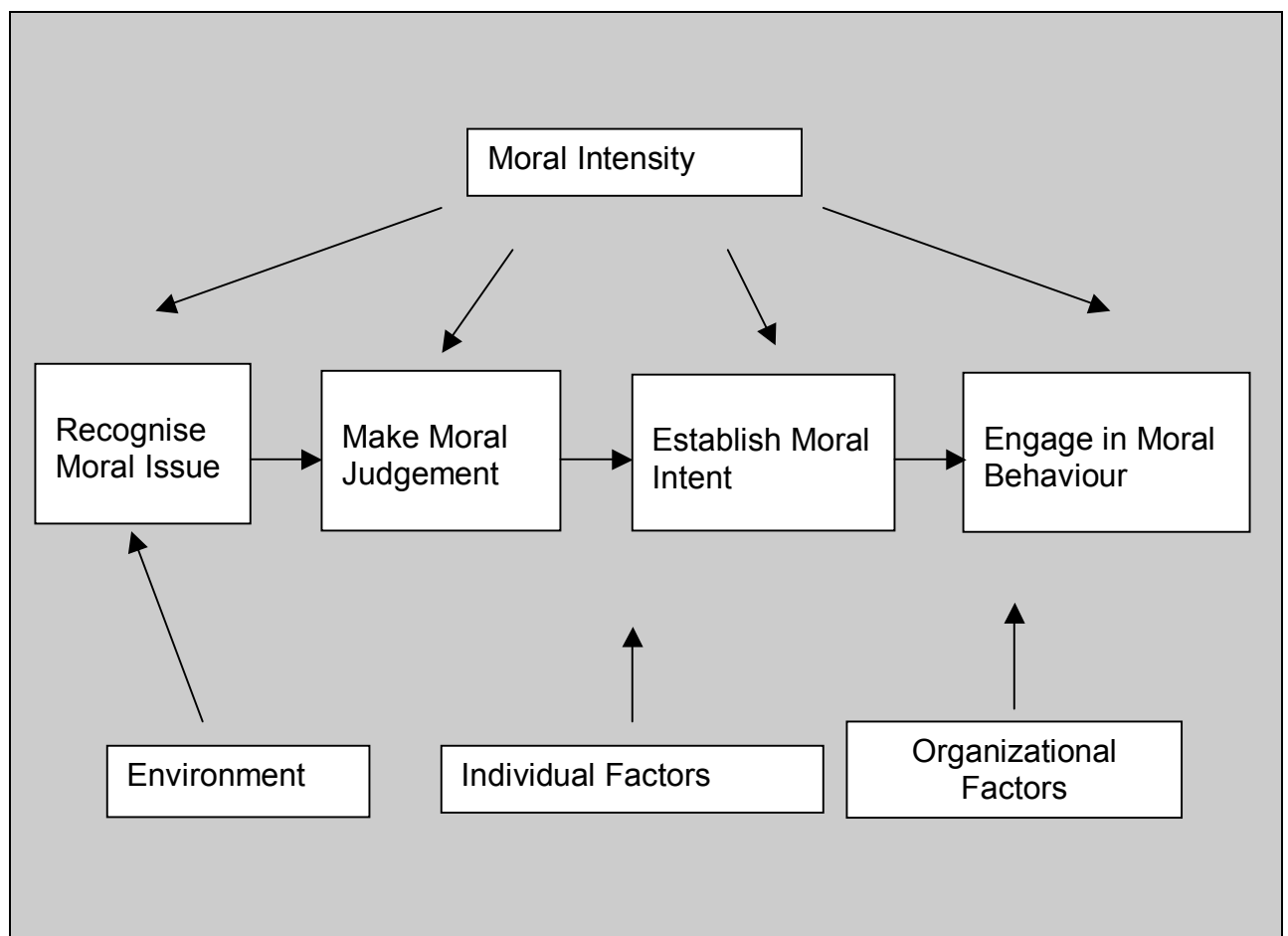


Figure 1 Jones' model of ethical decision-making

It is argued that using Jones' model as a guide to how pharmacists in this study may try to resolve ethical problems may be helpful. It is a synthesized model and is based

upon five previous approaches (Rest 1986, Trevino 1986, Dublinsky and Locken 1989, Ferrell and Gresham 1985, Hunt and Vitell 1986) and, as such, appears to be quite comprehensive. However, in the same way that various ethical theories have been considered in this thesis, the intention again is to be guided by, but not restricted to, such theoretical insights. Following Holm's empirical study involving the ethical reasoning of doctors and nurses, the use of Jones' decision-making model is to be considered as a guide or framework with which to consider how pharmacists might resolve ethical problems rather than a definitive theoretical account of how decisions may be made. As such, this thesis aims to remain open to other possible approaches but to use the model, and in particular the four central stages – of ethical identification, reasoning, intent and action – as a framework for analysing how pharmacists tried to resolve their ethical concerns.

2.7 CONCLUSIONS

The aim in this chapter has been to describe a number of theoretical concerns that are relevant to this thesis. These have included a consideration of existing normative ethical theories that may offer insights into how pharmacists make ethical decisions. A number of alternative, psychologically-derived approaches have also been described as well as those that rely upon intuition and narratives, to illustrate the range of approaches that have been theoretically considered as forms of ethical reasoning. The extant literature relating to empirical research in pharmacy has been reviewed and there appears to be little exploratory research that has considered what pharmacists in

the UK community pharmacy setting understand and experience as ethical issues and still less that has considered how such problems are actually resolved in practical terms. In identifying a number of models of ethical decision-making, it has been argued that these may be of use as an analytical guide to how pharmacists make ethical decisions and, in Jones' model in particular, that four central stages – ethical attention, ethical reasoning, ethical intent and ethical action – may be important. Furthermore, that the type of ethical problem and the situation, culture and overall environment might be relevant to ethical decision-making is also identified.

The status of empirical research has also been considered and it has been argued that empirical ethics research in the social sciences has been increasingly valued not only for the unique insights it may offer into areas such as the community pharmacy setting but also in terms of the contribution that can be made to, and even the possible change to, normative ethics.

Finally, the potential marginalization of ethics more generally in society has been explored as a possible approach to understanding the relevance of ethics. Increasing reliance upon expert systems, codes and laws and the separation of individuals from ethically important issues may provide an alternative way of considering how pharmacists' ethical issues and decision-making could be seen.

In the next chapter, a description of how the research was conducted is presented in terms of methodology.

3 METHODOLOGY

3.1 INTRODUCTION

The intention in this chapter is to describe the research strategy that was developed to best answer the questions that have emerged from the previous chapters: what ethical issues are experienced by community pharmacists, how they try to deal with such situations and how important is the community setting in relation to ethical concerns? This will involve a consideration of what data will best inform the study, how such data can be obtained and how it could be then analysed. It will be argued that using a qualitative methodology involving semi-structured interviews is most appropriate for answering the research questions posed in this thesis but the purpose of this chapter is not only to reflect upon how this particular research strategy was decided upon but also to reflect upon it critically. Specific issues relating to sampling, how interviews were conducted and their subsequent analysis will be developed, as well as concerns relating to research ethics, practical and logistical issues and also the concept of reflexivity. Firstly, an overview is presented of some general research questions which are common to much social science research, involving the choice of appropriate methodology. Then specific arguments are presented in relation to this thesis as to what methodology might be most suitable. This is followed by a consideration of which technique or method can be best used to gather the relevant data. Descriptions are then offered of how the actual research in this study was conducted in relation to sampling, recruitment, access, interviewing, recording and analysis. The chapter

concludes with a consideration of possible problems such as research ethics and issues relating to ‘quality’ and credibility in qualitative research (Seale 1999).

3.2 RESEARCH STRATEGY APPROACHES

The previous chapter hinted at how the empirical pharmacy ethics research may be influenced methodologically when reference was made to the chronological change from quantitative to qualitative approaches in the extant literature. Although this was identified as no more than a trend, it emerged that using the latter methodology yielded empirical data that offered not only a range of possible concerns but also captured the depth and complexity of ethical issues and reasoning. It is recognised that in using qualitative approaches to research, greater emphasis is placed upon the context and the richness of accounts of social phenomena and, as such, this may be one of the reasons why such a methodology would be chosen (Geertz 1973). Such a methodology values understanding of social phenomena rather more than explanations of them, as per quantitative approaches. However, there are other significant reasons for choosing a particular methodology in addition to what we expect such an approach to reveal about a particular subject area of research. A linked concern is the nature of the research questions that are being asking and that, although very generalised, the reduction of research questions into ‘what, why and how’ categories affords a very rough guide to the relevance of a particular methodology, namely that ‘what’ questions may be more amenable to quantitative approaches and ‘why’ and ‘how’ questions to qualitative approaches (Blaikie 2000, F. Smith 2002). Of course, these are relatively crude

approximations but to recap, the key research questions of the present study are:

- What ethical issues are experienced by community pharmacists in their work?
- How are such issues resolved or dealt with?
- How does the community pharmacy setting influence ethical problems and their resolution?

Most of the research questions, it can be seen, may be roughly grouped into those that would be particularly suited to qualitative approaches to social research. Furthermore, it is obvious from these research questions that no hypotheses have been advanced that would require the researcher to test them, obviating the need for an explicitly quantitative strategy, for example, that would be compatible with a hypothetico-deductive approach. In addition, as the previous chapter noted, how pharmacists make ethical decisions appears to have been treated in the extant literature very limitedly – with reference to the four principles of biomedical ethics or CMD theory. As has been argued, this does not necessarily exhaust the possibilities of ethical reasoning and so an approach that remains open to the potential diversity and complexity of pharmacists' reasoning is considered to be advantageous in this thesis.

Other influences upon methodology may occur in the nature of the social phenomena itself that is being studied. In the present research, this involves the concepts of ethical issues and ethical reasoning and at issue is whether a particular methodology is more or less suited to a particular object of research. In the physical sciences, for example, it is not contested that to study physical phenomena such as levels of rainfall or changes in blood pressure, for example, a quantitative approach would be most suitable.

However, in the social sciences this is less clear and in relation to what might be

understood by ethical statements, in particular, this has been the subject of debate.

Crane (2000) develops several concerns that he argues have stymied empirical ethics research in the business and organisational fields and notes, following Bonoma (1985) that the study of morality may 'simply defy counting approaches' (Crane 2000 p.241). Unfortunately, the suggestion of two separate paradigms of qualitative and quantitative methodologies are in part perpetuated by the convenience of their descriptions and in this study, the terms are used for this reason.

Finally, there is the reflexive concern that the researcher might import their own methodological preferences into the research. This can occur in a number of ways and, firstly, may be due to personal preferences for a particular approach to research.

Becker (1998), for example, argued that his choice of qualitative approaches was at least in part determined by his enjoyment and experience of this particular approach and he notes that:

It's the kind of research I've done, but that represents a practical rather than an ideological choice. It's what I knew how to do, and found personal enjoyment in, so I kept on doing it. (Becker 1998 p.6)

Secondly, it may be due to the enduring epistemological and ontological commitments of the researcher. Their position on the, admittedly difficult, metaphysical issues surrounding what are understood by knowledge and existence may be very influential in their choice of a particular methodology depending upon these metaphysical beliefs. Furthermore, some theoretical positions may require the use of a particular methodology - social constructionists, for example, would tend to reject a realist account of the social world, independent of the agent and so quantitative strategies

may be much less appropriate than qualitative ones. However, Avis (2003) notes that the choice of and, more pertinently, the justification for, a particular methodology should not simply rest upon an invocation of a recognised approach and the subsequent elevation of them to a revered status as ‘matters of faith’ (2003 p.1004). Avis cites the use of grounded theory, phenomenology and ethnography, in particular, as examples of methodologies that are:

All too often [...] used to justify a series of steps or procedures that been followed to produce evidence in a way that closes off scrutiny of the evidence by locating it as internal to a particular methodological theory. (Avis 2003 p. 1004)

As such, the choice of a particular methodology should attend to underlying metaphysical claims to knowledge and reality and not simply involve an uncritical appeal to a specific methodology.

A final concern relates to the audience the research is intended to be presented to, and of possible preferences or expectations about how findings are communicated to particular audiences. For example, in *Ethical Problems in Clinical Practice*, Holm (1997) devotes a significant amount of space to the question of qualitative research and, in particular, a defence of qualitative research in relation to the established scientific and medical communities *qua* researchers and also audience (Holm 1997 chapter 3 *passim*). It may be argued that such a defence is less necessary given the intervening ten years or so since his research but it remains the case that social research, in which this thesis would certainly be included, continues to distinguish between quantitative and qualitative approaches to investigating social phenomena and

at the level of government policy, for example, quantitative or statistically presented data are often preferred.

Having assessed, in a general sense, the various claims upon the choice of methodology for a research project, it is now possible to consider the approach chosen in this study. As the research questions reveal, the intention is not to test hypotheses or a specific ethical theory for its 'fit' against a set of data but rather to explore what is argued still to be a relatively unexplored area of health care ethics. As such, the present research may be distinguished from that of Latif, for example, in not seeking to test a theory or a hypothesis but to explore and understand what pharmacists experience as ethical concerns and how they resolved them in the community setting. Importantly, the choice of methodology involved choosing an approach that allowed a greater emphasis to be placed upon gaining insights that might differ between pharmacists but that also valued the situated, contextual nature of the research questions and explored how such problems are experienced and understood by pharmacists. It is an attempt not only to describe phenomena in a way which reflects their occurrence in a given situation or environment but to also understand them and to be sensitive to multiple perspectives. Such aims may be contrasted with attempts to quantify and measure ethical phenomena. Given these aims, then, the use of a qualitative approach is argued to be the most suitable. In addition, the choice of methodology was to some extent informed by my existing epistemological and ontological views as a researcher. My understanding of, and assumptions about, the world may be broadly described as idealist, in that I would align myself to theories of existence that do not admit of an independently knowable world. Although beyond the scope of the present study,

Kant's distinction between the *noumenal* and the *phenomenal* worlds is appealing – an idealism that rests upon the belief that the world that is known to us is agent-dependent and cannot be known except through the individual but yet recognises the possibility of another ontology albeit one that must always remain unknown to us. Such idealist ontology admits of an allied epistemological position, in that what can be understood as knowledge is bound up in our interpretation of social phenomena. Hence, an interpretative approach to understanding social phenomena, including ethical issues and ethical reasoning, is adopted in this study - an approach that recognises that what can be known about the world is dependent upon our interpretation or perception of it as individuals.

3.3 DATA AND METHOD

Having argued that a qualitative approach would be most appropriate for answering the research questions posed, the next concern involved which method would be most appropriate, allied to a consideration of the type of data that is to be collected to inform the research questions. The choice of research method or technique may vary depending upon the nature of the social phenomena under investigation and upon what one wants to understand about those phenomena. In the context of the present research, a number of different sources of distinct data could be relevant. For example, it may be possible to analyse documents relating to ethical issues if, perhaps, these have been recorded by pharmacists or to simply observe pharmacists at work or even to record pharmacists' interactions with others and analyse their conversations involving ethical

concerns. These represent three of the four main categories of qualitative method, according to Silverman (2001), the other being interviews. All of these approaches were considered in the early stages of this research but important problems, often of a practical nature, were identified with observation, textual and conversation analysis. For example, the use of observation was thought to be a potentially useful approach since it may reveal the problems experienced by pharmacists in the context of their actual work. This approach could yield detailed accounts of community pharmacy work and allow valuable insights into the context and process of ethical problems (Bryman 1988). However, whilst this approach may have been appropriate to answering the question of ‘what ethical problems occur’ it may be less suitable for answering ‘how do pharmacists resolve such problems’ since this involves reasoning processes that may not be apparent through observation – processes that Bryman (2000 p. 329) refers to as being ‘resistant to observation’. However, despite the potential richness of data that this approach might yield, more significant practical problems were thought to preclude the use of this method in terms of the difficulty in gaining access to the community pharmacy environment for observation but also in obtaining the necessary research ethics approval to conduct such a study⁴. Immediate issues were identified in terms of respecting the confidentiality of patients and customers in pharmacies. Several exploratory requests were made to ‘gatekeepers’ - pharmacists or pharmacy companies’ superintendents - to observe pharmacists working in a pharmacy

⁴ Although possibly due to a range of factors, empirical ethics research by Z Deans was initially attempted as an ‘observational study of pharmacy practice’ but was refused ethics approval by North Staffordshire REC as detailed in their Annual Report 2003/04
www.active.sasha.nhs.uk/corporate/lrec/LRECAR0304NS.pdf

but access was frequently denied. Reasons cited included perceived confidentiality threats, as well as potential disruption to work activities within the pharmacy. So, despite the advantages that observation would have had in revealing the situated nature of ethical problems and their emergence in actual pharmacy practice, this method was rejected. Conversation analysis, involving recording and subsequently analysing pharmacists' conversations with other relevant individuals was also rejected since although this might offer insights into how pharmacists communicated ethical concepts and attempted to deal with them, practical issues arose in terms of how to record such instantiations of ethical problems. In contrast to other areas of pharmacy practice, such as medicines use reviews or patient counselling when handing a medicine out or giving OTC advice, recording pharmacists' conversations in instances where an ethical concern might be involved were, by their nature, more nebulous and difficult to predict. Furthermore, these could involve not only direct contact with others, such as patients or customers in pharmacies, but also telephone conversations that, due to their spontaneity, might be difficult to gain access to and consent to record from other parties, such as doctors, receptionists and company staff. Document analysis was also considered but it became apparent from both my own experience as a pharmacist and also from exploratory discussions with other pharmacists and companies, that specific documentation of ethical issues was not undertaken. The reporting of critical incidents, errors or 'near misses' was common practice in pharmacies but it was apparent that these were not usually of an ethical nature but rather of situations where a dispensing error had occurred, where a clinical intervention was made or where a customer or patient complaint had occurred. Although, as will be later seen, ethical issues *may* be

involved in such situations, documenting the ethical as well as factual and clinical aspects of such incidents was not required. Indeed, from my own experience as a pharmacist in many different pharmacies and pharmacy companies, I was aware that the various protocols for reporting incidents did not require pharmacists to include ethical concerns. Hence, the use of this method was rejected since it was considered not to reveal enough of the richness of potential ethical issues.

3.4 INTERVIEWS

The remaining qualitative approach, therefore, concerned interviewing, although it should be made clear that this approach was not finally chosen simply by the rejection of the other techniques but rather because it had a number of distinct advantages.

Firstly, it would allow pharmacists to describe their ethical concerns and reasoning and influences in their own language and in a way that they find most appropriate – to gain insights into their experiences. Secondly, it would allow me, as an interviewer, the opportunity to challenge their responses, not necessarily in a critical way, but to request further details and to clarify their responses. In addition, in adopting an interpretative approach to this research, the use of interviews may have the specific advantage of allowing pharmacists to reflect uniquely upon issues such as the ethical problems that they encountered and to reflect upon how they were managed. As

Blaikie notes:

Much of the activity of the social world is routine and is conducted in a taken-for-granted, unreflective manner [...] It is only when enquiries are made about

their behaviour by others (such as social scientists) or when social life is disrupted, and/or ceases to be predictable, that social actors are forced to consciously search for or construct meanings and interpretations [...]
Therefore, the social scientist may have to resort to procedures that encourage this reflection in order to discover the meaning and theories. (Blaikie 2000 p. 116)

Hence, interviews may be just such a ‘procedure’ that allows the pharmacist *qua* social actor to focus upon aspects of their lives.

Interviews are usually further sub-divided into structured, semi-structured and unstructured types and also include group interviews such as focus groups. Focus groups were initially the preferred ‘starting’ point in this study since it was believed that an initial exploration of the variety of ethical problems and how they were resolved could be gained using such a method, followed by individual semi-structured interviews. However, focus groups were not eventually used for logistical reasons since the first participants to be recruited were from geographically separate areas and it was easier to arrange distinct individual interviews since the pharmacists involved often preferred to be interviewed at their place of work or were reluctant to travel. The use of semi-structured interviews with pharmacists was chosen because it was important, given the research questions, to allow pharmacists to describe ethical concerns and their experiences and decisions using as much or as little detail as they thought appropriate. Rather than use a completely unstructured approach, however, it was considered necessary to shape the interviews by focusing upon a specific problem for a pharmacist and then having them explore the decision-making process and guide interviewees in relation to other issues such as influences.

In choosing semi-structured interviews for the research, it is important to consider the status of the interview data that emerges. Are respondents in interviews offering accurate descriptions of actual events or are they simply offering interpretations or narratives (Holstein and Gubrium 1995) that require distinct understanding and sensitivity? Even more radically, should they be thought of as Goffman-like role-playing exercises that involve the maintenance of an impression (Goffman 1959, Dingwall 1997)? It is acknowledged in this thesis that interviews conducted with pharmacists do not confer any privileged knowledge of ‘actual’ events necessarily and so does not fall foul of what Dingwall refers to as the problem of ‘simply assuming that interviews are literal descriptions of some underlying reality’ (Dingwall and Watson 2002 p.21). Although there is much debate as to the status of interview data that is beyond the scope of this study, what such debates do however, is force not only the researcher but also the reader to be critical of what interview data represent and not be, as Atkinson and Silverman (1997) note, seduced by the effects of an ‘interview society’ that assumes that this form of social interaction is definitive. In relation to the media, especially, the assumption that the interview is a social technology that can assist in the construction of individuals’ identities and selves through the interview process is a pervasive but distracting assumption.

The role of the researcher in the interview must also be remembered in terms of the reflexive concern about the shared constructions of possible ethical concerns. In this study, the use of semi-structured interviews is considered to offer, epistemologically, data about ethical concerns as understood *by* pharmacists – hopefully, it will offer descriptions and insights of what they experience but in conducting interviews, such

data are not claimed in a positivistic sense to correspond to 'true' events. Rather, pharmacists' interpretation of ethical issues in their work, their perceptions of how they resolved problems and of how the community pharmacy setting influenced matters, is valued. Furthermore, it is accepted that using semi-structured interviews, such constructions are further shared in terms of my role as an interviewer and that the interview process is not a static or unidirectional event but, instead, one that involves both interviewer and interviewee. Importantly, though, my role as not only a pharmacist but also as an 'expert' in this field of study was recognised as a potential problem. Kvale notes (2006) that there is a common misconception that qualitative interviews are 'warm, caring and empowering' (Kvale 2006 p. 480) and that this disguises differences or 'asymmetries of power' between the researcher and the participant - asymmetries that have methodological consequences, since:

In a methodological context, close analyses of the specific power dynamics within different forms of interviews are warranted. With knowledge produced in the social interaction of interviewer and interviewee, the power play of this interaction could be made transparent by the presentation of the method of an investigation, so that readers may ascertain the potential effects of the power play on the knowledge reported. (Kvale 2006 p. 496)

Hence it is important in this thesis to be sensitive to, and also transparent about, possible epistemic and power differences and this may be manifest in several ways. Firstly, in relation to my status as a fellow pharmacist, this may have the potential to alter interviewee's accounts and yield 'insider versions' rather than 'public versions' of ethical concerns (Dingwall and Watson 2001). This may have the advantage of enabling interviewees to feel that they could discuss issues that a 'public' account would not permit such as, for example, financial aspects of pharmacy work and

profitability that, from my locum pharmacy work, are often 'hidden' from public accounts of pharmacy work. Secondly, although all the respondents knew that I was a practising pharmacist, I did not make a specific attempt to indicate my full academic background beyond being a university research student. However, at various points in the research, I did make reference to having studied ethics and law more formally but the intention in such instances was to be deprecating and this would often follow instances where a pharmacist sought re-assurance about being ethically uncertain and I would perhaps respond that even training in such issues does not guarantee certainty. Such admissions were not thought to compromise interviews but have been recognised as ethical problems in the research process itself (Oakley 1981) and are considered later in this chapter. However, the potential epistemic imbalance with myself as a supposed expert and the pharmacists as ethically naïve interviewees did not appear to restrict the interviews and offered the advantage of my being able to guide interviews and probe a response given a background in moral philosophy. However, this fell far short of an antagonistic interview situation in which conversation could be considered as a battlefield (Kvale 2006). Such disclosures were never used as an attempt to impose any superiority or power advantage but, rather, to allow me to question pharmacists further in a sensitive manner and in a way that might reveal more about their reasoning and responses. For example, as chapter five will indicate, appeals to consequences were often used by pharmacists and during interviews I was able to identify such responses and then further question them as to whether only one specific consequence had been considered or whether others had too, or to explore what measure of utility the pharmacist was referring to.

3.5 SAMPLING

Having chosen a semi-structured qualitative approach to study the research questions identified, and considered some of the possible problems with such a method, the next stage was to identify pharmacist interviewees and begin the process of recruiting participants for the study. Early in the design of the research, it was decided that community pharmacists would be the main focus of study, given that the overall research was concerned with *their* ethical concerns and *their* reasoning. However, in relation to questions such as how the community pharmacy environment influenced ethical issues and their resolution, the views of other significant parties was considered. In particular, representatives of the RPSGB and also organisations such as the NPA and employers were believed to be useful in informing the study. As the study proceeded, however, the data which emerged from community pharmacist interviews was found to offer so much in terms of emergent themes that it was decided to concentrate on pharmacist interviews rather than other stakeholders or key individuals in pharmacy. However, several interviews were conducted early in the study and these included a number of superintendent pharmacists, who were recruited from national organisations and were asked about issues relating to the ethical assistance offered to their pharmacist employees, to company policies that might have an ethical impact and to concerns about increasing corporate ownership; two further interviews were conducted with a member of staff from the RPSGB and also the NPA about ethical issues generally. Unfortunately, the latter two interviews (both conducted by telephone with one being recorded, the other annotated) did not produce

rich data and I was given the impression that these were almost like public relations exercises rather than personal insights into the respective individual's work. As a result, these were not considered to be very productive interviews although some insights were gained into general issues such as how ethical and legal advice was given to pharmacists and the staffing of the respective departments. As noted, the richness and depth of data that emerged from pharmacist interviews meant that these provided plentiful data and themes from which to answer the research questions but the interviews conducted with superintendents and staff of the RPSGB and NPA did provide useful background information (Cooper *et al* 2005) and informed the research in terms of, for example, questions in the interview guide.

The question of how to gain access to potential pharmacist respondents was considered in a number of ways. Firstly, it was thought that a randomized approach could be attempted, using lists of pharmacies from Primary Care Trusts (PCTs) or from the list of registered pharmacists held by the RPSGB. However, as a practicing locum pharmacist, I had considerable experience of working in many different pharmacies. Although seldom working with another pharmacist (a concern that will be developed later in relation to isolation), using this aspect of my professional work, I was able to foster initial contact with pharmacists by virtue of having worked in their pharmacy in a locum capacity. It was originally thought that this approach could be used to inform several initial pilot interviews but a number of factors led to this form of access being used on a number of occasions in the study. Firstly, it gave valuable logistical insights into whether a pharmacist might be able to participate in relation to whether the shop

closed for lunch or how many prescriptions were dispensed (a busy pharmacy was often cited as a reason for non-participation). Secondly, the pharmacies in which I had worked were extremely varied and the range of different organisations, locations and size of pharmacies did not appear to limit the sample. Thirdly, having worked in the pharmacy of some prospective participant, I was able to gain information relating to purposive sampling issues and, for example, was able to recruit one pharmacist because I was aware that he did not sell EHC and, at that point in the research, I wanted to include a pharmacist who held such convictions in relation to this aspect of pharmacy work. One further area of potential access arose because I was working in an academic pharmacy department that included several practising pharmacists and two pharmacists were approached in this way.

An initial number of pilot interviews were decided upon which it was hoped would help inform the interview questions and guide to be used in subsequent interviews and also provide me, as a novice researcher, with experience in interviewing, in addition to my theoretical training.⁵ As noted previously, the intention was to use a focus group method as an initial exploration of the research questions but upon beginning recruiting pharmacists, it was apparent that, logistically, a focus group would in fact be harder to organise than separate interviews, despite the latter taking up more time in terms of interviewing and subsequent transcription. In relation to sampling, an initial set of pilot interviews was envisaged, involving around four or five pharmacists. The

⁵ Kvale's criteria of a successful interviewer were a useful resource and were referred to throughout the research (Kvale 1996).

sampling process involved an initial approach either by letter (in the form of a participant information sheet (appendix one)) or telephone call. If the latter, a participant information sheet was subsequently sent. With either approach, a follow-up telephone call was made approximately two weeks after the initial contact to allow prospective participants the opportunity to consider their involvement and identify any questions. A more formal consent form was then sent to participants for them to read and sign (appendix two).

A total of five pharmacists were recruited for the pilot interviews, and the intention was to gain initial insights into not only pharmacists' problems but also how they described their resolution. As noted in the previous chapter, existing studies had offered some insights into the type of problems or 'dilemmas' that community pharmacists experienced and had hinted at their reasoning but the intention was to consider issues such as, for example, whether my initial interview questions were understandable and relevant, whether interviewees required prompting, what amount of detail pharmacists would provide, how long interviews might take to conduct and what would be the most suitable place to conduct the interviews.

Following the five pilot interviews, a formal sample grid was constructed to assist in further systematic and purposive sampling. The reason for this was twofold: firstly, it would ensure that a representative sample was obtained, taking into account differences in gender, age, ethnicity and type of pharmacy work; secondly, it would accommodate categories that emerged from earlier interviews and allow for the selection and analysis of deviant cases. For example, if it emerged that, like Latif's work, pharmacist owners were less able to use ethical reasoning to resolve their ethical

problems, it would be possible to identify this group in the sample grid and undertake further recruitment amongst such pharmacists to further investigate this theme. The recruitment and interviewing of pharmacists occurred between January 2004 and July 2005 and, in total, twenty-three pharmacists were interviewed, selected from two regions (Yorkshire and Nottinghamshire) in the North of England. The choice of these two areas was logistical since they represented the areas where I lived (Yorkshire), studied (Nottinghamshire) and worked (both) and both these geographical areas are broadly representative of pharmacies nationwide. Table three summarises the characteristics of the respondent pharmacists and more detailed information about the participating pharmacists is provided in appendix three.

Following initial approaches, a total of eight pharmacists declined to participate in the research and a number of reasons were cited. Some argued that they were too busy in their pharmacy work, two were concerned that their employers would not give permission for them to be interviewed, and several mentioned that they simply could not think of any ethical concerns in their work and hence an interview would, they thought, be unproductive.

What became evident during the research was that, in trying to identify the work status of pharmacists and for employee pharmacists in particular which company they worked for in terms of company sizes and types (whether large national companies such as Lloyds, Moss and Boots the Chemist, supermarkets such as Asda, Sainsbury's and Tesco or smaller provincial firms), many pharmacists had changed employers frequently and also relatively recently.

Pharmacist	N=23
Gender:	
Male	16
Female	7
Age:	
20s	6
30s	8
40s	5
50s+	4
Ethnicity:	
Caucasian	19
Asian	3
Afro-Caribbean	1
Employment:	
Owner proprietor	5
Employee of:	
Small company (<10 pharmacies)	3
Med.company (10-50 pharmacies)	8
Large company (>50 pharmacies)	4
Locum	3
Additional roles:	
Superintendent	8
Academia, Research	2
PCT prescribing advice	1

Table 3 Characteristics of Respondent Community Pharmacists

Hence, although purposive sampling using the sample grid was undertaken to recruit pharmacists from particular employers and sizes of company and with locum experience, in practice, pharmacists had often had experience with other employers or as locums.

3.6 INCENTIVES

It became apparent in the research that recruiting proprietor pharmacists was harder compared to those who were employees. Pharmacist owners were more likely to cite a

busy work environment than employee pharmacists, as a reason why they could not participate. It was as a result of this difficulty that a decision was made to offer some form of remuneration to participants, an approach that Dingwall and Watson (2001 p.21) argue is 'essential for securing uninterrupted interviewing time.' Unfortunately, funds were not available to financially remunerate pharmacists for their participation but because of my existing experience as a locum pharmacist, I was able to offer locum cover in return for sparing time to be interviewed. In practice, this meant my either staying at the pharmacy after the interview had ended so that the pharmacist could take some time to eat lunch or, on other occasions, pharmacists asked if I could provide a half-day's cover for them. Although I was concerned that such incentives might influence the interviews, with pharmacists feeling that they were therefore expected to provide a certain level of response in return for my working for them, this did not appear to be the case in practice. Some pharmacists accepted such an offer whilst others declined it.

3.7 INTERVIEWING

Having so far considered what has been argued to be the most suitable research methodology and method – qualitative semi-structured interviews – and then gone on to describe how pharmacists were recruited, the nature of the interviews themselves should be explained. In this section, the interview question schedule will be considered, as well as issues in relation to the location and recording of interviews.

One of the aims of the pilot interviews was to assess where was best to conduct

interviews and also how long to allow for the overall interviews. What emerged was that pharmacists preferred to be interviewed during a quiet period or a lunch hour and, for convenience, in their place of work. It appeared that they valued their private time and only two pharmacists offered to be interviewed after work. Hence, the majority of interviews were conducted in pharmacies and, specifically, in the dispensary, either when the pharmacy was closed for lunch or when there was a quiet period. Exceptions did occur and one of the initial interviewees preferred to be interviewed in my home whilst another asked to be interviewed in a supermarket cafeteria. Three interviews took place in private offices at the University of Nottingham and one pharmacist who was also a superintendent preferred to be interviewed at his head office location. The issue of privacy was considered during interviews, especially in those where the pharmacy remained open or where other members of the public might be present. In practice, this did not appear to affect the interviews.

Interviews were recorded so that later transcription could be undertaken but three pharmacists preferred not to be recorded. For one pharmacist, this was because he was concerned about a record being made of what he perceived to be unethical conduct and on the other two occasions, this was because I had been invited to interview them whilst they were working and it was impractical to record in such circumstances. However, in these three interviews extensive notes were taken during the interview and follow-up notes also made summarising key points in the interview.

The initial question schedule or interview guide was informed by the research questions that emerged but also from the existing literature and also, to some extent, from my own experiences as a community pharmacist. These underwent several slight

revisions as interviews occurred: some changes were additions to the questions as themes emerged, such as whether, for employee pharmacists, they perceived any pressure from superior staff such as managers or their views on which values might be important in pharmacy work and whether these might be shared by other health care professionals. Some were removed due an obvious lack of response such as, for example, asking whether extended roles might lead to additional problems since pharmacists struggled to predict what changes might occur in their work, let alone what attendant ethical issues might arise.

The interviews with superintendents and RPSGB and NPA representatives also influenced questions and the final interview schedule is shown in appendix four.

However, the interview guide was exactly that, a ‘guide’ to what could be asked and it was not used in a rigid manner and additional questions were posed in response to particular pharmacist’s responses and some questions were occasionally omitted.

However, one important aspect of the recruitment process involved asking prospective pharmacists to reflect, before interviews, on a couple of what they considered to be ethical concerns in their work. The intention was, as stated earlier in this chapter, to identify what pharmacists *themselves* found problematic, rather than offering them examples of ethical dilemmas or issues drawn from the normative or empirical literature. What quickly became apparent was that many pharmacists struggled to recollect examples of ethical concerns in their work, despite having had many weeks to reflect upon these – a significant emergent issue that will be returned to in chapter five in relation to ethical inattention. The use of hypothetical situations or vignettes was, however, resisted despite this concern because it remained a central aim of the research

to have pharmacists describe *their* ethical problems rather than their *responses* to vignettes. Prompting was used but the intention was to do so in a subtle and non-leading way. As Holm (1997) noted (and see chapter four generally), after being interviewed about ‘ethics’ for an hour, interviewees may come to expect that everything must have an ethical aspect to it. At various points in the interviews, participants were reminded that this was about their problems and their experiences and opinions and it was hoped that this limited the expectation that whatever the interviewer raised somehow *must* be ethical.

Following the initial pilot interviews, prospective interviewees were asked if they could allow for around one hour in which to conduct the interview. Interviews varied in duration from about thirty-five minutes to around ninety minutes but the median interview time was around fifty minutes. The reasons for such variation were related to logistical concerns such as the pharmacist only being available for a specific period of time (for example, the closure of a pharmacy for lunch) but other interviews were determined by the loquaciousness or otherwise of interviewees. One early pilot interview ended after only thirty-five minutes but this was a combination of the pharmacist’s limited replies and inability to recall more than one ethical issue.

3.8 RECORDING AND TRANSCRIBING

With the exception of three interviews, recordings were made of interviews, with the permission of the participating pharmacist. This was performed using either an analogue cassette recorder or later in the study a digital recording device, the latter

offering the opportunity of better sound quality and more convenient and prompt transfer of data into a format (MP3 file) that could be managed using PC dictation software. After interviews, brief notes were made about the overall ‘feel’ of the interviews in terms of how talkative the interviewee was, whether there were any difficulties such as interruptions or underlying problems – one pharmacist, for example, mentioned that they were under pressure on the day of the interview to finish checking a full month of prescriptions for the residents of a nursing home. Each recording was assigned a date and pharmacist’s initials as a reference to protect the anonymity of data.

Transcription was undertaken as soon as possible after interviews and was performed by myself. Although this was a lengthy process, it offered advantages over professional transcription in allowing me to add comments and some measure of conversation analysis in terms of pauses and their duration, emphasis on particular words or phrases and even laughter. These, together with some measure of overlapping speech and instances of hesitation and hedging (‘um’s’ and ‘ah’s’ for example), gave me valuable insights into whether, for example, pharmacists felt strongly about a particular issue or were confident in discussing a point. Conversely, it revealed many pharmacists’ difficulty in articulating ethical concepts and pauses were more common. Although, as stated above, it was not the intention to undertake a detailed form of conversation analysis, they did inform the analysis of interviews in a general sense. In addition, it allowed me to remain close to the data and also enabled me to begin analysis of the data at an early stage, and in the next section this aspect of the research will be developed.

3.9 ANALYSIS

Hopefully, this chapter has made the research process as transparent as possible, in charting the choice of research strategy and method of data collection and in the sampling of participants. Another significant part of the research process involves how the data that were collected from interviews were then analysed, moving from what Blaikie terms data collection techniques to *data reduction* techniques (Blaikie 2000 p. 235). This stage of the research is an attempt to not only reduce the amount of data collected - which in this thesis amounted to more than twenty four hours of interview transcripts – but also more importantly, to engage in a meaningful analysis of such data in relation to the identification of emergent themes and concepts and also possible theories.

In qualitative research, two main analytical approaches are often identified - analytical induction (Lindesmith 1947) and grounded theory (Glass and Strauss 1967). The former proceeds by the identification of a research hypothesis and the iterative process of finding data to confirm the hypothesis or deviant cases which would necessitate a reformulation of the hypothesis and further data collection. This approach was rejected because the intention was not to form hypotheses from the initial research questions and seek to test them in the field but to explore and gain an understanding of possible ethical issues, albeit in a way which was sensitive to existing theory. However, one of the concepts of analytic induction – deviant case analysis – was used since it was considered to be a technique that could assist in the validity of the research, as will be considered later in this chapter.

Grounded theory, in contrast, is an extremely popular approach to social science research although, as Bryman (2000) notes, references to its use may be as much in name rather than any sustained and thorough application of the principles, as originally advanced by Glaser and Strauss (Bryman 1988, Locke 1996). In the present research, analysis of interview transcripts proceeded using some of the approaches that are found in grounded theory but this does not imply that the theory was used in a comprehensive manner. Partly, this was because a balance was sought between being sensitive to developing theory (as grounded theory aspires to) but also being informed by existing theories, as the previous chapter indicated. Hence, the use of framework analysis was also undertaken – a process that is not usually associated with grounded theory and which utilizes an existing theoretical approach. As the previous chapter indicated, Jones' synthesized model of ethical decision-making was argued to offer a relevant framework for considering how ethical decisions may be made in practice. But aspects of grounded theory were utilized in relation to their perceived advantages and benefits to sampling and also to the management of the data collected in terms of coding. Hence, theoretical sampling and saturation were adopted to inform the sampling of pharmacists and involved recruiting pharmacists and collecting data in the form of interviews as an on-going, iterative process that meant that sampling was informed by analysis early in the research. Using theoretical saturation meant that sampling of pharmacists was delimited by new themes no longer being identified and, accordingly, themes that had emerged, becoming 'saturated'. Constant comparison of data was also used so as to remain sensitive to the connections between data and emergent themes and to ensure that analysis of data occurred at an early stage. Coding

of data was also undertaken, not just as a data reduction technique, but also to move beyond the simple description of data involving ethical issues and reasoning and to be aware of categories and, again, the connection between data.

An attempt was made to use computer-assisted qualitative data analysis software (CAQDAS) in the form of NVivo and all transcripts were converted into rich text format for this purpose. However, after gaining experience in the use of this software through tutorials and a workshop, it was not found to be any more helpful in analysing the transcripts than simpler, word processing software or even pen and paper techniques. As Stanley and Temple argue (1995), most computer word processing packages can perform many of the tasks that more dedicated CAQDAS can and throughout the research, computer word processing software was used to transcribe and then facilitate analysis of transcripts by the use of ‘cut and paste’ techniques and a simple spreadsheet was used to manage the emergent codes. Although coding was considered useful and necessary for analysis, respect for the overall ‘feel’ and tone of interviews was thought to be important (Coffey and Atkinson 1996). This, as will be indicated in chapter four, was important in identifying how difficult some interviews were to conduct and where there could not be said to be an easy flow or narrative to some interviews in what will emerge as ethical passivity.

3.10 PRESENTATION OF DATA

In this section, how best to present the data and emergent themes of this research are

considered. The coding of interview data leads to a further concern that must be addressed methodologically – how best to present the data that has been collected during interviews. This involved not only what amount of detail to include in examples of interview data and whether, for example, some form of conversation analysis could be represented, but also how to illustrate emergent themes in terms of pharmacists' speech. The use of fragmented extracts of interviewees' speech, although often necessitated in published papers by the word counts required in academic journals (Silverman 2005 p.210), may be problematic and give rise to concerns about 'anecdotalism' which may be problematic for qualitative research and as Bryman notes 'there are grounds for disquiet in that the representativeness or generality of these fragments is rarely addressed' (Bryman 1988 p.77). Of course, there must be a balance between one extreme which involves reproducing huge chunks of transcribed text and the other extreme, in which only attempts are made to 'cherry pick' the most appropriate excerpts from interviews or, worse still, to use them to fit emergent themes or theories, at the expense of ignoring deviant data or cases. For Seale (1999), the use of what he terms 'low-inference descriptors' is an important aspect of qualitative research and this involves the use of *verbatim* versions of participants' speech, in contrast to summaries and abstract interpretation by the researcher.

Hence, in this thesis, an attempt is made to respect the authenticity of the interview data and avoid, wherever possible, reducing pharmacists' responses to fragmented snippets, although it is recognised that this is unavoidable on some occasions and may be required to avoid reproducing large sections of text that contain one pertinent comment, for example.

In considering how to represent the data from this study appropriately in terms of issues such as low-inference descriptors, this leads onto a consideration of the evaluation of qualitative research – what Silverman calls ‘credible research’ (Silverman 2001 Ch.8 *passim*) and Seale terms ‘the quality of qualitative research’ (1999) and this is now consideration in relation to two key issues, validity and reliability.

3.11 VALIDITY AND RELIABILITY

As noted earlier, the aims of this chapter were not only to consider what might represent the best research strategy in terms of methodology and method but also to reflect upon these critically and this is no more evident than in the concepts of validity and reliability. Although these represent terms that were initially associated with the quantitative tradition in research, relating to the truth and genuineness of data and the reproducibility and stability of data, respectively, they are recognised as being of significance in qualitative research, too (Seale 1999). Although some commentators use quantitatively grounded conceptions of reliability and validity to assess qualitative work (Mason 1996), it is common to consider the two concepts as they apply specifically to qualitative research.

3.11.1 Validity

This is a measure of the extent to which the data that is collected can be said to

represent and reflect the concept under study. This has already been considered in relation to the status of interview data earlier in this chapter and it was argued that, in contrast to a correspondence account of interviewee's accounts, the data that emerges from interviews do not represent the 'reality' of the interviewee but is a complex interpretation and re-interpretation of not only the interviewee but also the interviewer. But even if this account of the interview data is used, issues relating to whether the research process reflects such an account may be necessary. Two common techniques are usually employed in qualitative research to substantiate validity claims and these involve appeals to some form of triangulation (Denzin 1970) and to respondent validation. However, following Silverman (2001 Chapter 8 *passim*), it is argued that qualitative data may be seen as, firstly, unique so that attempts to triangulate using quantitative measurements of a social event to validate qualitative accounts of the same event ignore what is distinctive about the latter approach. Combining methods may have relevance and can result in richer accounts but it is not the case that it can be used as a conclusive way of validating qualitative data. Following Silverman (2001), respondent validation is also considered to be problematic since, although it may produce additional data which can be useful to a study, it may be of less use in assessing the analytical stage of the research process, since the participants may often not understand either the process of analysis or the language and theory used in presenting subsequent findings. Validation may, however, involve providing participants with other versions of data such as reports or transcripts and in three of the pilot interviews and also in two of the background interviews with superintendents and a RPSGB member of staff, interview transcripts were provided. In the pilot interviews,

pharmacists were asked for any comments upon receiving a copy of their interviews but no questions were raised and it was apparent that, although the transcripts were perhaps somewhat ‘embarrassing’ to the pharmacists, they appeared not to be particularly interested or concerned about the content or representativeness of the data. The responses from the pilot interview pharmacists reflect reservations made by Bloor (1978) in his frequently cited study involving doctors’ decision-making and the use of reports for respondents and it was decided not to utilize respondent validation in this research.

However, despite being critical of attempts to ensure validity using triangulation and respondent validation, several techniques were used in the present research that may be relevant to the issue of whether the data actually represents what it claims to represent. In particular the processes of constant comparison and deviant case analysis were employed in both the sampling and analysis stages of this research. Constant comparison was used to assist in the coding of data and to help categorise emergent themes. Although the process is associated with grounded theory and, in later forms, to a very structured and formulaic approach to data analysis and sampling (Strauss and Corbin 1990), constant comparison offers an approach that can ensure that the data is treated comprehensively and that sampling is also informed by theoretical saturation. Open coding was initially used to generate ideas about the data from interviews but a second stage of analysis involved how these stages were interrelated. As an example that will be considered in chapter five, it appeared that religious faith amongst pharmacists made them sensitive to ethical issues and this emerged from a comparison of religion as a guiding influence and the emergence of ethical attention and

sensitivity. Theoretical saturation was also used to develop the research in relation to the selective sampling of pharmacists who it hoped might offer further insights into the research and the final limitation on the sample in terms of no further emergent themes.

Seale (1999), following Becker (1970) and Coffey and Atkinson (1996), argues that the recognition and treatment of negative instances or deviant cases is a key aspect of credible research and this concept was used in this thesis. Again, the example of religious faith is relevant and during the initial pilot interviews, one of the pharmacists appeared to be aware of many different ethical concerns in his work and to have reflected on these, both around the time of the ethical issue itself but also subsequently. This ethical concern, as will be seen, is at odds with the emergence of ethical passivity amongst the pharmacists in this study but in considering this case it was apparent that the pharmacist's faith – or rather the potential conflict between faith and other ethical and professional requirements – had led to his sensitivity to ethical issues. As such, the analysis and explanation of this deviant case is argued to strengthen the credibility of the data.

3.11.2 Reliability

The reliability of qualitative research involves a number of possible concerns, including the extent to which emergent theory, themes and coding of data in a study could be similarly produced by other researchers and to whether a study could be replicated in terms of design and sampling. In this thesis, a number of concerns were addressed in relation to reliability and these involved transparency about the research

process and also attention to some of the techniques used in managing the data that were collected. A concern about the external reliability (LeCompte and Goetz 1982) of a qualitative study – the extent to which others may be able to replicate the same study design and samples - may be addressed by an overall transparency about the research process and it is hoped that this has been achieved in this thesis by considering concerns such as, for example, my role as a researcher with a particular practical and theoretical background, offering full descriptions of interview guides and participating pharmacists, details of how sampling occurred and how existing theory influenced the research. In relation to internal reliability – the extent to which others would reach the same conclusions and to which there is consistency in categorisation across time and observers (Hammersley 1992) – a number of techniques were used to attend to this aspect of credible research. One point, already considered in this chapter in relation to the presentation of data, relates to the use of ‘low-inference descriptors’ that are accurate, *verbatim* representations of what was said in interviews that avoid unnecessary truncation of quotations or convenient summaries of what pharmacists might have meant. The recording of interviews was also used so that an accurate record of what was said during interviews could be kept and referred to at a later point. Although transcription was undertaken as soon as possible after each interview and there was a process of ongoing analysis of transcripts, the data collection occurred over a period of more than a year and it was helpful to have a record of earlier interviews and transcripts to use comparatively. The research was conducted by myself and, although this may introduce the concern that there was no additional perspective available from another researcher in terms of my data analysis, a general process of

peer review (LeCompte and Goetz 1982) did occur in the form of discussions with my supervisors in relation to the data and the overall thesis.

Using all of these approaches, it is argued that attention has been given throughout the thesis to issues of quality and credibility and that the themes, discussion and theory that emerge in the chapters that follow, are as a result of a thorough and sensitive approach to the research process.

3.12 RESEARCH ETHICS

It would be somewhat ironic if a research project that considered ethical issues as the subject of its enquiry were at the same time neglectful of possible ethical issues of the research itself. Early in the research, attention was focused upon possible ethical concerns that might emerge from the research. Some of these concerns were general to much social science literature and some arose more specifically in the context of the nature of this particular study. Regarding general concerns, the research design took into consideration the risk of coercion in recruitment, recognised the voluntary nature of pharmacists' participation in the research and a number of concerns in relation to anonymity and confidentiality. As noted earlier, a participant information sheet was developed that provided information for prospective participants about the nature of the research, its aims, what would be expected of participants and how any research findings would be disseminated. As noted previously in this chapter, some form of participant observation was rejected as a method partly because of the perceived problems in obtaining ethical approval.

In choosing an interview method, however, certain ethical concerns did require consideration. Firstly, pharmacists were being asked to describe what they considered to be ethical concerns in their work and this would probably involve making reference to individuals in the course of interviews. Hence, to ensure the anonymity of individuals, pharmacists were asked in the introductory letter and also prior to interviews not to make explicit reference to named individuals (who might include, pharmacists were reminded, not only patients and customers but also other pharmacists, staff, doctors, nurses and receptionists amongst others).

Secondly, the issue of whether pharmacist might be harmed in some by participating was considered. This involved being attentive to any possible emotional or psychological harm that might occur as a result of being interviewed. One possible concern that was reflected upon throughout the research was whether pharmacists might feel under examination during interviews in being asked to reflect upon ethical concerns they had experienced and how they attempted to resolve them. Although the intention was never to offer judgments about pharmacists' decisions, it was nonetheless hoped that such decisions could be considered critically and this involved me challenging responses and occasionally making pharmacists aware of possible inconsistencies in their answers. During the pilot interviews, pharmacists were asked afterwards whether they had felt they had been criticised or put under pressure in being asked how problems were dealt with but no concerns were reported. In fact, as the next chapter will indicate, many of the pharmacists interviewed reported being confident about their ethical decision-making. So in contrast to research such as Oakley's involving interviews with women about childbirth (Oakley 1981), the ethical concern

about whether one should respond to interviewee's requests for more information or for advice did not arise in the present study, except in very general terms when, as noted earlier, I would occasionally mention to interviewees that my own background in ethics and law did not mean I knew how to resolve all ethical issues. However, in the participant information sheet, a specific remark was included to the effect that if any pharmacist felt that they had been affected in any way by participating, they could contact either myself or be referred to another appropriate individual.

In relation to more formal research governance approval, this was not sought since the community pharmacists interviewed in this research were not employees of the NHS. However, internal pharmacy department advice was sought in relation to the potential ethical concerns identified above and relevant ethical approval was obtained from the School of Pharmacy at the University of Nottingham. In addition, the ethical guidelines of the British Sociological Association and also the Social Research Association were followed during this research.

3.13 DISSEMINATION OF FINDINGS

Although this research is presented as a thesis, the intention is also to report the findings of the research to appropriate audiences. Various aspects of the research have already been reported to both pharmacy and non-pharmacy audiences at peer-reviewed conferences and also as peer-reviewed publications. It is hoped that the reporting of this research in such a way can promote discussion about empirical pharmacy ethics and the intention is also to prepare further relevant papers for publication.

3.14 CONCLUSIONS

The aims of this methodology chapter have been to not only reflect upon the choice of the most appropriate research strategy with which to answer the research questions that emerged but also to reflect critically upon a number of aspects of the chosen methodology. The choice of a qualitative approach using semi-structured interviews with community pharmacists was determined by the need to use an approach that emphasised how an understanding could be gained of pharmacists' ethical issues and their resolution, that valued the richness and possible diversity of pharmacists' accounts but that also allowed me to question pharmacists about their decisions and about aspects of their environment that may be ethically relevant. However, it has been shown that in choosing interviews as a method, the status of this form of data must be recognised and it has been argued that the accounts that pharmacists offer do not necessarily represent 'true' accounts of what they have experienced. Instead, these should be regarded as interpretations not only by pharmacists but also myself as a researcher, of what they understand by ethical concerns and ethical decision-making and ethical influences and what is also valued, therefore, is pharmacists' descriptive language (Lowe 2002).

So far, this thesis has attempted to consider why a number of questions arise in relation to ethical concerns in community pharmacy, how existing philosophical, sociological and empirical theory may be of relevance, and how to answer these research questions in terms of an appropriate research strategy that is sensitive to transparency,

reflexivity, reliability, validity and research ethics. In the following three chapters, the emergent themes and data from this research will be presented in relation to the key research questions of this thesis. The next chapter begins the presentation of the research findings with a consideration of the first question – what did the sample of pharmacists in this thesis understand by, and experience as, ethical issues in their work?

4 ETHICAL PROBLEMS IN COMMUNITY PHARMACY

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 [...]. The daily round of the pharmacist in hospital or the community simply lacks that drama. (Brazier 2001 p. x)

4.1 INTRODUCTION

What are ethical problems in community pharmacy? Do pharmacists experience ethical concerns relating to what Braunack-Mayer (2001) termed 'neon issues' or is community pharmacy practice in the UK to be described more by ethical concerns of a parochial nature or by what Caplan and Kane (1990) termed 'the morality of the mundane?' The purpose of this chapter is to consider this question with reference to the examples provided by the community pharmacists interviewed. The intention is to ground such ethical concerns in the context of actual pharmacy practice and in so doing it is hoped inform Brazier's comment about community pharmacy lacking the drama of the high profile dilemmas that pre-occupy lawyers, philosophers and academics.

It will be argued in this chapter that in using a qualitative approach which is also sensitive to a range of theoretical insights, a more complex and contextual understanding of community pharmacists' ethical issues will emerge than has been possible in previous research. In particular, it will be shown that the pharmacists interviewed identified problems predominantly in the core tasks of dispensing and selling medicines but also in other areas not identified in previous research; that what pharmacists considered to be ethical dilemmas or problems were often only nominally

so and may be better described as being quasi-ethical, that is practical problems with an ethical component; and that a legal and procedural approach to pharmacists' understanding of ethics and their description of ethical problems was significant for many of the issues raised. Indeed, the relevance of formal legal rules and procedures is important since it is relevant to pharmacists' basic ethical understanding and underscores much of this chapter's aim of describing what ethical issues pharmacists found problematic in their work. As noted, the aim of this chapter is to offer a predominantly descriptive account of *what* were ethical concerns for pharmacists and it is left to the next chapter for a fuller consideration of *how* such problems were dealt with and in the chapter after that to consider more fully *why* such problems occur and *why* pharmacists attempt to resolve them as they do.

In the next section, consideration is given to how such a descriptive account can be best presented in terms of thematic analysis and typology. Ethical problems are then introduced in relation to key areas of community pharmacy practice, as identified by pharmacists as being ethically problematic. These include the dispensing of medicines and the over-the-counter sale of medicines but additional issues that are argued to be common to other health care settings are also described. The centrality of a legal and procedural conception of ethics is advanced and examples are provided including controlled drugs and emergency supplies. The question of whether pharmacists' ethical issues in their work are dilemmas or problems is then raised. A brief conclusion is then made, drawing attention to these points but also identifying the nature of community pharmacy work as inimical to pharmacists developing relationships with patients or customers.

4.2 THEMES AND TYPOLOGY

An important initial concern in this chapter, and one that follows on from concerns previously addressed in chapter three, is how to present the research data in relation to pharmacists' ethical issues. As well as being attentive to how to present individual extracts of interview data appropriately, how such data should be organised and arranged is no less relevant and this is now considered.

One way to proceed and account for the ethical issues identified by pharmacists would be, of course, to simply list them. However, in rather the same way that the list poem is often considered one of the most basic literary forms, using a similar approach in social science research may lack relevant intellectual insights relating to, for example, argument and interpretation and the possible meaning and concatenation of what is being listed. Some form of thematic analysis or typology is therefore appropriate in relation to the problems described. In previous empirical ethics research within pharmacy, a basic thematic analysis was apparent (Hibbert *et al* 2000, Chaar *et al* 2005) and 'ethical dilemmas' were reported in terms of the values involved or the factual context of the situation. In this respect, a purely descriptive account of an ethical problem for pharmacists was considered alongside either the pharmacist or the authors' understanding of the ethical content of problems in terms of values and principles. In this thesis, the intention is to initially describe ethical problems but then subsequently analyse such problems in relation to ethical decision-making as a distinct task. One may question, however, whether leaving the relevant values and content of an ethical problem to subsequent analysis might limit the description or identification

of an ethical problem. Can one, in fact, separate a description of an ethical problem from its composite values and ethical features? Whilst it will be argued in the next chapter that the concept of ethical attention is vital for seeing ethical problems and the values involved, focusing instead upon an overtly factual account in this chapter does not unduly impoverish the description of pharmacists' ethical problems. As will be shown, in identifying and constructing ethical problems, most pharmacists seldom referred to the language of ethical values in great detail and instead focused upon practical and legal aspects of problems – a feature that will be developed in the next chapter in terms of ethical inattention and ethical passivity.

In contrast to the limited empirical ethics research in pharmacy, studies involving medicine have utilized additional distinctions. The study by Hurst *et al* (2005) used the principles of grounded theory to generate '*coding and analytical elements*' and the authors initially coded their interviews with US hospital doctors in terms of general descriptive issues and then separately in terms of emergent values. Braunack-Mayer (2001), however, distinguished how Australian GPs used different levels of generality or construction with respect to ethical problems and found that three different approaches were evident: issues were either described in general terms or in the form of particular examples or as non-specific anecdotes from practice. Another insight into the construction of ethical problems was identified by Uden *et al* (1992) in relation to the differences between doctors and nurses. Doctors mentioned ethical problems *prospectively* and appeared to be unsure of what to do whilst nurses tended to develop ethical problems *retrospectively* and construct narratives based upon thwarted outcomes. Such differences appeared to relate to more general issues such as

professional hierarchy and autonomy wherein nurses especially were more constrained in their professional and ethical actions. Such constructions were not discussed in any of the pharmacy studies unfortunately but may offer further valuable insights into how ethical issues are in fact understood, communicated and also related in some respects to the work environment.

In addition to considering pharmacists' ethical concerns in terms of how they are described, it may also be possible to analysis ethical problems in relation to the area of pharmacy practice in which the problem occurs. For example, pharmacists undertake a number of key tasks in community pharmacy such as dispensing medicines, the sale and supervision of OTC medicine sales, the provision of advice and, more recently, the extended and enhanced roles relating to medicines management and supplementary prescribing amongst other developments. Is such an analysis in terms of these aspects of pharmacy work relevant and useful? Such an analyses may offer a number of insights into the diversity of particular tasks. For example, the task of dispensing medicines will be shown to include ethical concerns relating to a wide range of issues including the availability and legality of prescriptions, challenges to prescribing, financial considerations, confidentiality, controlled drugs and addict patients. One possible consequence of this typology is that as community pharmacy moves towards delegated dispensing and the use of technicians to perform many dispensing tasks, will such ethical problems still occur and the question arises as to who will resolve them? Conversely, considering enhanced or extended roles might indicate additional ethical problems and these are also considered.

Finally, analysis of pharmacists' ethical problems may be made in terms of particular

themes or ‘frames.’ Social science approaches offer the possibility of not only describing particular socially occurring phenomena but also offer a way of seeing them that might not be immediately apparent. As was noted earlier in this chapter, the ethical concerns of community pharmacists may be ‘framed’ in terms of a legal or procedural understanding and this thematic approach effectively concatenates different areas of pharmacy practice – revealing common and perhaps underlying trends and, again, reference is made to this in the following analysis. It is possible to develop the ethical problems of community pharmacists, then, in three distinct ways:

- In terms of the area of pharmacy practice the problem originates in,
- In terms of how the problem is described by pharmacists,
- In terms of themes and concatenations.

In this study, an attempt is made to accommodate all three of these approaches since each offers a valuable insight into the construction and description of ethical problems by community pharmacists. However, in relation to the overall structure of this chapter, problems will be developed initially in terms of the broad area of practice to which they relate and issues of pharmacists’ construction and additional themes will be considered both within these broad heading and also as distinct concerns later. So, in starting to answer the question of what ethical problems arise for community pharmacists, the first area of practice to be considered is the dispensing of prescription medicines.

4.3 ETHICAL PROBLEMS RELATING TO DISPENSING MEDICINES

The dispensing process in community pharmacy is included as the first category in relation to ethical problems for community pharmacists since it appeared to be an aspect of practice that generated most ethical concern and also the most commonly cited example of ethical problem – the paradigm case of the controlled drug prescription. It also remains the central activity within community pharmacies, despite changes that have encouraged pharmacists to undertake additional and enhanced roles within UK community pharmacies. Statistics for 2003 indicate that around 686 million prescriptions were dispensed in England alone, the majority of these in community pharmacies (Health and Social Care Information Centre 2005), so it is perhaps understandable that the task would generate several ethical concerns simply by virtue of occupying much of pharmacists' time. However, the dispensing process was often viewed disparagingly by the pharmacists interviewed, despite being a major part of their work, and as Philip noted:

‘At the moment, it’s quite monotonous. You don’t go to university [to just dispense], and obviously you’re there as a safety measure, for the knowledge that you have, but generally you’re churning out volumes of prescriptions and that’s it.’

Despite the routine and monotony of the task, the pharmacists interviewed raised a number of distinct ethical issues relating to dispensing. These included challenging prescribers, refusal of medicines, the use of compliance devices, financial concerns and confidentiality but by far the most frequently cited problem involved the dispensing of controlled drugs and this is considered first.

4.3.1 Controlled Drugs

The most commonly cited ethical concern for pharmacists involved situations in which a decision had to be made by the pharmacist as to whether to supply a controlled drug where, for a variety of reasons, doing so would not be legal. Controlled drugs are those medicines that possess an abuse potential and several categories are defined in legislation ranging from specialised drugs such as LSD, opioid analgesics and benzodiazepines. They are ‘controlled’ in the sense that a number of additional procedures are necessary in relation to their storage, supply and use and, for example, many must be stored in a secure place or can only be legally supplied if there is a valid prescription. This latter feature of controlled drugs – of how the legislation governs their prescribing and subsequent supply – appeared to be the problematic aspect for pharmacists. Ethically problematic situations were raised both spontaneously by pharmacists as an initial example that they had considered prior to the interview but were also mentioned by others during the interview or following prompts. Many variations upon the general theme of dispensing controlled drugs were mentioned: pharmacists described situations in which a prescription was presented that was not written correctly or could not be verified by the prescriber or where a faxed alteration to an existing prescription was received with the prescriber’s intention that the alteration be acted upon by the pharmacist or where, in several cases, a doctor had provided details of a prescription by telephone and promised to send the prescription but wanted the medicine to be supplied urgently. In common, however, was the existence of a legal requirement of one sort or another that could not be complied with

and pharmacists were then faced with a choice as to whether to make a supply despite the illegality or to follow a strict and legal approach and not supply a medicine. In each situation, pharmacists appeared to be balancing the legal requirements of such controlled drug supplies with the needs of the patient to receive a medicine. In the following example, a description is provided not of one specific incident but a generalised hypothetical situation that includes features that the pharmacist remembered being typical of such controlled drug dilemmas. Such an approach to describing ethical situations is similar to that identified by Braunack-Mayer amongst her sample of GPs and appears to be a resource that allows interviewees to articulate and emphasise situations despite not being able to recall a specific incident. Shahid described the type of problem thus:

‘A classic one is palliative care: a cancer patient on, say, morphine and loads of controlled drugs. Scripts incorrectly written, no date, not signed. You know it's a definite patient, they know they've been coming in regularly and in that case it's a dying patient and they're going to be in pain...in pain over the weekend period just for you not supplying something just because a doctor, from his mistakes, has forgotten to put something down. From the Misuse of Drugs Act and the MEP, we can't really give it without it being illegal [...] We're supposed to be pharmacists looking out for patients and to turn someone away who needs palliative care, that's going to be pain over the weekend just because there's not a date there.’

This example contains many features that were echoed in other pharmacists’ responses. Centrally, it involves a legal concern and there is specific mention of the relevant legislation - The Misuse of Drugs Act 1984 and the Royal Pharmaceutical Society’s *Medicines, Ethics and Practice* guide to practice (Royal Pharmaceutical Society 2006a). The pharmacist is aware of the legal and procedural requirements,

particularly in the form of the prescription not being written correctly. What appeared to make the situation problematic for the pharmacist was that the decision as to whether to supply the controlled medicines involved the competing claims of complying with the law or doing what was best for the patient and preventing suffering or distress. In addition, as the above hypothetical situation notes, such ethical problems involving controlled drugs frequently related to terminally ill patients and often occurred at difficult times – when clarification or replacement prescriptions would be difficult. Previous studies have identified such ethical problems in relation to legal compliance (Hibbert *et al* 2000, Chaar *et al* 2005, Haddad 1991, Kalvemmark *et al* 2004) and the present study confirms the significance of this perceived ethical problem for community pharmacists. But what makes this an archetypal and recurrent type of problem in empirical pharmacy ethics studies? As noted, dispensing is a central activity in UK community pharmacy and one might expect such situations to arise in relation to being part of this main activity but prescriptions for controlled drugs, however, are relatively rare. One explanation may be related to how pharmacists defined ethics and what it meant to them and it is argued that this is due to a predominantly legalistic and also procedural understanding of ethics – one that not only allowed pharmacists to make sense of ethics *qua* ethical problems but also shaped to some extent what they experienced in practice.

4.3.2 The Meaning of Ethics and Law

To gain a better understanding of the context not only of the first type of ethical

problem identified by pharmacists – the controlled drug supply – but also many subsequent problems, a consideration of what pharmacists understood by ethics is relevant, especially in relation to law and regulation. The question of what ethics and ethical problems meant was asked of most of the interviewed pharmacists and the predominant answer involved the use of legal examples or definitions. The intention was to avoid providing a definition for pharmacists but, as the following extract from William’s interview indicates, some prompting was required to explore, for example, his claim that as both a pharmacist and also a superintendent of around fifteen pharmacies, he had never encountered an ethical concern in his work:

- Interviewer** One question I do find very fascinating because I do find when I’m doing this research into ethics that I’m doing something that other people haven’t thought about before. When I mention ethical problems or dilemmas within pharmacy, is it something that you’ve reflected on before? Obviously, I called you a while back and said ‘Can I come and talk to you’ - was this the first time that you’d thought, as you said, ‘I’ve not really thought about dilemmas in pharmacy that are ethical’? I’m interested in whether I’ve sparked something off in thinking about ethical things.
- Pharmacist** I’ve never really had any ethical dilemmas. [PAUSE]
- Interviewer** Right
- Pharmacist** [PAUSE]
- Interviewer** I mean definitions can vary. The problem I try to think of may be in terms of values being affected – if there’s a conflict between a pharmacist and a patient or a customer. Between health care professionals.
- Pharmacist** Yea, I’ve had a few of those. Not considering the number of shops we’ve got, they’re very few and far between. The customer complaints that come through, the errors that come through, we’ve dealt with them all. I think in five years, we’ve had two go to litigation.

William moved from his initial claim about never having encountered an ethical ‘dilemma’ to what appeared to be a legally grounded understanding of problems in his

work, despite attempts to allow for an open definition of problems within pharmacy work by the interviewer. Further typifying a legalistic conception was the response of Sharon, who had qualified three years previously and worked for a small multiple group, when she responded to what ethics meant to her by immediately framing ethics in terms of legal concerns and a specific example:

‘Ethics means to me, whether you should, if a patient comes with a prescription like a CD prescription and it’s not written correctly, whether you should dispense it or not dispense it, really. But also, you’ve got to look at the law side of it but also you’ve got to look at the patient’s best interests so it’s really about...as long as you can argue your case and the reasons why you’ve done it – dispensed the prescription or not, then fair enough and that’s what I think. So you can stand up in a court of law and say, you know, this is why I dispensed this prescription or this is the reason why I didn’t dispense the prescription.’

As in the previous example, an example is provided that involves the archetypal incorrectly written prescription. What is telling is that ethics *means* this type of situation – a concern about particular legal requirements, and also of legal justification and defence. More so than the previous example, however, this reflects not only a legally framed ethical situation but also a legally defended situation and Sharon relied upon a battery of overtly legal phrases - to ‘look at the law side of it’, to ‘argue your case’ and to ‘stand up in a court of law.’ Again, what appears to make this a problem is the conflict between acting legally and acting in a way that is best for the patient. Deans (2005) identified just such a legalistic approach in her focus groups with pharmacists, identifying a fear of disciplinary action in relation to ethical issues that might be detrimental to ethical decision-making. She noted that ‘in some cases this was linked more strongly to a fear of the disciplining authorities than a desire to do the

right thing for the sake of morality' (Deans 2005 R95). The pervasiveness of a legalistic understanding of ethics extends not just to a fundamental sense of what ethics might mean but also to a more practical concern for what ethics mean *qua* justification.

The interrelationship between law and ethics is recognised in other professions and the BMA, for example, in its guide to ethics for doctors, *Medical Ethics Today*, advises that whilst doctors must follow the law, this may actually be more difficult and complex. The relationship between law and ethics is argued to be a reciprocal one according to Dickens, and the concepts of law and ethics actually inform each other in practice and 'law frames the setting within which ethical choices may be practically exercised but ethics frames the limits within which the law is voluntarily obeyed and respected' (BMA 2004 p. 13). As such, pharmacists were not alone in connecting law and ethics and despite arguing that a predominantly legal conception of ethics is apparent for many pharmacists in this study, it is no less a problem for them and ethics appears to have relevance in framing the decision as to whether to obey and respect laws as they relate to pharmacy.

It was as undergraduates that pharmacists studied law and ethics, often as a single subject. Does ethics ostensibly mean law for many pharmacists, as the above quotation indicates, or are the terms synonymous or perhaps syncategorematic in the linguistic sense and that law and ethics are only meaningfully understood together? This may explain not only how ethics was defined by some pharmacists but also what was meant by an ethical problem and the prevalence of the controlled drug situation. Being aware of a particular legal aspect of pharmacy work was also agreed to be directly linked to

ethical decision-making, as Jane illustrates:

‘It’s interpretation of the law - that’s all the ethical dilemmas, ain’t it? [...] I’m a bit more up to date and, like, I’m a bit more and I can make the decisions easier because I know the law.’

Some pharmacists, however, attempted to distinguish legal and ethical concepts rather than using the terms interchangeably and this was illustrated by Dan, who offered the following aphorism that he remembered hearing from one of the professors on his undergraduate course:

‘What is ethical is not always legal and what is legal is not always ethical.’

However, this still appears to reinforce the syncategorematic nature of the two terms and pharmacists’ undergraduate training certainly appeared to be relevant to their understanding of ethics. Examples were frequently provided, often with surprisingly good detail, of what was studied at university, although this was frequently of either solely legal instruction for older pharmacists or predominantly so for the more recently qualified. Julian, an owner-proprietor who had been qualified for four years at the time of his interview, appeared to recognise the limitations of his undergraduate course and identified the lack of any substantive ethical content on his course but recalled instead the legal and procedural aspects of pharmacy. In the following extract he responded to an earlier remark in the interview about confidentiality (an ethical concern that will be returned to later in this chapter):

- Interviewer** Just to go back to what you said about what you'd learnt at university, is it, I mean, are you able to distil that into sort of...I mean you said it meant confidentiality and other things, is it because it helps with these things? What happened at university, for example, what were you taught?
- Pharmacist** Er, from University we got taught when you were allowed...well, a lot mainly about dispensing. You didn't get taught a lot about confidentiality. We didn't cover it at all, to be honest but we did a lot of script law, legislation and entering private prescriptions, documenting all the paperwork and what you can do with a CD script and what details you require on the script, a controlled drug prescription and all different kinds of groups of drugs that require different details on the script. Handwriting or dated, stamped as well, date stamped. So we learnt all that, we even went into the sales of cyanide and, you know, got an exam on what you could use for killing moles and all that...
- Interviewer** ...things you never need to know? ...
- Pharmacist** ...yea, so we did a lot of that legislation type of thing...
- Interviewer** ...it sounds like a very legalistic kind of approach. I mean, do you remember anything about ethics. Obviously, I'm trying to bring out ethical...
- Pharmacist** ...we didn't do that much, to be honest. We didn't cover the ethics in that sense – the grey area. [We did] Anything that was documented or had paperwork. So anything that...morally correct, we didn't cover that much to be honest. No. I suppose there was law in the course.

It is argued that references to pharmacists' ethical understanding are important initially since they help frame and contextualise the subsequent exploration of both the ethical concerns in this chapter and ethical decision-making in the next. As regards the former, a legalistic approach is relevant since it informs what pharmacists perceive as being ethical problems in their work and extends to concepts such as pharmacists' moral vocabulary. As Lowe noted (2002), a concern for moral vocabulary is important for societal groups in terms of contextualizing claims and statements. He identified a number of possible uses of moral vocabulary ranging from the attribution of motives, the justification of deviant behaviour and how agents make sense of situations. The

tendency for pharmacists in this study to offer a legal basis for what ethics might mean and to describe situations of ethical concern in an ostensibly formal or procedural manner is argued to result from their making sense of situations. This is illustrated in the language of the above quotation, which uses the vocabulary of colour and of ethics as the '*grey area*'. This chromatic metaphor appeared several times in the interviews with pharmacists and was used to indicate situations that were recognised as problematic for pharmacists and appeared to be a linguistic resource that offered descriptions of situations that could not be articulated in another way. Furthermore, such metaphors were comparative in that they were contrasted with what pharmacists often described as 'black and white' legal rules and regulations, as Shahid indicates in the following quotation when referring to what he perceived was the strict and inflexible legal approach of other pharmacists:

'Some people would revise the MEP and go strictly by the MEP and [say] 'this is not legally right' but then that's a bit detrimental because it's that black and white thing at the end - there's always shades of grey.'

It is not the case that ethics is law but rather that ethics cannot be seen in a way that is inseparable from law and is defined by a syncategorematic relationship. For other pharmacists, phrases such as 'entering the grey area' or 'getting a bit grey' appeared in their conversations, and appeared to be used to indicate an issue or situation that was more indeterminate than the clearly defined and highly contrasted legal or procedural rules that were associated with pharmacy work.

How does such an overtly legal conception of ethics have relevance to the question of what ethical problems are encountered by pharmacists? As noted in the methodology

chapter, this study does not use hypothetical ethical situations in contrast to some similar empirical studies (Holm 1997) but instead values what pharmacists perceive as being of ethical concern and clearly if an initial conception of ethics is overtly legal, it is not unreasonable to expect the examples provided to be of a legal nature. Hence, the example of controlled drugs within the dispensing process in community pharmacies as an archetypal example is not unexpected. However, many additional ethical concerns emerged still within the core dispensing tasks and these are now considered. Pharmacists' examples relating to emergency supplies, the use of compliance aids and re-dispensing medicines are explored and argued to be illustrative of not just a legal but also an overtly procedural manifestation of ethical concerns.

4.3.3 Emergency Supplies

Ethical problems arose for several pharmacists with respect to emergency supplies of medicines to patients. These involved circumstances where a prescription was not available and a patient was without their regular medicines and had asked the pharmacist to provide that medicine. In much the same way that the previous example of supplies of controlled medicines generated practical ethical issues in relation to compliance to legal rules, emergency supply procedures led to similar concerns for a number of pharmacists. Specific situations were described as being ethically problematic that involved requests by representatives of the patient rather than the patient themselves and where a local doctor's surgery was closed and a series of emergency supply requests occurred as patients could not collect their regular

prescriptions or where pharmacists believed a patient expected or demanded a supply be made. These examples were identified spontaneously by pharmacists in response to ethical problems in their work. These situations, like those relating to controlled drugs, required pharmacists to make a decision, often quickly, and involved further documentation. The difficulty and urgency of many ethical problems identified by pharmacists is shown in the following example. Compounding the problem in this example, however, is that the emergency supply of medicines needed to be made-up into what is known as a compliance aid – a device that assists in patients taking their medicine at regular intervals and which is further discussed later in this chapter. Clarissa, who worked as a part-time locum in the community, recounted the details of a situation in which a patient had apparently lost her medication and her relatives had called at the pharmacy to ask for an emergency supply and she explained:

‘[The original supply of medicine] was nowhere to be seen but the patient did have a bit of a tendency to kind of throw things out and was obviously in some sort of dementia as well and, an older lady, throw things out or hide it and never know where she’d put it again so it could be absolutely anywhere. Apparently, they’d had the house upside down. Now obviously I don’t have a script for a replacement but it’s a Saturday, no GPs are open at all now on Saturday mornings so, can’t really do much about that so I decided that I’d dispense it from the PMR and put up a new one for them. But first of all I decided that maybe I’d just give them enough for the Saturday and Monday and get them to go back on the Monday but then I’d have to go back and put it...well, no...thinking about it now I should have done it that way but, anyway, at the time I thought, we’d have to put it in bottles and it might just be better for me to fill a [compliance aid] up and then they don’t have to come back in and it can all just be okay again [...] and I didn’t have much time to sort it out. It closed at one, the shop for the day, you know, we weren’t open in the afternoon and I felt under pressure from them, clouding my view in a way. [Also] I felt, financially, am I giving something without a script that’s not going to get remunerated for. Primarily, my main concern was I didn’t think this woman was going to get her medication that weekend if I didn’t provide at least some.’

For Clarissa, making an emergency supply was beset by many possible concerns – the welfare of the patient without medicine and her impaired capacity, the financial loss incurred by making up the patient’s medicines without a prescription to claim reimbursement from the NHS, legal concern about what quantity to supply since the MEP permits only five day’s supply for emergency medication, the urgency of the situation and finally the fact that like many of the situations described in this chapter, the pharmacist was dealing not with the patient but with a representative. Emergency supplies appeared to be a source of concern for pharmacists simply because of all these possible factors and the above pharmacist was not alone in feeling ‘under pressure’ to supply. Amadika also appeared to experience emotional difficulties in relation to such supplies:

‘There is a lot of pressure. I mean, like on a Saturday, we get a lot of tourists, well I think it’s our busiest day and we get a lot of tourists in this place and I think, you know, they run out of their medication and I’m made to feel guilty for them not having gone to pick up their prescriptions on time. You know, I feel obliged then to give them emergency supplies then and they don’t want to pay for their emergency supplies and things like that.’

Emergency supplies were also identified by Hibbert *et al* (2000) as being ethically problematic for their sample of pharmacists and similarly, the Swedish study by Kalvemmark *et al* (2004) provided specific examples of acute situations where a decision about legal compliance was required urgently. In both these studies, the authors suggested that pharmacists were balancing legal concerns with the welfare of the patient and this is indeed found in the present study but, in addition, factors such as

dealing not with the patient but their representative are apparent and such situations appeared to be emotionally charged with references to 'guilt' and 'pressure' from individuals. Little research has considered the problems of emergency supplies but O'Neill *et al* (2002) did identify several concerns amongst UK community pharmacists and found that, despite many pharmacists feeling that such supplies represented a means of exercising professional judgement, not supplying was common. They noted that:

Many pharmacists had refused to make supplies on the basis that the situation did not constitute an emergency and/or that a prescription could be obtained. They also experienced cases in which they doubted the suitability of the requested product. (O'Neill *et al* 2002 p. 82)

The present study reveals that as well as a number of practical concerns about whether to supply, pharmacists also appear to experience ethical concerns but that such emergency supplies illustrate the predominance of a legal and procedural manifestation of ethical problems in pharmacists' work.

4.3.4 Compliance Aids

The above example of making an emergency supply into a compliance aid was actually but one of several ethical problems that involved this aspect of the dispensing process but have not previously been described in the empirical pharmacy ethics literature. As noted, a compliance aid allows patients or carers to control or remember medicine doses in the community and is a physical device that is used instead of bottles or cartons to store dispensed medicines. Although available in many forms,

they share a compartmentalised design in which days of the week and times of the day can be selected. They are particularly suited to patients with reduced intellectual capacity or memory problems such as occurs in dementia, for example. The identification of ethical concerns relating to this distinct aspect of community pharmacy dispensing illustrates that what is considered ethically problematic for pharmacists is often not of a high drama, 'neon' issue variety. Nevertheless, they remain ethically problematic for pharmacists and their use appeared to lead to a range of ethical concerns. Examples included whether patients should initially be provided with such a device and service, with concerns about the use of deception in relation to the storage of such compliance aids, to whether patients should be charged for such services, whether controlled drugs should be used in them and receiving requests to re-dispense hospital issued medicines into compliance aids.

Shahid mentioned that the very morning before being interviewed, he had faced what he considered to be an 'ethical dilemma' in whether to supply a regular compliance aid patient, a woman with psychiatric problems which resulted in her taking over-doses of some medicines, because no prescriptions were available. He had returned to work following a holiday to discover the local doctor's surgery had not issued any prescriptions to legally allow the pharmacist to supply the patient her weekly medicines in a compliance aid. Of concern for him in this scenario was that the 'ethical dilemma' was acute and needed to be resolved immediately but crucially, in describing the problem the pharmacist did so in an almost entirely non-ethical way. Reference was made to specific legal requirements for emergency supplies (which the pharmacist also considered) but also how they might defend themselves legally if a pharmacy

inspector became involved – further re-enforcing the emergence of a legalistically defensive conception of ethics and ethical justification. Just how the pharmacist describes the situation in a legal and defensive manner despite defining the situation as an ethical dilemma is shown in the following quotation from Shahid:

‘So I'm issuing her some prescriptions again now, a week's supply, and it's basically without a prescription. That's an ethical thing there where you're taking a word of mouth from the doctor and the receptionist. There's nowhere in the MEP where it says that a doctor can do it, it's seventy two hours if they do an emergency supply over the phone or five day's emergency request, but we're going up to two weeks now - that's a classical ethical dilemma. I spoke to [the doctor] and she's assured me that they'll be ready so we've given something out today without a script present and, you know, if an inspector come in, I can go...it's something that when I was training to be a pharmacist, it's something you've got to do, something that can you defend yourself in a court of law and we've got a patient who's got no medication over the weekend so basically...’

Although the pharmacist identified trust as an ethical concern in the scenario, as per the second of Braunack-Mayer's categorisations of descriptions where a specific ethical concept is identified, no mention is made of the welfare or needs of the patient. Even though it may be argued that the pharmacist did in fact supply the patient and must have had her welfare in mind, what is telling about this description of an ethical problem is the centrality of what is legally correct or legally defensible. This further illustrates pharmacists' tendency to both identify and subsequently describe what they consider to be ethical dilemmas in terms of laws and procedures.

So far, examples relating to controlled drugs, emergency supplies and the use of compliance aids have been considered. These have, it is argued, illustrated pharmacists' preponderance in framing ethics and ethical problems in terms of legal

and procedural concerns and this is continued in the next example, still related to dispensing medicines, involving re-dispensing medicines. This is then followed by a consideration of how best to describe the ethical concerns identified by the pharmacists in this study, namely as dilemmas or problems. The section then concludes with less procedural or legal examples relating to challenging doctors' prescribing and financial interests.

4.3.5 Re-dispensing Medicines

A further ethical concern for pharmacists that involved the dispensing process and the use of compliance aids, as described in the emergency supply example, concerned requests to re-dispense medicines. Again, these were raised spontaneously as ethical problems and typically the situations involved requests from patients, carers or other health care professionals for the pharmacist to make-up a compliance pack. Of concern, however, was that there was no prescription available and the request was for the pharmacist to re-use existing medication from the patient and effectively transfer it from an existing form, usually a bottle or blister pack that commonly originated as a hospital supply, into the compliance aid. Despite the outward simplicity or mundane nature of such a task, pharmacists described such requests as being ethically problematic since it was not good practice to use medicines that could not be verified in terms of either the original prescribing instructions or details of the medicine itself, such as a supplier or expiry date. Such ethical problems reflect a pattern of apparently trivial tasks within community pharmacy that are a source of ethical concern for

pharmacists in this study. Pharmacists often appeared to be aware of the competing concerns when faced with such situations and, as in the following example provided by Sharon, to consider the consequences of not providing medicine in a compliance aid but some were still reluctant to help patients because of over-riding concerns about the legal and procedural requirements of the situation:

‘[The situation involved] a patient of mine, he’s an unstable diabetic and he’s also got learning difficulties as well. He lives on his own as well, but he has a Mencap [charitable organisation helper] goes in, as well, I think twice a day and they prompt him to take his medication. We do his [compliance aid] up weekly for delivery on a Wednesday. But he’s always in hospital and this particular morning, he was discharged from hospital and it was a Saturday morning, discharged from hospital with medication but it wasn’t in a blister pack [...] There was a dilemma: do I do it because I know that the patient couldn’t, wouldn’t be able to take the medicine out of the original containers and hence they’d have to go straight back into hospital but to also looking after myself from my own point of view, from a professional point of view, that I couldn’t dispense the prescription because there was no actual prescription to dispense off.’

What emerges from this and the other examples of ethical problems provided so far is that what is considered ethically problematic for pharmacists is a conflict, but not one of competing ethical values but rather one of whether an ethical value, often the welfare or best interests of the patient, can be accommodated in a strict and, for many pharmacists, influential legal and procedural framework. The laws relating to controlled drugs and emergency supplies and the re-dispensing of medicines appear to result in a relatively inflexible professional environment that make professional and ethical judgement and decision-making often a matter of whether to break the law. The identification of conflicts not between values but rather between a legal and procedural concerns and a value (such a patient welfare) challenges the definition of a

dilemma as understood in philosophy, despite the term being used by pharmacists. Is a concern for this terminology relevant? In the next section it is argued that considering the ethical issues often described by pharmacists in this study as ethical or quasi-ethical problems rather than ‘dilemmas’ may be a more accurate way of describing and categorising them.

4.3.6 Dilemmas or Problems?

Despite referring to many of the ethical examples so far as dilemmas, is this an appropriate term for the issues they experience in practice that often involve a legal or procedural aspect? At a meta-ethical level, there is an extensive literature relating to ethical dilemmas (Lemon 1962, Macintyre 1990) and the question of whether, in fact, true ethical dilemmas can ever be said to arise. True ethical dilemma involves an irresolvable conflict between two choices – both of which ought to be done but cannot both be done and so to choose one option would lead to a moral wrong as one could not also perform the other option. However, amongst traditional ethical theories, Kant’s Categorical Imperative famously prohibits dilemmas since the rational agent can only act in accordance with one particular formulation of the moral law – there can never be two obligatory ethical acts that the agent should perform. For Ross (1930), dilemmas were similarly prohibited because *prima facie* duties were not conflicting but hierarchical and so one duty could always be chosen over another, avoiding a dilemma. Specific examples abound and mention is often made of Sartre’s philosophical example of the son who has promised to stay by his mother but who also

wants to fight for his country or in literature, the dilemma in Sophie's Choice (Styron 1980) of which child to save and which to leave. However, in relation to applied ethics, several commentators have argued that moral problems rather than moral dilemmas may exist, at least in practical terms (Jackson 1996, MacLagan 2003). Such problems are usually defined less stringently than dilemmas as they involve choices that are not exclusive or mandatory – so one could in an ethical problem, for example, choose between two moral options without the rejected option having a mandatory weighting. As Jackson (1996) notes in relation to ethical issues in business:

People commonly describe as 'dilemmas' any situations that face one with a difficult choice [...] Let us distinguish two types of hard choice: those that are dilemmas and those that are problems. By a problem, here let us understand a choice between alternatives where whichever you do would not be wrong, but where moral considerations might tell in support of one rather than the other. By a dilemma, let us understand a choice between alternatives where whichever you do appears to be wrong. (Jackson 1996 p.67)

The relevance of Jackson's problem/dilemma distinction for the present empirical study is that the problems described so far in this chapter represent neither category. The issue for the pharmacist appears to be one of legal or procedural compliance. Ethical concerns such as the welfare and potential suffering of the patient are present but it would appear that these situations stem not from a conflict of ethical choices or values but from ethical and legal choices. In the studies by Hibbert *et al* (2000) and Chaar *et al* (2005), such examples were clearly defined as dilemmas and were problematic for their sample of pharmacists but should these and also the ethical issues identified in this thesis be regarded as ethical dilemmas? Certainly, for the pharmacists interviewed they were often described as such and led to emotional as well as ethical

concern. Such examples do represent difficult decisions but perhaps, as Beauchamp and Childress note (1994), they should not be regarded as true moral dilemmas but as merely difficult situations that are ‘hard choices’ but not ‘hard moral choices’ (1994 p.12) However, referring to such ethical situations as mere practical or quasi-ethical problems admits one further consideration, that of self-interest. As MacLagan notes (2003), by adopting such a definition for some lesser ethical problems, it is possible to accommodate an agent’s self-interest as a competing claim or value. The issue of self-interest manifests itself in the distinctly legalistic and defensive approach adopted by some pharmacists in the above examples. The question of whether self-interest is, in fact, a defensible form of justification and ethical reasoning is considered in the next chapter but, in adopting the term ethical problem to mean merely a practical problem with an ethical aspect, one is able to frame pharmacists’ ethical problems as being of practical concern, if not a correspondingly philosophical concern.

4.3.7 Challenging Prescribing and Subordination

So far, examples relating to dispensing medicines have been described that involve a conflict between an ethical value, usually the welfare of the patient, and a legal or procedural matter. However, several pharmacists identified ethical concerns in relation to whether to challenge a prescriber with respect to a clinical problem in their prescribing. Often the pharmacist had identified a problem on a prescription presented to them that they believed would not be appropriate for the patient, either in terms of a dose or an interaction, for example. Michael described his particular ethical situation

involving a repeated drug interaction from a nearby rural doctor as follows:

'Is this interaction serious, is it not? Is it ethical to let it go? Is it clinically wrong? And there you enter the minefield and that...that's one of the big problems and one of my scenarios in an interaction and how far do you go with it. Do you take it to one patient? Do you take it to the whole practice? [...] But one interaction kept coming up from the same doctor and I rang up [and the GP said] *'Oh yes, I'm aware of it. It's not a problem. Tell the patient to continue'* but if that's the GP's action to one, and knowing the GP that would be the action to all of them, and then you're into that dilemma of do I ring him again or do I just do as I did before except it hasn't been his patient or do I tell the patient what the GP said on one occasion and does it apply across the board? And there you enter the dilemma.'

What appeared to make this and similar examples ethically problematic for the pharmacist concerned was whether it would be appropriate to contact the prescriber to discuss the problem or whether to go against the intentions of the prescriber and not dispense the medicine. Here, in contrast to the ethical problems identified so far in this chapter, are ethical situations that do not centralise a legal or procedural matter but, rather, the welfare and best interests of the patient balanced against the wishes of another health care professional. Such concerns have previously been identified amongst hospital pharmacists and nurses (Kalvemmark *et al* 2004), and were attributed, at least in part, to organisational and professional structures and that 'sometimes a person who is below in the hierarchy has to carry out orders from a superior against their own conviction' (2004 p.1081). This difference in professional hierarchy contributed to the ethical conflict, anxiety and moral distress (Jameton 1984) experienced by professionals such as pharmacists and nurses. Some pharmacists in the present research certainly referred to feelings of pressures and guilt in relation to

ethical problems in their work, as previous examples have indicated, but for others such as Michael and his problem of challenging prescribing, the result was simply one of uncertainty. The issue of professional hierarchy or subordination is not limited to the example of challenging GP prescribing but appeared to pervade several aspects of community pharmacy work and examples are provided later of difficulties in reporting suspected abuse by doctors by pharmacists, supplying emergency hormonal contraception and in the identification of atrocity stories. Subordination will be returned to as a significant ethical concern in this thesis in the next chapter in relation to the concept of ethical passivity and also in chapter seven in more detail, but this section on issues relating to the dispensing of medicines ends with a consideration of ethical problems that emerged in relation to financial aspects of dispensing.

4.3.8 Financial Implications of Dispensing Medicines

In the earlier examples of emergency supplies, Clarissa noted that the financial aspect of making a new supply of medicines without a prescription was a factor in her decision but do such commercial decisions lead to ethical problems for pharmacists in relation to dispensing? Although this theme of financial considerations will be developed later in relation to other aspects of pharmacy work such as the sale of medicines, it is relevant to the dispensing process and several pharmacists referred to issues such as remuneration, profit and general financial factors. Many of these issues involved the cost of medicines and, in particular, whether pharmacies should provide patients with a more expensive brand than would be remunerated by the NHS. Such

situations often arose due to customer requests for a particular brand or where the unavailability of a cheaper medicine meant the pharmacist had to decide whether to provide a more expensive alternative. Such situations were not often raised as spontaneous examples of ethical problems but during interviews some pharmacists did identify occasions where such decisions were needed. Pharmacists appeared to weigh up such situations in terms of the cost differential and potential loss to their pharmacy but also considered factors such as whether acceding to patients' wishes might encourage repeat custom or if an expensive brand were refused, whether the patient might suffer a delay in treatment. For Robert, being ethical amounted to *not* taking into account such financial worries about substituting an urgently needed medicine but this was contrasted with more routine situations where regular medicines were involved:

'I mean I think we all try and act ethically as much as we can, yes, certainly when it comes to patient care. I, personally, don't really hesitate in giving an expensive brand of a drug when we haven't got the generic version even though we'd lose money. I'm not sure that everyone at central office would be particularly pleased about that but [...] what I won't do is give an expensive brand to a patient on a regular basis – who claims that the generic isn't as good as the expensive brand.'

The implication in this quotation was that it might be *unethical* to prevaricate over the cost of supplying an expensive brand in situations where there was an urgent need for the patient. For others, however, appeasing the patient *qua* customer who was capable of taking their business elsewhere was relevant and several pharmacy owners considered the net gain that could be made, as the following quote from Julian illustrates:

‘It depends how much difference it is. I look at prices. If they get a few items, you know, and it’s fifty pence difference or just a pound difference from what they want, then I’ll give them it – I just use my judgement. If you’re making a loss, then no, I won’t do it but if somebody’s getting fifteen items and they want something that, you know, costs just a few quid more sometimes then you’ve got to say ‘Yea’ and then you’ve got to look at it and put your financial head on and say ‘Well, I’m losing a few pounds here but I’m generally making more.’”

Generally, the financial implications of dispensing were not often considered ethically problematic for the pharmacists interviewed. Some pharmacists, however, did make reference to financial implications not in terms of possible losses for the pharmacy but rather in terms of burdens upon the NHS or even the patient. In one case, a pharmacist described as one of her initial ethical concerns the example of making claims for uncollected medicines. The pharmacist was concerned that when patients did not return for medicines that were owed to them, the prescription still needed to be processed so that payment could be made for the part that was supplied but there was no mechanism for claiming only part of the prescription. This ethical concern was one of the few occasions where a pharmacist considered the implications of medicine cost in broader terms, as a claim against the finite resources of the NHS. In another case, Julian was concerned that a local doctor was writing prescriptions for his own use but using the name of his daughter to obtain such prescriptions free of charge. This example is used in the next chapter in relation to ethical attention but Julian did not see the potential abuse potential of the medicine being self-prescribed as an ethical concern but the fact that the doctor was using deception to avoid paying an NHS dispensing charge:

‘He was writing prescriptions for temazepam under his daughter’s name which...I think it could be abused. He wasn’t doing too many, you know [...] but it was probably for him or his wife but he was putting them on his daughter’s prescription ‘cos she was getting them free [...] If they need some sleeping tablets, they can get them on prescription but under your own name. If you pay for it, you’re rich enough - you’re a doctor.’

A further example involved an ethical concern not related to costs to the NHS but to the patient. Of concern for Clare was whether a patient should be charged for a compliance aid that the pharmacy made up and supplied each week but for which her employer required that a charge be levied for such a service. Clare found this problematic and decided to waive such a charge based upon a consideration of the economic difficulties faced by the patient, an elderly man with little income.

The commercial nature of community pharmacy did appear to lead to some financial conflicts of an ethical nature but despite the examples offered, most pharmacists were aware that they worked in an inherently profit-driven environment that meant such influences were inevitable and expected, as Robert noted:

‘It’s almost the thorny issue of pharmacists are making money out of the health service. I think we, we need a balance. I think we should be professional, we should be altruistic but, ultimately, being a professional doesn’t mean working for nothing.’

In previous research, the commercial imperative for increased profits was considered in relation to pharmacists’ responsibility to provide counselling (Resnik *et al* 2000) and this remains a potential source of conflict. However, amongst the pharmacists interviewed in this study, none identified the increase in prescription dispensing or the related commercial incentive as being ethically problematic although some described

additional strains upon their time and a feeling of monotony and routine, a concern returned to in chapter seven. Latif (2000c) has identified a possible concern about moral reasoning and pharmacy ownership, arguing that proprietors may, in fact, have more of a financial interest and may have become socialised into a commercial pharmacy environment to the detriment of ethical decision-making. The owner proprietor pharmacists in this research did appear, at times, to provide more examples that related to commercial concerns such as the financial example above that considered the custom that a patient with many prescription items might generate. Further examples of commercial values competing with ethical or legal concerns did emerge in this thesis and these will be considered in the next section involving medicine sales.

4.4 ETHICAL CONCERNS RELATING TO MEDICINE SALES

Community pharmacists are also frequently involved in the supply of medicines not by way of dispensing a prescription but as an over the counter medicine sale. Several ethical concerns emerged in relation to this aspect of community pharmacy work and these often followed prompts about this area of work rather than being spontaneous examples of ethical problems. Although several financial conflicts were identified in relation to dispensing medicines, the sale of medicines is by definition a financial transaction and perhaps highlights most clearly the commercial nature of pharmacy work as pharmacists interact not with patients but customers. What were considered to be ethical problems for pharmacists in relation to the sale of medicines? Medicine

sales encompassed several areas such as pressure from individuals *qua* customers to purchase medicines, company policies such as promotions, link-selling and refunding medicines, intervention into sales by staff, unlicensed indications, therapeutically dubious medicines and, a cause of considerable ethical concern for some, the sale of EHC. Each of these areas will now be explored and pharmacists' relevant examples provided. As in the previous section, the aim is to present the ethical problems as described by pharmacists but also to illustrate one of the central claims of this chapter – that pharmacists often define and experience ethical problems in a manifestly legal and procedural way. These will be contrasted, however, with the ethical concerns of EHC, which it will be argued, represent a valuable opportunity for pharmacists to re-engage ethically in an environment that is increasingly regulated and legislated for. But before considering this particular ethical concern, more general examples of ethical problems in relation to medicine sales are explored first.

4.4.1 Pressure to Sell Medicines

The commercial nature of community pharmacy appeared to cause ethical concern for some pharmacists in relation to medicine sales. Such concern appeared to stem not only from customer demands but also, for employee pharmacists, from company pressure to generate sales. Regarding customers, some pharmacists talked in a general way about concerns that there was an expectation to be supplied medicines despite pharmacists' concerns about the suitability of the medicine and possible harm to a customer. One pharmacist observed that customers felt empowered and because of the nature of pharmacy, would simply try another pharmacy if refused a sale in their

pharmacy. Overall, concern about customer pressure was not common but amongst employee pharmacists, ethical doubts were often raised in relation to their employer's policies and procedures for selling medicines. For example, several pharmacists noted that promotional activities that followed the removal of re-sale price maintenance such as 'three for two offers' were a cause of ethical concern. Such promotions appeared to cause conflicts as pharmacists considered such multiple sales to be often clinically unjustified but felt unable to prevent sales. One pharmacist felt it was unethical of his employer to ask him to accept prescriptions from another pharmacy in the company that did not have an NHS contract. The policy of link selling was also identified as being ethically problematic for several pharmacists, involving not only ethical concerns about the welfare of patients potentially receiving inappropriate medicines but also the autonomy of the patient and whether they should have such promotional activities imposed on them. Using link-selling as a generalised example of an ethical concern, Amadika identified pressure from her line manager to link-sell medicines and expressed her concern thus:

'So, you know, you always feel pressure and when [company line managers] do come, they're just watching you to see if you are link selling, as they call it [...] I think if I was a customer I wouldn't like it so I don't like giving it, no. No, I wouldn't do it and you see that's pressure – I'm succumbing to pressure, aren't I?'

The pharmacist noted that this was a source of ethical concern since she was forced to balance the independence of the patient with what she considered to be 'pressure' from her manager and her employer's strategy for generating further sales. Pressure and ethical problems from pharmacists' employers was not limited to the sale of medicines

but also to more general policies that influenced, for example, whether a medicine supplied following a pharmacist's advice could be returned and these are considered later in relation to company policy in general. The above example also appears to illustrate the construction of an ethical concern *retrospectively* and indicate that, perhaps like the nurses in the study by Uden *et al* (1992), pharmacists struggle not with what ethical acts to perform but rather the awareness that their work environment prevents them from acting ethically. The influence of constraints upon what community pharmacists believe to be acting ethically is further illustrated in the next examples relating to employee pharmacists and company policies.

4.4.2 Company Policy

A further ethical problem of a procedural type involved several pharmacists' concerns about companies' refund policies in relation to medicines. This was raised both as a specific and spontaneous example but also as a general example of unethical practice. Typically, situations involved larger companies for whom the pharmacist was either employed or working as a locum and where customers had returned medicines due to their supposed inefficacy, were offered a refund and where an attempt was made to put the product back into stock. Several pharmacists found this practice ethically problematic with one arguing that such refunds undermined the professionalism of the pharmacist's initial recommendation and another claiming that such refunds were symptomatic of a pro-customer attitude that sought to placate and please the disappointed customer. In both cases, however, pharmacists were also concerned for

patient safety due to the product having possibly been tampered with and, as Shahid commented about a previous employer's policy:

'If a person wants their money back, they can have it. I wasn't happy with that, either. They said somebody wrote a letter of complaint and I goes 'Well, ethically, you can't make me return this.'

Although the influence of pharmacists' employers will be considered later in relation to ethical help, it would appear that company policy actually precipitated ethical concerns.

4.4.3 Intervention in Medicine Sales

Further ethical concern arose in relation to medicine sales in a spontaneous example from a pharmacist working in a deprived city area who described overhearing a patient's request for a cough medicine following smoking cessation. Although discussed more fully in the next chapter as an example of ethical attention, Andrew recalled that a member of staff in their quiet, low turnover pharmacy had recommended a product that he thought inappropriate. The situation became an ethical problem for the pharmacist not only because of the competing financial concerns of the revenue that the sale would generate versus the relative poverty of the customer living in this deprived area but also because of not wanting to offend the assistant and undermine her initial decision. The example also illustrated how many OTC medicine sales were performed by pharmacy assistants rather than the pharmacist. In Andrew's example, he overheard the conversation but other pharmacists explained that such

activities in community pharmacies would be completely delegated with relevant protocols and policies in place to guide assistants and involve pharmacists as necessary. As previously noted, the pharmacist would often be involved in the dispensary. The question of who is actually involved in the ethical problems raised in this study is considered later in this chapter but the section continues with two further examples of an overtly legal or procedural nature followed by a contrasting and potentially emancipatory ethical activity, that of the sale of EHC.

4.4.4 Licensing

Ethical problems in relation to medicine sales were raised far less spontaneously than dispensing problems, probably reflecting the relative amount of time pharmacists spent engaged in these respective activities, as noted earlier. In contrast to the dispensing problems, ethical concerns in medicine sales were less legal and pharmacists seldom referred to legislation in relation to sales. As the example of company policy pressure illustrates, though, even if the problems occur not because of an explicitly legal concern, there is no less a regard amongst pharmacists for some procedural aspect of a medicine sale such as employee pharmacists' concern about sales promotions, for example. One overtly legal concern, though, involved the licensing of medicines and several pharmacists commented upon difficulties associated with patients' requests for medicines for which there was not an appropriate licensed indication. In one case this coincided with customer pressure to purchase a medicine and involved the recent deregulation of a medicine for the treatment of heartburn. One pharmacist, Robert, noted

that several customers had asked to buy the medicine but upon questioning the customer and discovering the medicine was not in fact licensed for their particular symptoms, the customer still demanded to be sold the medicine:

‘If they see it plastered all over the television, they’re gonna want to come and buy it. Do I sell them it? The license says no, I shouldn’t and that’s gonna cause difficulties [...]and yet you get loads and loads of people, who’ve had it in the past off the doctor for various other reasons where it’s not licensed for it, coming in and demanding it. Do I sell it or don’t I sell it? I have in the past tried to resist selling it but it is a very, very difficult thing to do.’

Further pressure appeared to stem from the aggressive promotion of medicines by some manufacturers, which he found additionally problematic, and to which his employers also contributed by organising prominent citing of such new medicines or sanctioning the use of advertising material to further promote such medicines.

4.4.5 Commercial Decisions

The sale of medicines has not always conflicted pharmacists in terms of imposing actions upon them as in many of the above examples where pressure, policy or procedure militate against ethical behaviour and previous studies have identified occasions of pharmacists acting unethically in relation to commercial interests. In the study by Chaar *et al* (2005), for example, the business environment was argued to have considerable influence upon ethical decisions and examples were provided of pharmacists prioritising profit and commercial gain over customer welfare. Are such examples evident in the present study? Several pharmacists, all owners of pharmacies,

did reflect upon occasions, especially in relation to the sale of medicines, where they believed there was an ethical concern and where, in fact, they acted unethically. Such admissions correspond to findings from the study by Chaar *et al* (2005) but, in this thesis, appeared to be in the minority. Several proprietors described situations in which over-the-counter sales might be influenced by commercial factors such as the amount of stock they were holding or the expiry dates of particular medicines. As Julian argued:

‘I’ve got twenty bottles that might go out of date so I’ll get rid of those [...] it could be conflicting but with your over the counter medicines, there’s a limit to what difference you can make in the actual outcome.’

Independent pharmacists appeared to accept commercial values more readily and sometimes referred to the threat of losing custom to another pharmacy as outweighing any possible harm to the customer. One proprietor, Simon, described a situation in which a house-bound patient and customer of the pharmacy had asked to be supplied with two similar topical analgesics. Simon ceded to the request, claiming that had he refused to supply her, she would just go somewhere else, even though he recognised that using both medicines was not recommended and potentially harmful. In another example, Philip, a proprietor in an economically deprived area of a large city, recognized that there was an ethical issue in selling confectionery despite the associated dental and nutritional concerns but argued that such sales were important for the pharmacy’s profits and were, he argued, sold next door in a newsagent’s shop anyway. Such examples support previous research (Kennedy and Moody 2000) which found that pharmacists generally rely upon clinical and patient factors when

recommending medicines for sale but that proprietor pharmacists were more likely to be influenced by economic factors.

4.4.6 Emergency Hormonal Contraception

So far it has been argued that pharmacists commonly identified ethical problems in their work, whether in dispensing or selling medicines, that involve conflicts of an ethical value with a non-ethical value such as legal, procedural or occasionally financial concerns. One important example of an ethical problem, however, that involved none of these concerns for some pharmacists and instead concerned more fundamental ethical concerns about autonomy, welfare and definitions of abortion was identified in the case of selling EHC. Apart from the ubiquity of the previously described illegal controlled drug prescription, the sale and supply of EHC was the most frequently identified ethical problem for the pharmacists interviewed, especially in terms of previously considered ethical problems that pharmacists mentioned spontaneously in interviews. Although considered again in the following chapters in relation to ethical decision-making and subordination, EHC appeared to be ethically significant in one way or another for many of the pharmacists interviewed. Four distinct positions were apparent in relation to sales. Firstly, some pharmacists appeared to oppose EHC sales completely and recalled that the decision to deregulate EHC led to considerable ethical concern and anxiety for them since it was believed to be a form of abortion and, for them, religiously and also ethically wrong. Secondly, some pharmacists also opposed sales but did so contingently and framed their decisions and

ethical concerns in terms of their lack of training, a perception that EHC might lead to promiscuity or a need to provide a consistent stance on supplies in a pharmacy that used many locums. Thirdly, there were pharmacists who found such sales ethically problematic because of basic beliefs in the wrongness of taking a life but for whom other consequentialist considerations were more important such as working in a deprived area and having concerns about the number of potential unwanted pregnancies or the inability of poor parents to care for such children. Fourthly, and most commonly, were pharmacists who were in favour of EHC sales and for whom the main ethical concern was that customers should be free to choose such medicines since decisions about termination should not involve the supplying pharmacist. What was apparent, however, was that EHC tended to be thought of as an ethical problem mainly for those pharmacists who opposed such supplies. As Hilary mentioned, ethical problems with EHC originated in fundamental religious beliefs that led to her belief that EHC was a form of abortion:

‘I think it causes an abortion. They say it doesn’t but that’s what I think and I’m just totally against that, erm, which originally comes from a religious belief [...] and when it became that it was coming over the counter, I thought ‘Oh, no, am I going to be forced into doing something that I don’t want to do?’’

Even referring a customer to another pharmacy was problematic for Chris, whose firmly held moral and religious convictions meant that providing any form of assistance in obtaining supplies was contradictory to their beliefs. As Chris argued in the following quotation, even the Royal Pharmaceutical Society’s conscience clause in relation to EHC could not prevent ethically problematic situations arising:

‘If we have an objection to it, we need not provide contraception but we must tell the patient where else they can go to get it. Now even that, telling someone else where to go to get the morning after pill which, to me, is a means of terminating life, is almost as bad as doing it yourself. So there’s a conflict immediately because I’m having to tell someone where to go to get this thing that I am particularly, strongly against.’

However, both these pharmacists did provide EHC on prescription, arguing that in such cases, the prescribing doctor was taking the responsibility for the supply – a concern that will be developed in the next chapter relating to inaction and ethical passivity and again in chapter seven, as an example of the subordinate role that pharmacists appeared to adopt at times in relation to ethical as well as professional issues.

Although most pharmacists agreed with the OTC availability of EHC and identified ethical concern only in relation to respecting customers’ freedom to use such a medicine, some pharmacists did raise concerns about their non-supplying peers. Such concerns were often related to a tension between respecting their peers’ ethical decisions and the consequences of non-supply for the customer and the customer’s autonomy in determining whether to use the product, as Clare illustrated in the following extract:

Interviewer What about an area related to emergency contraception and the idea of a conscience clause? Having chatted to various pharmacists about this, what if, for example, a locum pharmacist had, for religious reasons, not wanted to deal with it. It’s a two-stranded question but are you happy with it and have you had any problems where people have come back?

Pharmacist Yes, I have had problems. I’ve had somebody come in and

complain before, because – I think it was a Saturday as well – because he wouldn't sell it because of religious reasons and I have to admit, I can't understand why not because if they can give it out on a prescription with a clear conscience then why can't they sell it with a clear conscience?

Interviewer Okay.

Pharmacist Right, now I did work with somebody who refused to give it out on prescription completely. Now, that, well, okay, it is a really strong belief and she really didn't agree with it but that was in hospital as well so there was plenty of other pharmacists about. But I think that as long as there are other places they can go to then it's not a problem. During the week it's not a problem as they can just go down the road but when it's a Saturday and stuff then, no, I don't think it's fair because it's not their fault – they're thinking too much of themselves. This poor person has got to, if they can't get this hormonal contraception and they end up pregnant then...

As will be discussed later in this thesis, EHC appears to offers community pharmacists an opportunity to re-engage with ethical concerns but as the above examples indicate, it would appear that non-supply is ethically problematic not only for those pharmacists who would not want to sell EHC but also for other pharmacists who disagreed with their peers and who were concerned about the consequences of non-supply.

So far, the ethical themes identified have focused upon the central activities within community pharmacy – of dispensing and selling medicines – but the pharmacists interviewed also identified other ethical concerns. In the next section, ethical concerns are developed that are not necessarily unique to community pharmacy such as confidentiality, whistle-blowing and advocacy and these are discussed with reference to other empirical ethics research involving other health care professionals.

4.5 ETHICAL PROBLEMS COMMON TO HEALTH CARE

So far, an attempt has been made to describe what pharmacists understand by and experience as ethical problems in their community work and several pharmacy-specific issues have been identified that originate in the particular tasks of community pharmacy such as providing a dispensing service and selling OTC medicines.

However, several areas of ethical concern emerged in the research that were more general in nature. For example, several ethical problems were identified that, although broadly associated with the dispensing process, featured concerns that are similar to those encountered by other health care professionals such as doctors and nurses. These include problems such as refusal of treatments, withholding of treatment and confidentiality (Hurst *et al* 2005, Braunack-Mayer 2001, Rogers 1997, Bremberg 2000). Other issues that have general concern across health care and which were also identified in this study include whistle-blowing and advocacy and all these will now be considered in turn. The intention is to illustrate that, despite the foregoing depictions of ethical concerns in community pharmacy as being overtly contextual and specific, there are in fact areas of common ethical concern amongst health care professionals.

The existence of such over-lapping concerns may have relevance to issues such as the Tavistock proposals (Smith *et al* 1999) for a shared code for all health care, rather than health care professions' present specialised ethical pronouncements as codes of ethics, for example. The following examples indicate that there were some areas of common ethical concern but that they were not frequently cited examples of ethical problems and their inclusion should not detract from the overall claim in this thesis that what

pharmacists considered to be ethical problems and experienced in their work were more often of a legal and procedural nature and were very specific to community pharmacy work.

4.5.1 Treatment Refusal

Within bioethics, concern about patients' decisions as to whether to accept medical treatment are common and often high profile in nature. Cases involving Jehovah's Witnesses, for example, and issues relating to incompetent patients abound in the medical ethics and medical law literature (see Gillon 2000 and *Re T (Adult: Refusal of Treatment)* [1993] Fam.95). The pharmacists in this research, however, did not identify ethical issues in relation to these high profile concerns and only one example was provided by a pharmacist that concerned a patient refusing treatment. The pharmacist, Shahid, was concerned about a request by the patient to reduce their dose of methadone, which the pharmacist usually supervised. At issue, however, was not just whether the patient should be able to refuse part or all of their dose but also the pharmacist's duty to supervise. As Shahid described the situation:

'Giving methadone out, that's a classic one - giving methadone out. If a person wants to reduce his...if he's a supervised patient [...] we, can't force patients to take methadone, we just supervise them. Now if they leave half of the supply there, fine, inform the actual care worker and stuff like that [...] but I actually found out not from them but also from the law department because you can't force someone to take it - it's not in your remit as a pharmacist to make sure they drink it. You're supervising but if they don't want to drink the rest of it, then fine, you just need to inform them and write it down on the prescription that they know what you did and what you saw and that's fine.'

So as much as the situation was about the patient's ability to control their own dose and refuse a part of it, the pharmacist was concerned with their legal responsibility and with documentation, illustrating again the dominance of a legally contextualised problem.

4.5.2 Withholding Treatment

Although referred to in the literature as a problem faced by physicians, pharmacists potentially face situations in which they must decide whether to withhold treatment in the form of a prescribed medicine. In this study, two areas of concern emerged in relation to treatment refusal by the pharmacist: firstly, where a patient was prevented from using a pharmacy initially and, secondly, where a particular incident lead to an ethical concern about whether to provide a medicine.

In the first type of situation, several pharmacists described situations in which a patient might not be allowed into a pharmacy. In one example, this related to previous attempts by the patient to steal stock from the pharmacy whilst being treated for drug dependency. Although initially not considered an ethical problem, the pharmacist, Julian, considered during the interview that the situation might involve a number of ethical concerns:

'I refuse anybody that's shoplifted in here. Even letting them in the shop, I won't let them in which is, I think, from a shopkeepers point of view, is fine but you could look from the ethical side, that everybody's got the right to get their medicine. I do say that it's something they're allowed to take

out of the pharmacy, then somebody else can come and pick it up for them and I think that's being very generous [...] I mean, there's other places and that's a penalty for thieving and abusing.'

Despite the apparent economic basis for the decision and origin of the problem – to prevent loss of profit from theft – the pharmacist recognised the need to consider how the patient was to obtain their medicine and why should the addict be treated any differently. Helen described two problems in her work relating to whether to withhold medicines. In one case, she described a patient who was verbally abusive to the staff but who had been refused access to other local pharmacies. His behaviour was unacceptable but he required regular medicines and the ethical problem was:

'We have one very aggressive epileptic gentleman we do a [compliance aid] for and he'll be very aggressive to the staff. I've got to the point where he's nearly had me in tears and I wanted to say 'Right, you're not coming here anymore' but there's no-one else who'll have him. So that's my ethical dilemma, every time the staff say 'we can't deal with him' - the staff won't, they hide - so I have to go out and I have to deal with him and I'm nearly in tears and they're 'You shouldn't have to do this' and I'm like 'Well, if I won't do it, who will?' Everybody else has refused him [...] and it's not his fault, he's got problems and I understand that but that is one of my big issues because every time he really gets me down, I just want to say 'I've had enough but then I think who else? Where would he go?''

The problem of aggressive behaviour is recognised as both a social and also an ethical problem within health care and the BMA, for example, provides ethical and legal guidelines for doctors on this aspect of healthcare (BMA 2004). They claim that concern about whether to supply a violent patient treatment indeed 'raises dilemmas for clinicians' but do not explore the ethical concerns further focusing, instead, upon

legal and practical aspects of such situations, drawing upon the broader government policy of ‘zero tolerance.’ What is distinctive about the above ethical problem for this pharmacist is that the problem is ongoing and remains a source of ethical conflict and concern.

Helen also experienced an ethical problem with supplies of methadone to an addict patient where the patient was collecting their daily medicine at an inconvenient time. The patient had been repeatedly warned about this but the pharmacist described finally having to make a decision as to whether to refuse the patient’s daily supply of methadone because of this persistent problem in late attendance and she eventually withheld the patient’s supply on one occasion, feeling that the patient was simply taking advantage of the pharmacist by not adhering to regular medicine collection times.

4.5.3 Confidentiality

Previous empirical pharmacy ethics research has not identified examples of ethical problems relating to confidentiality although one study (Deans 2005) reported that community pharmacists appeared to be confident in using the concept of confidentiality. Did the pharmacists in the present study identify confidentiality as an issue in their work or even consider it an ethical concept? Although the subject was prompted in the interviews, few of this study’s pharmacists cited confidentiality as an ethical problem in their work. Some provided the same generalised scenario of when it might be relevant and considered confidentiality in relation to staff within the

pharmacy and noted that as pharmacy managers, they encouraged pharmacy staff not to discuss patient information, especially in a way that could be overheard. In terms of more specific ethical problems, few pharmacists made reference to confidentiality spontaneously. In one example, a pharmacist recalled medicines having been delivered to the neighbour of the patient to whom the medicines belonged and a resultant complaint from the patient that they had not consented to this arrangement. Whilst the pharmacist identified the concept of confidentiality and noted that he had prepared protocols to avoid such problems arising, the actual problem described appeared to be of concern to the pharmacist not because of any ethical conflict but rather the need to apologise to the patient affected. Such situations once again reflect the typical practical problem often described by pharmacists in this study wherein ethical values were relevant to the problem described but were not necessarily the main concern of the pharmacist.

Other examples involving confidentiality were raised relating to whether pharmacists should provide confidential patient information to the police. In one example, Tanvir had been approached directly to provide details of an addict's medicine in relation to the suspicious death of the addict's partner. The ethical concern for the pharmacist appeared to be whether the patient's confidential details in the form of a patient medication record could be made available. The situation was resolved following advice obtained from the pharmacist's employer. Another pharmacist, Robert, described two situations in his work that related to confidentiality and the police but in contrast to the previous example, involved whether the pharmacist should volunteer information from pharmacy records that could assist in crimes. In one example, police

arrived at a pharmacy and asked the pharmacist if he could identify some capsules believed to have been sold illegally – the ethical concern for the pharmacist was not in identifying the actual medicine but the fact that, because of the small community in which he worked, he was confident that he knew who the medicine had been initially prescribed for. He was, however ethically unsure as to whether to inform the police of his suspicion, based upon the patient's confidential records. The pharmacist also described a situation in which the police were trying to locate a potential suspect who was known to the pharmacist as a customer of the pharmacy. The pharmacist was aware that the patient was on regular medicines which he would have needed to obtain to prevent serious health problems and debated whether to contact the police to inform them of the wanted patient's medical condition and medicines in case he had tried to obtain supplies at pharmacies in other areas. The outcome of these ethical problems will be considered again in the next chapter in relation to ethical passivity.

Despite the drama of these latter examples, pharmacists generally did not appear to consider confidentiality a source of ethical concern in their work and few of the pharmacists made reference to particular situations. This reflects, again, the claim that whilst occasional examples emerged of ethical problems that other health care professionals may encounter, pharmacists seldom identified them as being ethical problems in their work.

4.5.4 Whistle-blowing

The Royal Pharmaceutical Society recently issued guidance on whistle-blowing in

‘Raising Concerns. Guidance for pharmacists and registered pharmacy technicians.’

(Royal Pharmaceutical Society 2005a). The report follows several recent highly publicised scandals such as Alder Hey, Bristol and, of particular relevance to community pharmacy, the Shipman affair and considers how health care professionals might voice concerns about conduct or competence, especially in situations where they were ‘either being too frightened to raise them, [had] spoken to the wrong person or had their concerns ignored’ (Royal Pharmaceutical Society 2005a). Although none of the pharmacists in this study used whistle-blowing or reporting others as a pre-reflected example of an ethical concern, many pharmacists provided examples after being asked whether they had ever felt the need to report or question an activity or the conduct of another, especially in the context of pharmacy or a health care professional. Many examples were provided including the conduct of doctors, receptionists, nurses and other pharmacists and locums. Pharmacists described a range of approaches to reporting concerns that included formal mechanisms such as Pharmaceutical Society inspector’s, PCTs and the police but also informal ones such as seeking the advice of pharmacist colleagues or a superintendent. In one example, Julian spoke of a local doctor’s self-prescribing of a hypnotic drug and conceded that it is an ethical issue but he had not previously enquired as to whether it is unethical or un-professional for doctors to prescribe medicines of possible abuse for themselves:

‘I’ve often thought ‘what are the ethics?’ and people have often asked me as well but I’ve never really looked into the ethics of a doctor writing [...and] I suppose it’s ethical from two senses: should they be diagnosing themselves and should they be writing for themselves? So it is a good point, which I don’t really know the answer to.’

In fact, this situation involving a doctor suspected of self-prescribing or abuse of a medicine was the most common example of reporting conduct amongst the pharmacists. An informal approach was often adopted, as in the following example when Dan observed that after moving to a new town and pharmacy, he became concerned about whether to report a local and well-respected doctor:

‘There was an incident with a GP self-prescribing controlled drugs. This was pre-Shipman and I did have a concern about the private prescriptions that he was issuing for himself so I did approach him about it and highlighted the GMC’s code about prescribing for self and family and he was quite happy about it and his GP then started prescribing the controlled drug for him. That was a worry at the time and I felt happier knowing that another health care professional was prescribing for him and monitoring this prescribing. I didn’t report him as such [...]’

In the above examples, the pharmacists were aware that a problem had arisen but were unable to articulate their concerns fully or to reflect upon further ethical aspects of the situation in relation to whistle-blowing or reporting conduct. Some, though, did express concern about their decisions and in the following example, Edward details a range of relevant concerns and consequences relating to an ethical problem about reporting a locum pharmacist who had recently worked at his pharmacy and who had made several errors:

‘Another ethics point, am I grassing someone up there? No, I’m not. I’m ensuring that the next place he [the locum pharmacist] works at, he doesn’t kill somebody else. If he kills somebody else a week later and I’ve not reported it - that his practice is so shoddy, that he’s a threat to patients - what do I do? I’d want somebody to grass me up if I’d been behaving like that, I’d certainly want to know about it and so we informed the society.’

However, this pharmacist's certainty in the need to report another pharmacist's conduct coupled with an ethical concern about 'grassing someone up' was isolated amongst the pharmacists interviewed. In contrast, another pharmacist raised concerns about sexual conduct when she recalled an ethical problem involving a locum colleague at another pharmacy who had inappropriately touched a member of staff on a number of occasions.

Despite the prevalence of doctors and pharmacists amongst those who pharmacist considered reporting, some other individuals were identified. Gloria, for example, described becoming increasingly concerned about a nurse from a nearby surgery, who she suspected of consuming alcohol whilst on duty. The situation was ethically problematic because she wanted to protect the public but also the nurse and was unsure as whether to report her suspicions. In one final reported example of reporting and whistle-blowing, a pharmacist described becoming concerned about a local shop-keeper, who appeared to be selling a prescription medicine illegally. The situation came to light as customers requested to purchase the same medicine from her pharmacy and she visited the premises and found the medicines for sale. The situation was uncomplicated, according to the pharmacist, since it was clearly illegal and all she did was to get a local doctor to confirm her observations and the police then became involved.

4.6 CONCLUSIONS

The intention in this chapter has been to consider what are ethical problems for community pharmacists and to frame such problems in terms of pharmacists'

understanding of ethics and the particularities of community practice. It has been argued that the pharmacists interviewed in this thesis often identified problems that were highly contextual in nature – relating to unique aspects of community pharmacy such as dispensing prescriptions and the minutiae of practice. Many of the issues identified in this chapter correspond to the ‘ethical dilemmas’ that have been described previously in the empirical pharmacy ethics literature. But a number of additional and significant ethical concerns have emerged such as whistle-blowing, EHC supplies, compliance aids, OTC medicine sales and employees’ company policy. It would appear that pharmacists do not experience the high profile, ‘neon light’ issues that frequent the bioethics literature and engage philosophers and lawyers. Perhaps Caplan and Kane’s somewhat disparaging term, a ‘*morality of the mundane*’ is a more fitting term for community pharmacists’ ethical concerns (Caplan and Kane 1990). The phrase was originally applied to ethical issues that arose in American nursing homes but Caplan and Kane made it clear that such apparently mundane and ethically unexceptional environments were, in fact, no less worthy of ethical enquiry and discussion:

But ethics concerns not only questions of life and death but how one ought to live and interact with others on a daily basis. The ethics of the ordinary is just as much a part of health care ethics as the ethics of the extraordinary. (Caplan and Kane 1990 p.38)

The same may be said of community pharmacy in that pharmacists appear to be preoccupied by concerns about acting legally when other ethical values may be at stake and they identify ethical problems in apparently routine tasks such as filling

compliance aids or transferring medicines. Yet these remain ethical problems *for* pharmacists and despite not appearing to reflect what is often the subject of the normative applied ethics literature, they are of concern in community pharmacists' everyday work.

It has also been argued that these routine problems should be so described rather than referring to them as dilemmas. Although the pharmacists interviewed (and indeed previous empirical pharmacy ethics studies) often referred to examples of ethical concerns as dilemmas, it is perhaps more appropriate to term such quasi-ethical issues as mere problems to distinguish them from the truly irresolvable ethical value conflicts discussed in philosophy. Again, the intention is not to demote such ethical concerns but to hopefully distinguish and not diminish the importance of ethical problems for pharmacists and, as noted in the introduction, one of the aims of the present empirical research is to identify ethical issues that philosophers, social scientists and lawyers can comment on or assist with. This more apposite definition of ethical, quasi-ethical or even practical issues is intended to contextualise and appropriately categorise such problems.

But what else may be said of the issues identified in this chapter? It is apparent that as examples of micro-social phenomena, the various ethical problems raised relate to patients or customers of community pharmacies but that, commonly, pharmacists appear to deal with representatives or intermediaries. For example, in the initial examples of controlled drug prescriptions, emergency supplies and compliance aids, pharmacists often mentioned dealing with a patient's relative or carer and this appears

to distance the pharmacist not only from the patient, as the object of the ethical problem, but also the consequences of their actions. Moreover, in the case of medicine sales, whilst patients often presented at pharmacies, delegation occurred and assistants made most sales as in the example of the pharmacist who was unsure of whether to intervene in an assistant's medicine recommendation and sale. Medicine sales also appear to be discrete transactions that were transitory in nature and, as one pharmacist mentioned, patients were sufficiently empowered and mobile to take their custom to other pharmacies if their requests were not granted. It is in this context that one word in this chapter is conspicuous by its absence and that is *relationships*. In other studies (Holm 1997, Uden *et al* 1992), the relationship between health care practitioner and patient is identified and argued to be significant. However, differences are identified between health care practitioners and nurses favour the development of a relationship with a patient in relation to ethical concerns. As Holm describes the meaning of relationship amongst his sample:

Nurses speak more eloquently about this subject than doctors, not only when they recount their own ethical problems but also when they respond to the cases that were presented during the interview. The simplest explanation for the difference is that it is a function of their working conditions, as it is both easier and more necessary for nurses to establish relationships with patients. This explanation is somewhat supported by the findings that within the group of doctors interviewed, general practitioners and psychiatrists speak more about the importance of relationships with patients. (Holm 1997 p. 101)

As the above quotation alludes to, some environments such as hospital medical practice may be more inimical to developing relationships and this may be true of community pharmacy. The use of proxies and lack of proximity of pharmacists to

patients, and the discrete and transitory nature of medicine sales to customers may limit pharmacists' ability to develop relationships and result in the ethical environment often described in this chapter's examples. A sense of isolation appeared to prevail in relation to community pharmacists' ethical concerns and this theme will be more fully explored in chapter six.

This chapter has attempted to illustrate what are ethical problems for community pharmacists and to consider this thematically in relation to a typology of issues that are characterised by their practical quasi-ethical nature, their legal and procedural origins and their concern with routine tasks within community pharmacy. In the next chapter, the question not of *what* are ethical problems but *how* they are then resolved is considered, to build a more complete picture of ethical issues and understanding amongst pharmacists. The examples provided in this chapter are referred to again in relation to a framework of decision-making stages and to develop, as will be shown, a more complete picture of pharmacists as predominantly ethically passive in their approach to ethical concerns in their work. However, some of the issues developed in this chapter such as a legalistic approach to ethical understanding and practice, the routine nature of many pharmacy tasks, subordination and isolation are returned to in chapters six in discussing in more detail why pharmacists understand ethics as they do, why they encounter particular ethical problems and, as the next chapter will show, why they try to resolve ethical problems as they do.

5 ETHICAL DECISION-MAKING AND PASSIVITY

5.1 INTRODUCTION

In the previous chapter, the question of what were ethical problems for the community pharmacists interviewed was considered and a range of examples were provided. In this chapter the intention is to address the related question of how pharmacists then dealt with such ethical problems in their work. It is hoped that in so doing, a more complete understanding of ethical concerns in community pharmacy can be achieved. In particular, attention is focused upon several theoretical stages in the decision-making process, following the widely used model by Jones (1991) that was discussed in chapter two. This chapter begins with a consideration of ethical attention and draws upon empirical research by Holm and philosophical insights from Murdoch, Blum and Merleau-Ponty to relate the concept of what may be *seen ethically* to the overall process of ethical decision-making. It is argued that there are different ways of ‘seeing’ or describing ethical problems and that the examples of ethical problems identified in the previous chapter only partly account for what might be understood by pharmacists’ ethical attention in this study. This section concludes by introducing the concept of ethical activity and its antonym ethical passivity in relation to the pharmacists interviewed. It is argued throughout this chapter that using the framework of a four stage model, the cohort pharmacists could more often be described in the negative – as ethically passive – than as active ethical agents and examples of ethical inattention are provided. However, examples of ethical attention did emerge but whilst these are

argued to be illustrative of ethical activity, they may have attendant difficulties and resulted in ethical uncertainty for some pharmacists interviewed.

In the second main section of this chapter, pharmacists' ethical reasoning is considered and reference is made to existing ethical theory as considered in chapter two. It is argued that no common pattern of ethical reasoning emerges from the interviews and that, to paraphrase Wittgenstein, the interviewees 'hit bedrock' and 'turned their spades' quickly in relation to ethical justification. However, consequence-based reasoning, the use of the Golden rule and appeals to autonomy are identified as well as occasional use of narratives. Ethical uncertainty was apparent in several cases and, again, the relevance of ethical passivity is considered. The relevance of ethical assistance is also considered, particularly in relation to the influence of a code of ethics for pharmacy and also the formal channels through which pharmacists may seek ethical guidance – the Royal Pharmaceutical Society and the superintendent's office for employees, for example. None appeared to be of influence. Closely linked to this section is the third stage of ethical intent and it is argued that the concept of self-interest, especially as it is manifest in a legalistic defensive practice and concern for procedure, is yet again indicative of ethical passivity. In the final part of this chapter, the fourth stage of enacting one's ethical decision is considered and this, perhaps most obviously of all the stages, exemplifies the predominant ethical passivity of many cohort pharmacists and examples are provided of failure to do what was ethically required or to rely upon supervening circumstances. The chapter concludes with a discussion of what the ethically passive agent represents and a generalised summary of the characteristics of the ethically active and passive agent are advanced. It is argued

that passivity should be understood not in the sense of being acted upon necessarily, as per some definitions, but rather, of being *inert* or not active in relation to ethical issues.

5.2 ETHICAL ATTENTION

Ethical attention appears to be an infrequently studied and hence often overlooked concept in ethical enquires. It has gained some recognition in the empirical ethics literature, and in particular business ethics, but is far less discussed in normative ethical theories or in other areas of applied ethics. In the field of business ethics, it is often included in models of business ethics decision-making and, as described in chapter two, Jones' widely used model of decision-making includes the identification of an ethical problem as its first stage (Jones 1991). He does not, however, discuss this stage in much detail but does recognise the importance of individuals being aware of an ethical situation as the starting point of ethical decision-making, noting 'for the moral decision-making process to begin, a person must be able to recognise the moral issue' (Jones 1991 p.380).

In relation to health care, Holm found ethical attention (or perception as he referred to it) to be relevant in his empirical investigation of decision-making amongst doctors and nurses - in part because of his use of Jones' model of decision-making but also in explaining the ethical reasoning of his interviewees (Holm 1997). He draws upon the limited normative accounts of ethical attention or perception and refers to the works of Murdock and Blum amongst contemporary philosophers who have used the concept of ethical attention or perception. In contrast to empirical accounts such as Jones' model,

philosophical discussion values ethical attention not simply as part of a process but of importance in itself.

The relevance of ethical attention to the present study is that it may offer a more comprehensive account of how pharmacists resolve ethical problems and, drawing upon Holm and normative accounts, it will be argued that it is an *active* process and one that is beneficial to ethical decision-making but that may also be associated with ethical doubt and uncertainty. Most striking, however, is that ethical inattention was frequently identified amongst the pharmacists in this study, evidenced by a difficulty in recognising relevant ethical issues, and that this inattention is an initial descriptor of ethical *passivity* that will be developed as this chapter progresses. Issues relating to the variation in pharmacists' ethical attentiveness will be considered and the possible burdens of ethical attention developed in relation to uncertainty and scope together with the issues relating to inattention such as labelling, non-ethical issues and *post hoc* reconstructions.

One initial question is that the previous chapter has already provided numerous examples of ethical problems and do these not adequately illustrate pharmacists' ethical attention – in apparently recognising and describing ethical issues in their work? In some respects such descriptions do indeed reflect pharmacists' ability to perceive of situations as being ethical and to describe and discuss such ethical issues. However, as Holm points out in his study, it is possible that a *framing* effect may have occurred and that respondents might in fact be identifying issues as being ethical simply because they know that this is what the interview is about or that it is what the interviewer wants to hear. He notes that the data from his research suggest:

There must be a significant framing effect. In the context of the interviews, the problem area is defined as ethics. When the respondents reach [a certain ethical example] they have been talking about ethics for more than half an hour, and they therefore try to identify ethical problems. (Holm 1997 p. 102)

In contrast to the present study, Holm used hypothetical vignettes and was able to claim that framing may have occurred since at least one scenario (involving a poorly designed drug trial) was intended to be overtly technical in nature rather than ethical but some of his sample still identified ethical issues with it. The present study, though, did not set out to provide examples but rather to value pharmacists' spontaneous examples or responses to very general areas of practice and as such, whilst framing and the possibility therefore of bias and 'false positives' cannot be denied, such effects remain of interest since they represent, nonetheless, pharmacists' interpretations of situations. As such, the previous chapter's examples *are* relevant to ethical attention since they offer insights into the construction of problems, evidenced in the frequent construction of problems, for example, in a legalistic manner. This is explained by Holm in terms of the *labelling* of ethical situations in his study in terms of non-ethical features whereby health care professionals appeared to use technical, economic, administrative or legal terms in relation to their ethical reasoning rather than identify the ethical issues at stake. He argues that this labelling effect is a problem of ethical perception and prevented his cohort nurses and doctors from identifying salient ethical issues in hypothetical dilemmas. Pharmacists' legalistic labelling of ethical situations is strikingly similar to Holm's findings but does not explain nor fully reflect how pharmacists in this study 'see' ethical situations. Ethical attention and inattention must also be considered in terms of several emergent themes from this study that the

previous chapter did not illustrate and these will now be developed in terms of the variation in pharmacists' identification of ethical problems, the consequences of ethical attention, post hoc reconstruction and non-ethical issues.

5.2.1 Variation in Ethical Identification and Description

One of the most striking features of the interviews conducted with the community pharmacists in this study was the variation in how ethical problems were described by them. In particular, some of the interviews were very difficult to conduct in terms of eliciting detailed and rich accounts of ethical problems and issues experienced by pharmacists. Although hard to illustrate in short quotations, in the context of specific answers and also full interviews, some pharmacists were decidedly sparing in their description of either spontaneous ethical examples or even responses to general prompted areas of ethical concern. Open questions by the interviewer resulted in closed responses or even silence by some pharmacists. Hilary typified this and in the following quotation, she concedes that it was difficult to identify an ethical situation from her work prior to the interview and admitted that she had not thought of some prompted issues, such as selling medicines of potential abuse, as being ethical in nature:

'The only thing I could think of was that emergency contraception one. I couldn't think. It doesn't occur to me that these other things are ethical but I suppose they are, like hiding kaolin and morphine under the counter.'

For Hilary, events in her work such as hiding medicines to avoid confrontation with

customers who may be abusing a medicine were simply not recognised as being ethical. Later in the interview, Hilary was asked directly about her difficulty in identifying ethical issues in her work and in this more extended extract, she explains again that in the course of pharmacy work, ethical issues are simply not recognised:

- Interviewer** [...] did this throw you completely? I'm interested in this for future interviews and also [about] that question when you thought that it was quite hard to think of ethical examples?
- Respondent** Yes.
- Interviewer** I mean, was that just because conceptually do you think that you come across them but you're not thinking about them?
- Respondent** That's it, yes. You don't realise that it's an ethical issue that you're dealing with and you just deal with it everyday, yea. So, yea, I think that was it.
- [...]
- Interviewer** Do you think you're doing things correctly, in an ethical way?
- Respondent** ...
- Interviewer** For example...
- Respondent** Yea, I do.
- Interviewer** I'm curious about the fact that you don't necessarily see everything as ethical but would you imagine that you are still dealing with them correctly?
- Respondent** Yes, I would say that I was dealing with them ethically.
- Interviewer** Even though you might not perhaps be aware of them?
- Respondent** That's right, yea.

What emerges from this extract is that the pharmacist still believed that they were acting ethically, despite not even being aware of an ethical issue. It is difficult to understand how the pharmacist can still confidently claim to have resolved a situation ethically whilst at the same time being unaware that the situation was ethical. Of course, fortuitous outcomes are possible and one can arrive at the 'right' outcome without necessarily performing the 'right' act. Kant's example of the unscrupulous shopkeeper who does not deceive customers because they might be more likely to

return rather than because deception is wrong is a fitting example. But this pharmacist's admission illustrates the claim made in this chapter that ethical inattention is a common and important factor in how pharmacists would appear to manage ethical problems – even if this means that they are not, in fact, identifying and resolving them ethically at all. It may be countered, though, that the difficulty in eliciting responses from pharmacists about their ethical problems may have resulted from interview method effect (as considered in chapter three). For example, bias may have been introduced from the interview setting and that some pharmacists may have been uncomfortable with being interviewed although the frequent use of the interviewee's place of work was intended to avoid the problem of an unnatural setting. Furthermore, it is possible that the interviewer simply was not skilled enough to elicit more and detailed responses but, again, this may be countered by the claim that although the interviewer gained more experience as interviews proceeded, some of the early interviews yielded rich and detailed ethical accounts from some pharmacists and, conversely, some of the last interviews were with pharmacists who appeared unable to consider instances of ethical difficulty in their work or to reflect upon them in their work.

The above example of ethical inattention was not uncommon amongst the pharmacists interviewed but, as noted above, what was striking was the variation in response and some pharmacists appeared to be much more attentive to ethical issues in their work. But ethical attention may also be further considered in two ways - as an awareness of distinct situations as being ethical in nature and the related identification of relevant ethical aspects of such situations. Of course, this study did not ask pharmacists to think

of as *many* ethical problems as they could but what emerged from the interviews was that some pharmacists appeared to struggle far less in considering ethical problems, in responding to prompted areas of possible concern and in generally describing ethically relevant aspects of problems. In the previous chapter, Andrew's ethical problem relating to supervising the sale of an OTC medicine was considered and in the following, intentionally long extract from his interview, it is argued that this illustrates a decidedly more attentive approach and descriptively rich account than was provided by some pharmacists:

'Well, the first one I thought of was I was thinking along the lines of all these doctors' mistakes and then I thought of a better one - maybe it's quite weird but I had a patient last week who came in, really simple, really, but they've got a cough and they need a cough medicine and I'd listened to the counter assistant saying 'yea, yea, yea' - goes to this [brand of cough medicine], puts it through the till and then she said 'Oh, I gave up smoking a few days ago'. And so I thought 'Wait a minute'. The cough, because she's smoking, the [cough medicine] would be no good to her so really it's...she doesn't need that. She needs counselling and advice on lifestyle. She's got a cough and maybe what's going to happen because she's stopped smoking and what she can expect. Ethical dilemmas? A very, very quiet shop and the cost of [the cough medicine] is about four or five percent of the daily takings so do I get in there. Also, she doesn't really need it and am I butting in on what the counter assistant has done and the advice that they've given and taken away from them and their advice - which was good. I mean, admittedly, they hadn't asked about the smoking but they can't be expected to say everything and I'm trying very hard not to do that because very often I'm butting in and trying to take over people's things. So I'm thinking 'Do I do that?' and I suppose take away from this feeling that they've achieved something and that they've done that and that they've made a correct sale and but basically I just said 'You don't really need this.'[...] The real ethics of it? Well, I suppose there was the financial, slightly, although it was very small and financially that sort of money coming in, in an area where people spend three pounds on a night out is quite a lot. I'm not joking when I say that for a night out - seriously. They don't even buy face cream or anything like that because it's too expensive. So, financially, it was something that was, in that sense, in that area, to this shop, was quite a lot. Also I suppose - I don't know if it's an ethical one or not - but butting into what somebody else has done

and taking away from what somebody else has achieved when I'm trying very hard not to do that was something that I had to think about [...]

What emerges from this extract is the sense that the pharmacist was attentive to many aspects of the situation despite it being in his words 'simple, really.' Furthermore, the pharmacist was aware not only of clinical and economic issues but ethical ones, too – of concern for the customer's health, the assistant's possible distress and the ethics of selling a medicine that may not have benefits to a patient who may not be able to afford it. Other detailed and rich examples of ethical problems were identified in this pharmacist's interview and in some other pharmacists but such examples of ethical attention were, overall, the exception in this study.

According to normative philosophical accounts, ethical attention has been considered important and may in fact make ethical decision-making easier. For example, although Blum argues that ethical perception is valuable in itself, he notes that being aware of salient ethical features of a situation provides the setting for subsequent moral action (Blum 1991). Murdoch, however, uses ethical attention in an attack upon existential accounts of freedom to act and although a full consideration of this conflict is beyond the scope of the present study, her discussion of ethical attention provides insights into how it may assist in ethical decisions (Murdoch 2001). She argues that ethical attention is not an isolated act but rather an attribute – virtue even - that allows the individual to avoid difficult instantiations of ethical choice:

I can only choose within the world that I can see, in the moral sense of 'see' which implies that clear vision is the result of moral imagination and moral effort [...] One is often compelled almost automatically by what one can see. If we ignore the prior work of attention and notice only the emptiness of the

moment of choice we are likely to identify freedom with the outward movement since there is nothing else to identify it with. But if we consider what the work of attention is like, how continuously it goes on, and how imperceptibly it builds up structures of value round about us, we shall not be surprised that at crucial moments of choice most of the business of choosing is already over [...] The moral life, on this view, is something that goes on continually, not something which is switched off in between the occurrence of explicit moral choice [...] I would like to use the word ‘attention’ as a good word and use some more general term like ‘looking’ as the neutral word.
(Murdoch 2001 pp. 35-36)

In distinguishing between two senses of how individuals perceive their world – of seeing and looking – Murdoch echoes the variation in ethical attention identified in this chapter and that whilst pharmacists like Andrew appear to see the ethical aspects of their work, others like Hilary only look but without seeing. Events occur to them and customers request medicines of abuse, for example, but these instantiations do not appear to register as being ethical. A fitting simile occurs in the work of Merleau-Ponty, who uses the word *bemerken* in a similar way to Murdoch’s use of the general term ‘looking’ and argues that it is like a searchlight, indiscriminately picking out objects without further discernment:

Since ‘bemerken’ or taking notice is not an efficient cause of the ideas which this act arouses, it is the same in all acts of attention, just as the searchlight’s beam is the same whatever landscape be illuminated. (Merleau-Ponty 2002 p. 30)

In interviews, pharmacists who did not appear to be ethically attentive were no less still describing their ‘landscape’ but in a manner that could not either register or differentiate ethical issues or aspects of problems. To continue Merleau-Ponty’s analogy, the ethically inattentive pharmacists in this study in fact appeared to pick-out

of their landscape non-ethical features. These were sometimes labels as in the previously considered legal descriptions or facts about situations that were considered relevant in both a descriptive and also influential sense. These will be considered later along with one other emergent theme in relation to inattention, namely that the interview situation appeared to allow pharmacists to identify ethical features in problems *post hoc* – that is during their reconstruction and subsequent discussion and to apparently adjust the focus and recast the searchlight’s beam.

5.2.2 The Burden of Ethical Attention – Uncertainty and Scope

Before considering the two themes of the non-ethical and *post hoc* reconstruction in relation to ethical inattention, it should be noted that the normative accounts offered by Murdoch and Blum do not necessarily fully explain or reflect the data that emerged in this study – especially in terms of the active process of ethical attention. In particular, Murdoch’s claim that ethical and moral choices are ‘almost automatic’ and ‘already over’ in those who are ethically attentive does not completely fit the findings of the present study in relation to those that it has been argued display ethical attention.

Pharmacists who appeared to be ethically attentive and who were able to identify and describe ethical problems often appeared to be *uncertain* about their ethical decisions, contrary to Murdoch’s suggestion that ethical attention may make deciding in such situations easier. In the following quote, Clarissa, who throughout her interview appeared to be attentive and receptive to ethical issues in her work, describes the difficulty she had in considering what might be ethical, as she was asked too prior to

the interview:

‘[It’s] difficult to define what ethics means to you, I suppose. I find it difficult. I know what ethics means to me and I know what, you know, basically a right and wrong thing [is]. But I don’t know how I use ethics, you know what I mean. [...] My friend and I were talking about [a particular ethical problem] and she was going ‘Well, the issue there is, you couldn’t dispense the drug’ and I said ‘Yea, that’s the issue, but is that an ethical issue?’ You know, what’s the difference between the actual factual issue and what constitutes an ethical issue?’

For Clarissa, despite identifying a number of ethical problems in her work and individual aspects of such problems and appearing ethically attentive, doubt and uncertainty were still apparent. Despite raising concern about what might be an ethically or non-ethically relevant aspect of the problem and having a conception of what is or might be ‘right’ or ‘wrong’, such awareness did not necessarily lead to ethical confidence. This may be contrasted again with the response of Hilary above, who despite admitting not recognising ethical issues in her work, still thought she was acting ethically – doubt did not appear to feature in her assessment of her ethical ability. Is it possible to reconcile the claim that some pharmacists are ethically attentive and *should* be, according to Murdoch, free from angst-filled moments of ethical crisis but yet appear to be often beset by uncertainty in their ethical decisions? Whilst Murdoch notes that she must tread a careful path between ‘how far what I say is to be taken as recommendation and how far as description’, it is perhaps more by reference to the present study that an answer may lay (Murdoch 2001). Whilst it is argued that some pharmacists display ethical attention - a characteristic of ethical activity - they are perhaps not fully-fledged ethical agents. What is important to

remember in this study is that the variation described is not so extreme – pharmacists were not completely attentive or inattentive agents or completely active or passive – but rather that they lay somewhere along a continuum of ethical activity. The uncertainty described by Clarissa may reflect genuine doubt about her ethical ability and these, as noted from the previous chapter, must be seen in the context of an overtly legal and not ethical undergraduate pharmacy education, for example, and an environment of ethical and professional isolation. Ethical attention does not necessarily lead automatically to ethical excellence and many other empirically relevant factors must be taken into account.

A related question that concerns the ethically active agent is how much should be seen in terms of ethical problems? Holm draws upon classical mythology to distinguish two extremes of ethical perception and argues that a balance must be struck:

The task of the health care professional is therefore to navigate between the Scylla of neglecting all problems and the Charybdis of taking all problems very seriously. (Holm 1996 p.111)

Does ethical attention potentially burden the individual to take into account every possible problem? This raises serious issues relating to the scope of ethical attention for pharmacists. The examples from the previous chapter indicate that many problems are of a routine and often quasi-ethical nature that occurred as encumbrances in pharmacists' work. However, some pharmacists appeared to be aware of the implications of ethical attention and, as will be considered in the next section, this was particularly evident in some pharmacists' consideration of the consequences of their ethical acts. Pharmacists who displayed ethically attentive approaches to their practice

sometimes identified issues beyond their immediate work environment and it was apparent that the scope of their ethical perception was not necessarily limited to the logistical or temporal immediacy of problems as the previous chapter's examples often typified. For example, Edward described what he thought was an ethical problem that began with a telephone call from a patient whom he knew whilst working in a different area. The patient had contacted him to obtain his help about how to speak to her GP, who was apparently hard to reach due to other surgery staff's obstructive tactics, apparently. The situation illustrates the scope of this pharmacist's ethical attention in that even though the situation was brought to him, he still recognised not just a procedural or logistical problem but rather one that involved ethical concerns: that patients' had a right to contact their doctors and not to be intimidated or demeaned. Clarissa further illustrates how ethical attention leads to a broadening of ethical concern in the following quote, in which she is responding to the interviewer's question of what ethics means to her with an initial claim about harm but then expands this to involve truth-telling and extrapolates this to issues surrounding unethical business practices and then clinical trial ethics:

'I always think to myself, doing something ethically wrong would be actually causing harm to someone or doing something deceitful which would involve an untruth. So if you're doing something unethical perhaps it involves anything...a company – then, I think of company ethics or something, I think of somebody selling something that they know it's not what it is [...or] when there's clinical trials, me providing a placebo when I know it's a placebo but the person receiving it doesn't.'

Holm notes that there would be practical and psychological reasons for not trying to deal with all the possible ethical issues that might arise in a health care professional's

work and argues that ethical ‘burn-out’ may result whereby, paradoxically, individuals may stop seeing. None of the pharmacists in this study appeared to suggest that they experienced ethical burn-out or even suggested that ethical concerns arose so often that they could not be attended to. In this study, it is ethical inattention that appears to be most apparent. However, ethical attention has been argued to still be of importance in considering how pharmacists make ethical decisions – by considering how it theoretically assists ethical decision-making but that in this study it appears to be accompanied with ethical uncertainty rather than solutions for some pharmacists and issues of ethical scope require consideration. In the next and concluding part of this section on ethical attention, issues that emerged in relation to an ethically passive approach to seeing ethical problems are developed and these further develop the understanding of how pharmacists appear to deal with ethical situations.

5.2.3 Post Hoc Ethical Attention and Reconstruction

As noted above, ethically inattentive pharmacists still appeared to offer accounts of ethical problems either spontaneously or in response to interview questions about possible areas of ethical concern. This has been argued to be relevant to an alternative, non-ethical way of merely looking or *bemerken* but these accounts are still of interest since they offer insights into how pharmacists appear to make ethical decisions. As a research method, semi-structured in-depth interviews allow participants to describe events from their past and as such are always subject to a degree of re-interpretation and even distortion. Depending upon what account of ‘truth’ one ascribes to interview

data, such reinterpretation may or may not be an issue. According to non-positivistic accounts, the interviewee's process of reconstruction is to be valued as a social process and it was apparent from many of the interviews that the interview itself was influential in shaping how pharmacists saw ethical situations. The example above involving Hilary illustrates this point and that only in the interview situation did it appear that prompted possible issues might be ethical for her. Phillip makes a similar point when he asked if he had any further examples of ethical problems, having provided two that were procedural and legal in nature, he states:

'In fact there's probably loads but until you actually sit and think about them.'

The process of sitting down and thinking may be argued to refer to the actual interview process in which he was participating and, similarly, Julian appears to identify ethical issues in a situation described in the last chapter relating to a local doctor self-prescribing medicines of potential abuse or misuse:

Pharmacist	I've often thought 'what are the ethics?' and people have often asked me as well but I've never really looked into the ethics of a doctor writing.
Interviewer	I mean, is it one that you thought was ethical?
Pharmacist	It is, but I suppose it depends on what they're getting but, yea, I mean I suppose it's ethical from two senses – should they be diagnosing themselves and should they be writing for themselves? So it is a good point which I don't really know the answer to.

Julian appears to be using the interview to reflect upon the situation but as this excerpt shows and what is considered more in the overall interview is that he had not

previously given the situation much prior thought – he had ‘never really looked into the ethics’ and it is argued that this is a *post hoc* identification and only in the interview does he become ethically attentive to issues such as whether health care professionals might be harmed by self-treatment.

Such reasoning and perception of ethically relevant issues during the interview cannot amount to ethical attention given their retrospective nature and this supports the view that pharmacist are often ethical inattentive in their work. This later recognition process is similar to aspects of the Socratic method and in particular the *maieutic* process. For Socrates, the ‘truth’ was already present but latent in the minds of individuals and all that was required was a process whereby the truth could be given birth. This process involves a series of questions and answers that, like a teacher and pupil relationship, allows the latter to grasp a concept. Is the *maieutic* process relevant? Such an account would imply that pharmacists are capable of being ethically attentive and all that would be needed would be a suitable process such as an in-depth interview or the development of skills to allow latent ethical understanding to emerge. Although it appears to be the case that pharmacists are able to consider previously unrecognised ethical issues or ethical aspects of existing problems, the *maieutic* process is just that - a process - and the focus is upon the method in which information can be made conscious rather than the agent. However, because the question raised in this thesis is how do pharmacists deal with ethical problems, the use of a *subsequent* process is interesting but not directly relevant, except that it re-enforces the argument that many of the pharmacists interviewed appeared to be generally inattentive to

ethical concerns in their work.⁶ The use of such a process may, however, represent an opportunity for ethical communication and this is considered in chapter six

5.2.4 Attention to the Non-ethical

Having considered the variation between pharmacists in this study in terms of ethical attention and argued that many appear to be inattentive, it is still possible to develop in more detail how they describe situations that are considered ethical by them. As noted initially in this section and building upon findings from the previous chapter, many pharmacists in this study used a legal or procedural conception of ethics and often described problems in their work in a legally defensive context or with regard to rules and procedures. This labelling effect is not the only possible problem of ethical perception and in this study, pharmacists often identified what for them were significant but non-ethical aspects of situations. These non-ethical features appeared to be relevant to the description of problematic situations but also appeared to influence decision-making.

Returning again to an example from the previous chapter, Julian explained a situation involving an incorrectly delivered medicine to a patient and raised the ethical issue of confidentiality. However, what appeared to be of concern for this pharmacist was not particularly the confidentiality issue but the fact that an apology had to be made. The problem was memorable because it was a mistake and the patient was angry and

⁶ For a psychological perspective on the problems of post-hoc reconstruction and the deficiencies of rationale and cognitive moral reasoning, see Haidt (2001)

wanted an apology. The ethical issue of confidentiality was there but this was essentially a practical problem that was decided by the pharmacist seeing the need to appease the patient. A further example occurred in the problem identified by two separate pharmacists involving, once again, controlled drugs and an incorrect prescription which the previous chapter identified as being archetypal. The pharmacists identified what were in fact, two comparable situations and in one, they described being presented with an incorrectly written (and hence illegal) controlled drug prescription for a terminally ill patient whilst in the other, an addict presented a similarly incorrect script for methadone. The issue of ethical attention arose since what both pharmacists 'saw' in these situations was a difference between both types of patient and even though one of the pharmacists noted that there might be potential harm to a addict if a supply was not made, there appeared to be discrimination based upon facts about the patient rather than their potential suffering. Gloria summarises her reasoning as follows:

'If a methadone script is wrong? I suppose the ethical dilemma is that somebody might resort to going back to drugs [but] if it's a controlled drug and someone is in a lot of pain, say with cancer, then it's a different matter [...] you might well say 'why don't you help the methadone patient?' and I don't know whether in my mind there is a distinction.'

What this pharmacist sees in both situations is, as she admits, an invidious distinction based upon non-ethical aspects of each patient and although there appears to be attention to ethical aspects such as the consequences of not supplying methadone, what is finally seen is a non-ethical distinction. Of course, non-ethical decisions are made all

the time quite legitimately but what may be problematic is that where there is a relevant ethical concern, to decide based upon the non-ethical aspect may be inappropriate.

In another example, Michael discussed a new computer software package that connected OTC medicine sales made in the pharmacy to purchasers' prescription medication records and details and allow an interaction check to be made. Of relevance was that Michael did not appear to appreciate possible ethical issues in relation to this arrangement and, in particular, to issues such as consent and confidentiality and in fact referred to the possibility that making such checks against patient's records was actually a business concern – contrary to consumer-driven, *laissez faire* economics. He describes the situation and his decision thus:

'I feel that it's something that we ought to be doing and I think on a patient safety basis it's much better that they don't have the choice, if you will. I know it's not exactly good free market practice and what have you but I do feel that it's something that needs to be done.'

Many other examples emerged from the pharmacist interviews supporting the argument that what pharmacists were attentive to in problematic situations was not usually an ethical concern but the prior labelling of such situations as legal or a non-ethical issue focus.

The intention in this section has been to explore the relevance of ethical attention or its lack in the context of the pharmacists in this study. It has been argued that inattention is common and this may lead to an incorrect labelling of situations by pharmacists, that ignores ethical aspects in favour of legal constructions or non-ethical features. But

conversely, some pharmacists were ethically attentive and capable of considerable insight and sensitivity but at the possible expense of uncertainty. Despite such variations, pharmacists were not found at the mercy of either the Scylla of seeing nothing or the Charybdis of seeing all but appeared to navigate between two distinct but not extremes of ethical attentiveness. In the next section, the attention moves from how pharmacists might 'see' ethical problems to a consideration of their ethical reasoning but it is hoped that this section has indicated that ethical attention is not merely an initial procedural stage or the handmaiden to other stages such as reasoning, but an important issue in itself with concomitant problems and relevance.

5.3 ETHICAL REASONING

If I have exhausted the justification, I have reached bedrock and my spade is turned. Then I am inclined to say, 'This is simply what I do.' (Wittgenstein 1953 p.85)

In this second section related to how ethical situations are resolved, the issue of pharmacists' reasoning is considered and attention is turned to the justification of ethical decisions. Although attention was considered as not just the handmaiden of the reasoning process, it is nonetheless this latter process that is often the focus of much empirical work. This may be explained variously: empirical study is often concerned with matching empirical ethical reasoning to normative ethical accounts (Hibbert *et al* 2000, Chaar *et al* 2005) but also because in practical terms, health care professionals must often justify their actions and this is most obviously manifest in terms of their reasoning rather than implicit processes such as ethical attention. In terms of broader

policy, ethical reasoning is also where attempts to educate or guide health care professions are evidenced too.

In chapter two, consideration was given to a number of ethical theories, especially as they relate to health care and it was seen that the four principles of biomedical ethics approach, for example, is popularly used to guide and explain ethical matters in health care settings. The approach in this study, however, is to be sensitive to a range of possible ethical reasoning and the key question that arises is what forms of reasoning and justification do pharmacists use in relation to situations that they consider ethically problematic. It will be shown that several forms of reasoning appeared to be used by pharmacists, some of which corresponded to general ethical theories, but that variation in reasoning occurred – not just between pharmacists, but that individual pharmacists also made use of different types of ethical reasoning. As already noted throughout this study, though, the intention is not to rate or correspond pharmacist's ethical reasoning and decision-making to the normative general ethical theories sketched out in chapter two. A more sensible approach is to strike a balance between, on the one hand, expecting pharmacists to offer knock-down, analytically rigorous philosophical arguments for every ethical problem and, on the other, not expecting them to provide any form of justification at all. The danger in any analysis that tends towards the former, it is argued, is that the understanding gained either sets too high a standard or else reveals little about the context or subjective nature of phenomena such as pharmacists' ethical decision-making. Hence, even if one were to identify an ethical agent that was ethically accomplished by the standards of the philosophical literature, such analysis would tell us little of the less accomplished and ignore other relevant

features relating to even that accomplished agent. For example, what is being described in the following quote?

With its chains of pan-diatonic clusters[...] one gets the impression that they think simultaneously of harmony and melody, so firmly are the major tonic sevenths and ninths built into their tunes, and the flat submediant key switches, so natural is the Aeolian cadence at the end of 'Not a Second Time' (the chord progression which ends Mahler's 'Song of the Earth'). (Braun 1995 p. 67)

This is a review of a song by The Beatles and this musicological analysis appears to elevate The Beatles to the pantheon of classical standards but, importantly, it tells us nothing about the context of the song or how Lennon and McCartney actually wrote it.⁷ By implication, does the review's focus upon The Beatles imply that much other popular music of the time is inferior for not containing such classical figures? The review has a detached quality that dislocates it from relevant social, cultural and historical pointers but also invites unfavourable comparisons of other music from that genre. The relevance of this musicological analogy is hopefully apparent and it is the intention not only to use existing normative ethical theories but also Jones' model of ethical decision-making as guides or indicators of general areas on an ethical map. The intention is not to apply a standard of ethical reasoning that either manifestly unreasonable to achieve and hence insensitive to other forms of reasoning, or ignorant of the wider context and subjective nature of pharmacists' ethical problems. Given this qualification, a number of significant ethical themes emerged from the

⁷ Ger Tillekens claims that The Beatles were aware of the review and made fun of it and that John Lennon was reported to have said that he thought an Aeolian cadence was a kind of exotic bird. http://www.icce.rug.nl/~soundscapes/VOLUME01/A_Beatles_Odyssey.html#Note01

interviews and will be explored in this section. These included frequent appeals to consequences, as considered in chapter two, but also the use of the golden rule, a form of reasoning that has not been previously identified in the pharmacy ethics literature and is seldom mentioned in the broader medical ethics literature. Some pharmacists also referred to their previous experiences and to common sense in justifying their ethical decisions. The role of narrative, casuistry and intuition will be considered but as well as these internal justifications, analysis of interviews revealed that other influences were more limited – such as the code of ethics or the help and support of formal bodies such as superintendents' offices, the RPSGB or the information department of the NPA. One exception, however, was the influence of religious faith and this emerged as a significant influence upon ethical decisions for some pharmacists. This section is organised into emergent forms of ethical reasoning and begins with a consideration of consequences.

5.3.1 Consequences

As previously noted generally, pharmacists often struggled to describe ethical situations and this was also reflected in their overall inability to articulate how decisions were reached. When asked specifically about what were relevant ethical considerations, there was often a poverty of ethical explication. However, this by no means meant that there was a total absence of ethical justification and, to the contrary, almost all the pharmacists interviewed offered *some* insights into the reasons for their decisions. This section begins then with perhaps the most frequently identified form of

ethical justification – pharmacists’ concern for the possible *consequences* of an ethical action. The following quote illustrates a typical consequence-based statement wherein Edward explains how many of his ethical decisions were grounded in a consideration of a decision’s potential consequences:

‘So that, to me, was principle one as I’ve said before, I couldn’t reel off the code of ethics but the one thing that does stick in my brain is that pharmacist’s prime concern is with the welfare of the patient and the public and that, I would say, guides me. In most of my ethical decisions that I have to make, [these] are the things that I have to weigh up, basically: who’s at risk, who’s not at risk, who’s going to benefit from my interaction and should I do it?’

Hence Edward, in seeking to answer the fundamental ethical question of what ‘should I do?’ in relation to an ethical act, argued that he must ‘weigh up’ a number of positive and negative consequences and appealed to the possible consequences of acts in determining which to perform. The quote also illustrates that Edward valued particular ends too and specifically referred to ‘risks’ and ‘benefits’ and also the general welfare of the patient and the public. Such reasoning bears some similarity to normative consequentialist accounts, as described in chapter two, but there are important differences that an analysis of pharmacists’ reasoning in terms of consequences reveals. In particular, appeals to the outcome of ethical acts, despite being couched in a concern for particular values, lacked an aggregative component that is a vital feature of philosophical accounts – that is, as Pettit points out, a normative appeal to the attainment of the most value or utility, since ‘consequentialism is the view that whatever values an individual or institutional agent adopts, the proper response to those values is to promote them’ (Pettit 1991 p. 230).

So, for a substantive consequentialist ethical theory, what is valued is not only some form of utility but also the summation or maximizing of that value. As noted, the intention of this chapter is not to appraise pharmacists in terms of their ethical decisions with reference to the philosophical literature but rather to consider existing ethical theories as possible guides and analytical pointers. As such, pharmacists do indeed appear to lack a vital component of normative consequence-based theories but nonetheless appear to utilise appeals to consequence in justifying their ethical decisions. One additional point in relation to such reasoning and related to the previous section is that the concept of ethical attention may be relevant since appeals to consequence are potentially wide ranging and require attentiveness to many possible agents and outcomes. As such, Edward's concern for not only the patient but also the public, albeit in a very general sense, indicated an active and ethical attentive disposition. Amongst the pharmacists interviewed, the patient was often the limit of their ethical attention but, like Edward, some pharmacists considered other individuals and in the following example, Helen identified not only the consequence of not supplying for the patient but also the patient's partner and children. Her 'ethical dilemma' involved whether to supply a patient's methadone as the pharmacy was about to close for the day, despite the patient having been repeatedly told not to collect it so late and the extract from the interview begins with the background to the problem before a discussion of the possible consequences of not supplying:

'Obviously they start to push it a little bit and then the ethics is do you refuse if they come after the time? And in the end most of them, there was

a genuine excuse or it was a few minutes but there was one girl who just used to - I'm sure she just did it to annoy me basically. I don't know, but she always used to come in [late] and in the end I refused to give it but before I did, I had rung the clinic she came from and said 'Are you happy?' because she'd done it twice that week and I'd worked a whole week and I said 'If she does it again to me, I really don't like to give it to her' but I don't want to put a detrimental effect on her treatment [and] have I disrupted her or has she gone and used, you know, because I don't want to do that but in the same way, she was obviously playing the system [...] Yea, my main dilemma was am I going to send her back to where she's trying to get away from? I mean, her partner or boyfriend was also a...on the...and I'm thinking 'Is she going to try and take his off him?' and they had kids as well, which I suppose was my big concern'

This example is one of the more detailed and considered accounts of ethical reasoning identified in the pharmacist interviews and may be contrasted with many other pharmacists' accounts in this thesis – wherein if consequences were mentioned, they did not appear to be part of systematic consideration of who might be affected by an outcome. Holm similarly identified statements in his nurse and doctor cohort that involved consequences but these were related to the initial coding and open analysis and were not given any further consideration. In contrast to the present study, however, he noted that his sample referred to consequences involving not only the patient but also the public, society and also the health care professional and their department (Holm 1997 p.118). In the present study, consequences that appeared to be relevant for pharmacists were usually those of the patient but, as in Helen's example, occasionally broader consequences were considered. Shahid, for example, argued that *not* supplying EHC to customers was justified by a consideration of wider social issues and specifically his belief that pharmacy sales of EHC might potentially increase promiscuity. In relation to refusing such sales he noted that:

‘I don’t want to be a part because of the comeback that you can get from it as well and how the impact that it’ll probably have on the social side of things. I must be the only person in the whole world that’s doing it!’

Despite a concern for the ‘social’, what Shahid appeared to consider was, like many pharmacists, a personal concern about the ‘comeback’ and this will be considered later in relation to self-interest. Justification based upon consequences and specifically the best interests of the patient were a frequent form of reasoning for the pharmacists in this study but other forms of reasoning and indeed combinations of different types of reasoning were apparent. Whereas the use of consequences required the pharmacist to consider what and who might be affected by an ethical decision, the next form of reasoning involved pharmacist’s considering how *they* might be affected if they were the object of a decision, by the use of the golden rule.

5.3.2 Golden Rule

The golden rule has had a long tradition, often within a religious context, and is frequently stated positively as one should do for others what one would wish to be done for oneself. It is also stated in the negative such that what one would not want done to oneself, one should therefore not do to others (Wattles 1996). Although it may be regarded as a basic form of ethical theory and can be countered by numerous examples such as how the theory can defend why a masochist should not inflict pain on others, for example, it has persisted as a form of ethical justification. Midgley (1991 p. 10), for example, quotes Darwin (1981), as noting that:

The social instincts – the prime principles of man’s moral constitution – with the active intellectual powers and the effects of habit – naturally lead to the Golden rule ‘As ye would that men should do unto you, do ye to them likewise’ and this lies at the foundation of morality. (Darwin 1981 p. 106)

Even if one does not necessarily agree with Darwin’s argument that the golden rule is the obvious guiding ethical principle for a developed being, it may still be argued to be an elegantly simple form of reasoning. Its emergence in the present study, therefore, may possibly be explained by this simplicity since all that the ‘rule’ requires is a basic thought experiment and, in contrast to the previously identified consequentialist approach for example, does not require a protracted consideration of many potential outcomes, agents and utility. Many of the pharmacists interviewed relied upon the golden rule to defend their ethical decisions and this was typified by Dan, who considered the golden rule to represent his main form of reasoning:

‘One general principle is hoping I treat the patient as I would be expected to be treated; also viewing each patient almost like a relative - what would I try to do for them? Would I put myself out for them?’

This pharmacist was extending the rule to include other significant individuals such as family members in seeking to justify a decision and was a common approach to reasoning used by the pharmacists interviewed. Although Edward’s example of considering the consequences of others was identified above, he also made reference to the golden rule – illustrating the point that pharmacists did not appear to champion one particular form of reasoning but instead appeared to apply a ‘bottom-up’ style of argumentation that considered the situation first and then sought to find suitable ethical justification. In relation to his concern about the problem of a patient not being able to

contact her GP (considered earlier), he stated that:

‘I would imagine that there are decisions that I’ve made that people would disagree with but I always try and act on what I think is correct and more to the point, this is a point I made to the practice manager, how would you feel if that was your mother, father, being treated like that? And that’s the way I try and think of it, what service would you want? If you present in a pharmacy and go ‘Oh, I need an emergency supply’, ‘Well, the surgeries open, blah, blah, blah’ or we’ve got all these things in the way. If you were presenting in that surgery how would you feel and how would you want to be treated and that tends to be how I would try and...I ‘m not saying I’d break the law or bend rules, you know what I mean, but always try to take their [point of view...]’

The emergence of the golden rule is significant since it has not been previously identified in empirical pharmacy ethics research and scant reference to it was found amongst the more general health care ethics empirical literature.⁸ Its identification provides a valuable insight into pharmacists’ ethical reasoning and it represents, significantly, an approach that is not related to the dominant consequentialist, deontological or principle-based theories in both the normative and also empirical health care ethics literature. Despite its frequent manifestation in various religious doctrines, it did not appear to be necessarily connected to pharmacists’ expressions of faith although the influence of this will be considered later.

Before considering faith and the influence of other external sources of ethical insight, other forms of ethical reasoning emerged from analysis of pharmacists’ interviews and attention is now turned to the use of principles, narratives and appeals to experience and common sense amongst the pharmacists in this research.

⁸ Tai and Lin (2001) do briefly mention the golden rule in relation to Asian culture and medical ethics.

5.3.3 Autonomy, Principles and Intuition

The intention in this thesis has been to consider ethical decision-making not simply with reference to one particular theory but to remain sensitive to a variety of possible approaches in relation to ethical problems. Using this open approach, previously unidentified forms of reasoning amongst health care professionals such as the Golden rule have been identified. But were the pharmacists in this research found to justify their ethical decisions using such popular theories as the four principles of biomedical ethics (Beauchamp and Childress 1994), utilising appeals to beneficence, non-maleficence, autonomy or justice? Or indeed, did any other principle appear to be relevant to pharmacists?

What emerged from analysis of the interviews was that the principle of autonomy appeared to be significant and frequently cited. It was often related to the patient or customer but its invocation was always implicit, however, and none of the pharmacists interviewed used the actual word ‘autonomy.’ Within Western society, the value of autonomy has been given considerable importance. Stemming from a predominant concern for liberal individualism, a respect for self-determination and a freedom from interference appear to be central to social, political and ethical life. Hibbert *et al* (2000) identified examples of the principle of autonomy amongst their sample and similarly found such references to be implied from pharmacists’ explanations. How was autonomy used by pharmacists in the present research? Often, it was to defend decisions by pharmacists not to interfere with the wishes of patients or customers – manifest in situations such as purchasing OTC medicines in particular. In the

following example, Amadika discussed alternative medicines (such as herbal and homeopathic products) and argued that, since it was not an area she was an expert in, she believed that the customer should be free to decide:

‘I don’t think it’s my right to try and tell someone else, you know, about their beliefs. Because just as if I go into a shop and I say that I want a certain type of cream because I like it, I wouldn’t want to be told that it doesn’t work ‘cos maybe I feel that it does. So to me, it’s like imposing on someone else’s beliefs so it’s their right to try it. That’s how I see it and I couldn’t convince them otherwise. If they’d said they wanted a normal medication, fair enough, I will tell them, whatever.’

What is also striking from the above quotation is that two other forms of reasoning are apparent in the same situation – the use of the golden rule again evidenced by Amadika’s reference to what she would feel if she wanted to purchase a product and was refused and also the language of ‘rights.’ Regarding the latter, the use of rights was seldom encountered in this study and Amadika only referred to it in this particular example. Other pharmacists often used appeals to autonomy implicitly in relation to OTC sales and other examples related to:

The supply of EHC, where Michael argued that:

‘But it’s not my decision, that - it’s up to the individual and I don’t think that we should be sitting and making judgements like that for them – it’s up to them.’

The sale of OTC medicines in general, as Robert noted:

‘If they’re desperate to do something and I’ve given them all the information and they’re still desperate to do something then I will let them go ahead.’

What was not observed in any of the interviews, though, was any detailed *balancing* of principles such as autonomy with other principles, which is an important feature of normative principlist theories such as Beauchamp and Childress's. An obvious question that does arise from the identification of autonomy as a value is, were there not other values or indeed principles that pharmacists used in their ethical reasoning, even if no specific weighting or balancing of rival principles was evident? For example, were there not instances of pharmacists referring to beneficence, non-maleficence or justice as per the four principles and as previously identified in empirical pharmacy ethics research such as Hibbert *et al* (2000)? Furthermore, are there not examples of other principles that pharmacists rely upon in making ethical decisions such as those that arise from intuition, for example, or perhaps Ross's seven *prima facie* duties (Ross 1938)? Empirical investigations such as this thesis could be argued to be useful in identifying concerns that individuals find simply intuitively proper. As Ross notes 'the moral convictions of thoughtful and well-educated people are the data of ethics, just as sense-perceptions are the data of a natural science' (Ross 1938 p.40). Whilst autonomy has been argued to be a significant emergent theme in this study and one, therefore, that merited individual consideration, other principles and intuitive duties were far less evident in comparison. Of course, the above discussion of consequences identified a common value of the patient's best interests or welfare and this may be said to accommodate considerations of not harming or doing well for the patient. However, to focus upon one particular principle such as non-maleficence, although occasional reference was made to this principle, it was seldom identified amongst the pharmacists in this study. One exception involved Clarissa, who

included it in her definition of what being ethical might mean:

‘It means doing the right thing. It doesn’t mean anything else than that. It means trying to do something that doesn’t harm somebody. I think it’s always about harm and about, well, I suppose it’s just about...yea, I mean, it’s either harming...I always think to myself, doing something ethically wrong would be actually causing harm to someone or doing something deceitful which would involve an untruth.’

Explicit references to avoiding harm were the exception but it appeared at times that pharmacists made ethical decisions that could have resulted in harm. As will be shown in the next section, a concern for self-interest and a legally defensive approach to pharmacy practice may be ethically and professionally problematic.

The concept of justice was not specifically mentioned by any of the pharmacists in this study but several ethical problems may have involved such a principle. In the example of the doctor who was self-prescribing, although Julian identified several possible ethical concerns *during* the interview, his initial pre-reflective understanding of the problem was that the doctor was actually avoiding paying an NHS prescription charge by using a relative’s name as an alias. Clare, in discussing the issue of compliance aids, found it difficult to charge patients, especially the elderly, for such a service and believed it ‘disgusting’ that those who were financially disadvantaged should still be charged. In both these examples, however, the concept of justice was neither explicitly mentioned nor considered in anything but a fleeting manner.

What evidence of intuitive ethical justification was found, if any, apart from autonomy and the occasional identification of other principles? According to Ross, duties of truth-telling, reparation, beneficence, non-maleficence, justice, gratitude and self-

improvement should come to be known by any active ethical agent. This occurred, he argued, by a process of intuitive induction – of reasoning from particular examples that involve an ethical value and outcome and then reasoning to a more general formulation of *prima facie* duties. As will be shown in the next section, however, although some pharmacists appealed to experience and tacitly drew upon how problems had been resolved previously, there was no indication that an inductive process had occurred that revealed more general ethical principles. Despite the absence of an empirically observed *process* for accounting for how such principles are to be applied and decided in ethical problems, did any intuitive principles emerge? Analysis of the interviews revealed little that could be related to many of Ross's duties and, at times, evidence to the contrary was found. For example, in the previous section, Hilary described how she and her staff prevented sales of medicines of potential abuse (and hence non-maleficence to customers) by deception and lying about not having any stock. Although this involved two principles, Hilary was not aware that this might be an ethical problem and had not appeared to reflect upon this issue or tried to balance these competing principles despite having made a decision to deceive and not sell.

5.3.4 Narratives

Throughout the interviews, only one instance of a narrative approach to reasoning emerged. This involved the pharmacist having to consider whether to supply EHC to a patient who may have been under sixteen. The ethical problem was identified as being a conflict between a legal responsibility to sell only to customers over the age of

sixteen because of the product's license and the welfare of the customer and the possible consequences. Hence, the problem involved several approaches to ethical justification but in addition to consequences, the pharmacist, Andrew, drew upon a wider narrative relating to customers in the pharmacy's environ, involving the customer's wider social background and potential predicament:

'Well, it was somebody that was blatantly under sixteen and I just thought [...] it's not a legal indication and I could be breaking the law but where I am there is a big problem - there is a high percentage of teenage pregnancy and the problems associated with that. I see a lot of teenagers with kids and I see the problems that arise from that. There is a lot of violence involved because young people have kids. There's a lot of broken, not even marriages but couples, and problems with money from that, I've heard stories of kids being taken away from parents because of the age involved, drug use. There's one lady [...] and she's got three kids that for some reason haven't been taken away and you can see them occasionally. The mum sent them out with a screwdriver to go and rob the phone box and this lady has blatantly had kids sort of irresponsibly and it's whether it's led to problems or whether there were problems in the first place and she had to have the children. So I see a lot of that so my thoughts were down the line of, well, this girl doesn't want a child.'

Although relying upon a number of assumptions and second-hand 'stories', this example illustrates how Andrew provided justification for resolving an ethical problem using a narrative approach and appealed to a much wider, social and cultural understanding of the problem. In this particular example, the pharmacist went on to consider the cost of supplying EHC, too, and the narrative approach had an impact here in describing the relative poverty of the customer and eventually decided that the customer should contact the family planning clinic where an EHC supply could be made free. This narrative approach illustrates that ethical attention is important, too, in ensuring that the pharmacist *sees* all that may be ethically relevant, even if this means

considering a customer's wider social situation and the implications of costs and also consequences.

5.3.5 Experience and Common Sense

Experience was of no ethical value. It was merely the name men gave to their mistakes. Moralists had, as a rule, regarded it as a mode of warning, had claimed for it a certain ethical efficacy in the formation of character, had praised it as something that taught us what to follow and what to avoid. (Wilde 1991 p.48)

Having considered the identification of consequences, the golden rule and principles such as autonomy and an example of narrative as emergent themes in the pharmacists' interviews, these may be contrasted with the identification of an altogether more situated and basic appeal to ethical justification – pharmacists' previous experiences. Several pharmacists, when asked about how they made ethical decisions, argued that experiences gained in their pharmacy work were important for their ethical decisions. However, such statements were often irreducible to other concepts and, to use Wittgenstein's analogy, appeared to amount to 'bedrock' since no further explication could be gained. In interviews this was evidenced when pharmacists were questioned about particular problems but also when asked more generally about their ethical understanding. In the following quote, Phillip, although struggling to articulate his point clearly, located his ability to deal with ethical situations in terms of such pharmacy work experiences:

'I think that over the years you become...obviously there's always new

situations but you come across more. You've, you've run it, you've put... Because you've had the experience, you've been out in that situation, you just... there's less... And with time, there's less and less experiences that you haven't been through in the past already so you just know what to do instinctively and through experience.'

Similarly, Sharon illustrates in the following quote how her ability to resolve ethical problems was gained, not from her undergraduate pharmacy education, but from her pharmacy work experiences after qualifying:

' It's difficult because with ethics, I feel it's something that you learn in your job – you don't really learn it at university. You can be given all these things, all these scenarios, but really you need to put them into actual practice and then [PAUSE] you sort of use your gut instinct.'

Do such appeals to experience rely upon the use of previous cases and solutions to ethical situations in a similar way to casuistry? Despite research relating to GPs identifying a form of 'homespun' casuistry (Braunack-Mayer 2001), the present study identified no attempt by pharmacists to describe ethical situations and their resolution in terms of *previously* decided situations. Of course, pharmacists may have been referring to such paradigm cases when asked to consider several examples of ethical problems in their work but there did not appear to be any insight offered by pharmacists to the effect that such situations were influential in later practice.

Nonetheless, appeal to experience by some pharmacists suggests that by drawing upon previous problems and their solutions, this is used as a form of ethical justification, albeit in an un-detailed manner.

What also emerged were appeals by some pharmacists to their commonsense but these were again, like appeals to experience, not further explained. They appeared to

represent a ‘turning of the spade’ once again and signalled an end to further explication of ethical reasoning for pharmacists – ‘this is simply what I do.’ In the following example, Julian used appeals to commonsense and also the experiences he has gained in practice in dealing with patients to explain how an ethical problem involving confidentiality and the incorrect delivery of a medicine was resolved:

‘I think you use quite a lot of commonsense. I can see some people would struggle. Some people I know off the course would struggle and some people off the course would do a lot better than I would but, you know, you get people that unless they’re given the actual rules laid down, they won’t actually do it. But I think you tend to build up a sort of ruling in your own mind about confidentiality and that sort of ethics when you’ve worked with patients for a while, when you realise what they react to anyway – what you can expect of certain people even if you wouldn’t object yourself.’

Despite referring to confidentiality and ethics, it would appear that the justification for James’ actions was grounded more in psychology– of how patients might react differently to an error – rather than any substantive ethical or value-based reasoning. From this account, commonsense is not necessarily a form of ethical justification but also practical and pragmatic, too. Despite its potentially ambiguous character and pharmacists’ inability to expand upon its features, it appears to be important for justifying ethical decisions. It was also identified in previous empirical pharmacy ethics research and Hibbert *et al* (2000) and Chaar *et al* (2005) both noted that pharmacists’ ethical understanding was influenced by commonsense approaches but these studies did not offer further insights into the role of commonsense except to afford a contrast with evidence of pharmacist’s understanding of normative ethical principles. What is apparent about accounts of ethical justification that rely upon

appeals to commonsense and experience is that they are often from those pharmacists that were least able to apprehend ethically relevant features of ethical situations and were ethically inattentive. In addition, whilst the previous section tentatively claimed that ethical inattention might represent a passive process as opposed to an active one that sought out or was sensitive to ethical values and situations, appeals to experience and commonsense are argued to further support the emergence of an ethically passive pharmacist in this study – one that offers up these apparently irreducible and inexplicable terms at the expense of more detailed accounts of reasoning that are informed by appeals to consequences, utility or concepts such as autonomy. This ethically passive character will be further fleshed out in the last two stages of decision-making that concern self-interest and the enacting of one's ethical decision but before concluding this section on reasoning, the relevance of two influences must be considered.

5.3.6 Formal and Informal Ethical Guidance and Assistance.

The foregoing forms of ethical reasoning may all be said to share one general characteristic – they were internal in the sense that they involved practical reasoning that was derived from the pharmacist *qua* rational, autonomous ethical agent. As Gloria noted:

‘I have to decide what is right or what I feel is right [...] I apply my own principles because I don't know what other pharmacists think.’

However, whilst the emphasis so far has been upon micro-social phenomena of

individual pharmacists making ethical decisions, it was previously noted in this thesis that external sources of ethical influence, guidance and help might be available. These may be further sub-classified into formal structures such as the RPSGB's code of ethics and oral forms of ethical assistance such as those offered by specific departments of the RPSGB or the NPA or, for employees, a company's superintendent's office but also informal channels of guidance such as pharmacists' peers, work colleagues and friends. Were these of relevance to how pharmacists made ethical decisions and did they appear to influence ethical reasoning?

In relation to the code of ethics, this did not appear to be particularly relevant for any of the pharmacists. Most struggled to recall any of its content and it was seldom referred to in relation to their professional and ethical practice. In fact the code of ethics was often described synonymously with the broader published document, the *Medicine, Ethics and Practice: a guide for pharmacists* (MEP) of which the actual code of ethics forms but one part (Royal Pharmaceutical Society 2006a). When asked about their use of the code of ethics, most pharmacists made reference to the MEP and explained that it was for the overall guide's more practical content such as general legal requirements and list of medicine classification. As Robert remarked about the MEP generally:

'I do refer to it. I must admit it's more for the law and the finer points of the law when I'm thinking 'what class of drug is that?' or 'do I need to enter that?' This type of thing, rather than the ethics. I am aware that the ethics is there. I've read it but to say that I look at the code of ethics on a regular basis would be lying, cos no, I don't.'

For many, the relevance of the code in helping with actual problems in practice was

limited and this pragmatic scepticism of the code's value was exemplified by Clarissa, who stated that:

'I can't actually recall a single one of them [code principles] but, you know, I know where they are. I know roughly what they say [but] it's never going to give you an answer, is it?'

The following extract from Clare's interview illustrates both the practical inadequacy of the code and offers an explanation for this in terms of the code's fixed and rule-like structure:

Interviewer	You know the code of ethics, is it something you've ever used in practice?
Pharmacist	No.
Interviewer	Is there any reason why?
Pharmacist	I mean I probably do without thinking about it. I'm trying to think if I do. No, I don't even think that, no.
Interviewer	You know the list of principles?
Pharmacist	I don't sort of look them up, you know? I don't think, you know, 'Was I right in that?' but I think I've got a pretty good idea in my head so I obviously do follow them. I think it's because it's very rigid and sort of robotic and I mean, I don't sort of look them up but I do follow them.

However, despite claiming to follow the code's principles implicitly, Clare was unable to articulate any specific content of the code. In fact, among the pharmacists interviewed, only two were able to recall and relate a *specific* aspect of the code to their work and both made reference to the same principle - of acting in the best interests of the patient, a value identified by other pharmacists but without reference to the code. In one example, Gloria referred to the archetypal situation of the controlled drug and the incorrectly written prescription and supported her decision to supply thus:

‘I did it and I had no other option and the very first point in the code of ethics is that you have to help people where you can.’

The lack of relevance and influence of a code of ethics for pharmacists was also reported in the qualitative studies by Hibbert *et al* (2000) and Chaar *et al* (2005). Both studies reported that pharmacists appeared to have a limited understanding of the code of ethics and, indeed, Chaar *et al* emphatically concluded that the study’s sample of pharmacists had a ‘complete and absolute unfamiliarity with the professional code of ethics of the profession’ (Chaar *et al* 2005 p.200). The study by Hibbert *et al* concluded that a range of values influenced pharmacists but found that practical strategies relating to ethical understanding were more common than reference to the code of ethics.

There is also empirical evidence that other professions’ codes of ethics are also problematic in practice and Holm, for example, offers evidence from his own and other work. He argues that as well as his research involving Danish doctors and nurses revealing little mention or use of a code, American nurses were similarly unlikely to use the ethical code of the American Nursing Association (ANA) and he reports that Cox (see Holm 1997 p. 81) found that only 6.9% of nurses reported using the code to make ethical decisions in an American study.

As noted earlier, it is not only in the code of ethics that pharmacists may find ethical guidance and assistance is offered to pharmacists in relation to professional and ethical problems from a number of other sources such as information departments of the NPA, RPSGB and superintendent’s offices. Were these used by pharmacists to assist them in

resolving ethical problems or was there any evidence of ethical displacement and of ethical problems being ‘passed on’ to more appropriate bodies, as considered in chapter one (de George 1990)? There appeared to be variation in how pharmacists both valued and used such sources of assistance and not surprisingly, those that valued such departments and found them useful tended to refer to them more favourably in terms of assisting to the resolution of ethical problems.

Gloria typified those pharmacists who found such sources of advice of little use and, as her previous quote above alluded to, she believed that she needed to make her own decisions. Regarding the professional practice department of the RPSGB and the assistance it offers, she stated:

‘I think what I would like to be able to do is to ring somebody up and get some advice because when I have rung the RPS on a matter of ethics and asked ‘what should I do’ they have said, ‘well, its your professional decision’ which I don’t find very helpful at all’

This form of non-prescriptive advice appeared to be common and a further example will be provided in the section relating to ethical inaction wherein when a pharmacist asked for advice regarding whether he could disclose a patient’s identity to the police in relation to a serious crime, he was told that it was down to his own ‘*conscience*’ as to what to do and this, for him, ambiguous response may have contributed to his ethical inaction and reliance upon supervenience. As well as bespoke guidance being considered unhelpful for many of the pharmacists in this study, one additionally commented that even the formal guidance was problematic. Christopher described what was, for him a very upsetting and difficult, ethical situation in which he did not

want to supply a female customer with EHC and noted that the RPSGB's guidance on conscience clauses made the situation more difficult to resolve since he felt that he could not explain his reasons to the customer fully. The RPSGB advises that:

Where pharmacist's religious or personal convictions prevent them from providing a service they must not condemn or criticise the patient and they or a member of staff must advise the patient of alternative sources for the service requested. (Royal Pharmaceutical Society 2006a p.90)

Philip noted that rather than offering re-assurance and guidance, such advice actually made the situation more difficult and ethically problematic and he explained:

'Now the Society's advice is that we mustn't get involved in any personal conflicts with regard to this so, you know, I couldn't and I was prevented by the Society's advice from saying what my personal feeling were but she was very, very indignant and upset, even though I'd recommended other places for her to go, and she wanted to know why I wouldn't do that. And [...] the way I overcame it was I simply said that the Society did - the Pharmaceutical Society - did allow us to opt out of this particular service if you wished to do and I, you know I wished not to do it and that if she wanted to, she could obviously get it elsewhere. That's the way that I've understood how I was supposed to deal with it but I wasn't happy.'

For most pharmacists, however, both bespoke and general guidance and assistance from formal bodies appeared not to be used or thought relevant but occasional examples emerged of pharmacists who found such assistance of benefit. On one occasion, Clare described how her concerns about her employer's promotion of analgesics and in particular providing one medicine free if another type was purchased appeared to be answered by contacting her superintendent's office. Shahid appeared to find such advice helpful in many professional and ethical situations and described contacting a range of official bodies for guidance. But such positive examples of the

assistance of formal agencies were rare and no examples emerged that could be related to ethical displacement in an organizational sense, although the case of subordination and EHC is considered in the next chapter.

In relation to the informal ways in which ethical guidance was found, it was evident that some pharmacists occasionally communicated with other pharmacists and as the following example illustrates, non-pharmacist work colleagues such as pharmacy staff. Helen noted how informal social chats with pharmacist friends were important for reflecting upon ethical problems and comparing different approaches, especially regarding one friend who she contrasted with herself as being very legalistic in approach:

Pharmacist I have friends who are pharmacists and we often, you know, in a social setting. I have two friends that I see regularly, one works for a multiple and the other now worked in academia and we sort of chat about things [...] We do discuss stuff and we do have different opinions like one of my friends is very, very law abiding and it's basically straight down the middle, no variation, and if it's not there, you know, and I have these kind of 'Well, what about the patient?' and I think she's never really come across a majorly difficult dilemma which is quite lucky for her and I often would love to know what she'd do in that situation but she's very, very ethical and law-abiding person so we do have...it's quite interesting to have discussions with her because we do veer over certain issues.

Interviewer Do you find it useful doing that?

Pharmacist I do because I think it makes me re-look at whether she has a certain point. I mean, we do often have these big...often after a few drinks, it goes off into this huge and...and I do really enjoy them because you take things away from it and I think she looks at things in a different way from me and it sometimes makes me think 'Perhaps I need to step back from that angle' and maybe get a different perspective on things. I think, maybe, she does make me think more and I often think 'Well, I wonder what [she] would do in this situation?' and it makes you think about whether your route is the best or whatever.

For Helen, this informal way of discussing ethical and other work-related issues was important not because it could assist in resolving an immediate ethical problem but in terms of allowing a reflective process and one that may affect subsequent decisions. She also noted that one of her friends claimed not to have encountered a ‘dilemma’ and although she described her friend as being ‘ethical’ she appeared to more disparagingly refer to her as being ‘very law-abiding.’ Helen’s description of her friend seems to echo the emergent theme and claim in this thesis that a legalistic approach is inimical to ethical decision-making. The apparent contradictory description of her friend as also being ‘ethical’ is harder to explain and, although not challenged in the actual interview at that point, may imply an inflexible, Bauman-like interpretation of ethics that is indistinguishable from formal legal and procedural codification (Bauman 1993). Overall, however, such informal forms of assistance were not commonplace amongst the pharmacists’ interviews and, as chapter six will indicate, a distinct absence of communication will be argued to be inimical to ethical decision-making.

One final informal channel of assistance was raised by one pharmacist who used an internet-based pharmacy chat room where he could ask other pharmacists for their advice on not only professional but also ethical issues. He claimed that the diversity of pharmacists who used the site was helpful in providing guidance but this novel form of assistance was not identified amongst the other pharmacists interviewed.

5.3.7 Religious Faith

One other influence upon ethical decision-making appeared to be relevant for some pharmacists and this related to their religious beliefs. Historically, much philosophical discussion has been undertaken to provide an alternative explanation to the prescriptions and dogma of various religions but in recent centuries, such causes have been obviated by the rise of secularity, especially in Western cultures. What emerged from the interviews with pharmacists, however, was that for some, their religious faith was extremely influential in how ethical decisions were made. It was possible to identify three general groups in relation to faith: those who expressed no particular claims about their faith or its influence upon their pharmacy work; those who stated that they were of a particular religious persuasion but for whom faith was secondary to their pharmacy work; and finally those for whom faith appeared to be influential and also potentially conflicting to their work and, in particular, ethical decisions. For this last group, the values and prescriptions of their particular religion had an often over-riding weight in relation to what was considered the right action in various situations. For Chris, such an influence was beyond question and he noted:

‘The Christian ethic – and I’m saying ethic there and it’s not really – Christian values are definitely fundamental to my way of work and life altogether. I would come back...every kind of moral or ethic that I’m faced with, ultimately, comes back to my Christian experience and I’d measure it against my Christian value. Whatever it was.’

For Chris, religious values were distinct to ethical or moral values and he argues that these latter claims to prescriptive authority were narrower and related to, for example,

one's business dealings or one's social undertakings. Several points emerge from claims such as those made by Chris. Firstly, although he expressed a Christian faith this was not always the case for others and some Muslim pharmacists, for example, similarly made reference to the guiding nature of their creed in their pharmacy work. A second and related point was that for others, their faith was argued to be secondary to their commitments as professionals and pharmacists. In fact, some argued this point very strongly and believed it to be unprofessional to allow their faith to impinge upon their pharmacy work. For others, though, there was always a tension even if faith was not as influential and all embracing as Chris's. Andrew, for example, noted that his religious beliefs were very important in his life and resulted in him holding particular views about, for example, abortion but that this led to conflicts in his work and this led him to question the compatibility of professional and ethical pharmacy practices with his personal religious beliefs. He explained this ongoing tension in the following extract:

'I was thinking about what I kind of believe and how that transcribes into the work place and I do try very hard to sort of be, I suppose, true to who I am both at work and at home. So, my beliefs do carry... I mean sometimes, it is difficult to say but with things like EHC as an example of a difficult decision. But I do try to sort of stay true to what I believe, at work, even though[...]Your ethics often just affect you, so your decision to go to church or not, or to speed [in a car] - I suppose it's your beliefs and where you stand on them but in pharmacy your ethics are blatantly affecting other people – affecting the customers, the patients, affecting how you speak on the phone. So you've got to think carefully about how you force your ethics and whether your ethics are the right way to think.'

From this quotation, and also much of the interview with Chris, stemmed a sense of

conflict and an ongoing struggle to reconcile ethical, professional and religious values and commitments. As Andrew noted, this was no more evident that with EHC, as was described in the previous chapter and as the examples provided earlier in this section which described Chris's distress with EHC and the RPSGB's guidance.

Religious faith was identified in earlier empirical pharmacy ethics research and Haddad (1990) identified it as one of a number of sources of ethical understanding together with work experience and family values, for example. Unfortunately, given the study's aims it did not appear to be possible to explore the influence of faith on the pharmacists in the study by Haddad but one significant emergent theme in this research was that for the pharmacists that found faith important but conflicting, it appeared that they tended to be ethically attentive, too. Making inferences from this basic correlation is difficult but it is suggested that it is not faith *per se* that appears to foster an ethically attentive attitude since several other pharmacists who identified faith as being important but distinct from their pharmacy work appeared to be relatively inattentive but rather faith as it *conflicts* with other ethical and professional values. This insight is developed further in the next chapter in relation to ethical sequestration and engagement, when aspects of Giddens's sociological theory are explored. Despite religion being distinct from ethics, the influence of the former and the resulting conflict and uncertainty but also ethical attentiveness are hard to ascribe to a passive ethical approach and it is argued that despite being theistic rather than ethical in origin, it may nevertheless represent an ethically active approach.

5.4 ETHICAL INTENTION AND SELF-INTEREST

In the previous part of this chapter, the relevance of firstly ethical attention and then ethical reasoning has been developed but in considering the third stage of ethical decision-making, the focus is turned to pharmacists' intention to do what they have seen and reasoned upon as ethical. Although considered by Jones and many previous business ethics models as a distinct stage, some empirical models have omitted such a stage (Trevino 1986, Ferrell and Gresham 1985). The emergence of such a stage may reflect an emphasis in the business ethics literature to *predicting* actual behaviour from agent's stated intentions (Fishbein and Ajzen 1975). As such, this might represent merely a psychological distinction between stage three and four – between the intention to perform an ethical act and its actual enactment. However, what the present study seeks to develop from the analysis of pharmacists' interviews is that this third stage may even be considered to be related to the second since what emerged was a concern for self-interest. Continuing the legalistic theme that was first identified in the previous chapter in relation to the type of problems that pharmacist's experienced and also syncategorematically defined as being ethical, it is argued in this section that many pharmacists considered self-interest - manifest as a legally defensive approach to pharmacy practice – and that this conflicted with but often trumped rival concern for patients and customers in ethical situations. Moreover, this is argued to reflect an ethically passive approach to practice – one that does not actively engage with ethical choice but instead relies upon legal and procedural structures that mollify.

Jones notes that in relation to the third stage in his model of ethical decision-making:

A decision about what is morally ‘correct,’ a moral judgement, is not the same as a decision to act on that judgement, that is, to establish moral intent [...] At this stage, the moral agent balances moral factors against other factors, notably including self-interest. (Jones 1991 p.386)

Drawing upon the work of Rest (1986), Jones notes that self-interest is a ‘non-moral factor’ and accommodates concerns that might arise in the business context (but that are relevant to health care and pharmacy), such as organisational pressures and career incentives, for example. However, this claim that self-interest is a non-moral factor is undermined by extensive accounts in the normative ethics literature (Frankel *et al* 1997, Maitland 2002) and there exists a long tradition of a concern for egoism and the conflict between self- and other-regarding actions. Whilst an exploration of the legitimacy of this stage of decision-making is beyond the scope of this thesis, the identification of a concern for self-interest (whether it is a distinct stage or more properly a type of ethical reasoning) is relevant to the framework analysis of the pharmacist interviews in this study. In this section then, pharmacists’ intention to carry out an ethical decision will be considered in terms of self-interest and this concept will be argued to be an important consideration in most pharmacists’ ethical decision-making and one that is bound-up in what was identified in the previous chapter as pharmacists’ preponderance with law and procedure. Firstly, illustrations of self-interest will be provided and these contrasted with examples that involve pharmacists rejecting a legal approach to self-interest. The tension between ethics and law will then be considered to be an on going but distinct concern and the identification of reputation, as an additional type of self-interest, will be explored.

In the following example, Sharon typified a concern for self-interest in a situation that

involved an emergency supply and where she argued that existing law and procedures mean that a patient could not be given any medicines following his hospital discharge:

- Interviewer** Do you always imagine that you are doing the right thing?
'Cos I'm always curious...
- Pharmacist** ...I think, yea...as long as I can justify the reasons why I've done it, then I've done the right thing and I can explain to the patient or anybody the reasons why I've not dispensed the prescription, the reasons why I've not done this then I feel as though I've covered myself. But I always try and look after the patient's best...I do try and look after the patient's best interests but, I won't put my certificate on the line. I won't do anything that the law says that I shouldn't be doing, you know what I mean?
- Interviewer** Would you say that you tend to stay on one side more often than the other?
- Pharmacist** Yes.
- Interviewer** More covering yourself?
- Pharmacist** More covering myself, yea, rather than looking after the patient. That's terrible...it's not terrible but it's looking after myself.

This excerpt involves several issues: Sharon was aware that she must justify her actions and identified the best interests of the patient as being relevant but concluded that she tended to err towards self-interest and would not do anything that might threaten her career – 'I won't put my certificate on the line.' Many other examples were identified of pharmacists placing such a concern about possible disciplinary action or legal claims above other values. Of course, it may be claimed that pharmacists are not concerning themselves with self-interest but simply a legitimate regard for the law and formal pharmacy procedures that govern their work. As such it would be absurd to admonish an individual for simply complying with the law or a profession's regulations. But whilst this is true, it ignores the *context* of particular

ethical situations and that although laws should generally be followed, there are occasions where to act upon ethical considerations is not inconceivable. One may offer numerous examples where there should not be an absolutist approach to respecting the law and that, for example, theft is properly considered a crime but the act of my stealing a weapon from a dangerous individual might prevent further harm to others may yet be defended as an ethically proper action.⁹ Two quotes illustrate the point that pharmacists at times balanced a respect for the law with other concerns such as patients' welfare. In the first example, Michael described the common examples of the incorrectly written controlled drug prescription and claimed:

'The patient needs it and that comes first –hang the law as far as that's concerned [...] Hang it, dispense the bloody thing because they need it. Unless it's clearly a forged one or there's something not right about it but if it's something they need and it looks genuine enough and if they've just forgotten then, well, tough. Tough to the law. Get it dispensed and away with it.'

In a second example, John explained what he understood by justification and defending one's ethical decisions in terms of the circumstances and referred to the tragedy of Aberfan in Wales, an obviously extreme situation but nevertheless one that emphasised that the law was not unchallengeable:

'There was a time where I remember when I was training - to do with controlled drugs [...] Have you heard of Aberfan [...] it was the coal pit that destroyed the village? And there was a [...] manager there that just emptied his CD cabinet into a bag and took them up to the pit and that

⁹ This argument is similar to that used by Socrates to defend the breaking of a promise in not returning a weapon to someone who has become insane in Book *I* of *Republic* (Plato 1994)

had to be right to do. If there was a need for pain killers then, that's what needed to happen.'

Hence, some pharmacists were aware that legal or procedural concerns could, and at times should, be challenged by ethical considerations, especially in relation to the welfare of others. The tension between law and ethics is not new, of course, and the famous debate in the last century between Hart (1958) and Fuller (1958) illustrated an on-going concern about what the law should attempt to regulate, for example. But within health care ethics, law and ethics are often considered to be uneasy bedfellows but it is often conceded that an ethical investigation of the problems that arise in health care cannot be divorced from a legal consideration, despite the possible debates at a theoretical level. As Singer and Kuhse (1999) argue, within our society the law is distinct from ethics but nonetheless relevant:

Ethics is also independent of the law, in the sense that the rightness or wrongness of an act cannot be settled by its legality or illegality. Whether an act is legal or illegal may often be relevant to whether it is right or wrong, because it is arguably wrong to break the law, other things being equal (Kuhse and Singer 1999 p. 6)

However, the final phrase permits exceptions and it is argued that situations may arise that require pharmacists to consider their legal responsibilities in the light of more important concerns about the patient.

As noted above, is the use of legal or procedural mechanisms to protect pharmacists evidence of an ethically passive approach to practice? It is argued that appeals to self-interest in the context of conforming strictly to legal and procedural measures is a manifestation of ethical passivity. Whilst reliance upon such mechanisms may lead to

guilt or the opprobrium of patients, customers or representatives, it is nonetheless apparent that such approaches to dealing with ethical situations are negative and even though pharmacists may be aware of the ethical weight of situations (as Sharon acknowledged in the quote above) it meant that the uncertainty and burden of ethical action was avoided. This aspect of passivity is reminiscent of the legal duty to intervene in what are known as supererogatory acts. In the common example of a rescue, the law places no legal burden upon the individual to rescue another – one cannot be legally blamed for *not helping*. By analogy, it would appear that some pharmacists rely upon the law to exonerate them of ‘rescuing’ others in an ethical sense.

Before concluding this section on ethical intention and self-interest, one further theme must be considered that was raised by only one pharmacist. In considering whether to accede to a customer’s desire to purchase two similar and potentially harmful anti-inflammatory medicines, Edward referred to his professional *reputation* in not allowing the sale:

‘I don’t get paid any more, right, if I bend rules, flex rules, break rules. So why should I put my career at risk. [...] People want to buy something but you don’t have to sell it to them. If you explain to them why you’re not selling it to them [...] I find that counter sales increase immensely and your overall profit (if that’s your main bag which it isn’t) but if that’s your main focus and if you behave and treat people correctly and prescribe appropriately, they will come back next time for more appropriate prescribing. And that’s the way I look at it [...] - I don’t get paid more, so why should I risk my reputation. That’s more important to me than a fiver in the till.’

The quote is rich with other ethical features, though, and is another example of self-

interest, in that Edward makes reference to his career being potentially damaged. He also recognised but made clear that it is not a relevant factor that an *instrumental* effect of providing good advice is that customers will be more likely to return. Whilst this appeal to reputation was rare amongst the pharmacists interviewed, it has emerged in other empirical ethics research amongst doctors (Hurst *et al* 2005). Overall, however, it was a legal conception of self-interest – of not risking one’s career, for example – that many pharmacists’ decision-making engendered and numerous examples arose, even amongst those pharmacists that generally appeared to engage in other forms of ethical justification and who appeared to be ethically attentive, of qualifying their ethical decisions in the need to defend themselves *legally*.

5.5 ETHICAL ENACTMENT

To summarise so far, it has been argued in this chapter that a framework of ethical decision-making permits the identification of being attentive to ethical problems and their constitutive parts, to undertaking some form of ethical reasoning or justification and to a consideration of this in the light of self-interest. To complete the analysis of how pharmacists attempted to resolve ethical problems, attention must finally turn to the enactment of an ethical choice. What was apparent from the interviews was that several instances of pharmacists delaying and relying upon supervening acts and allowing others to make an ethical decision were identified. These are argued to further develop the features of the ethically passive pharmacist, as one who takes no action in relation to an ethical problem.

However, regarding a positive example of a pharmacist enacting an ethical decision, Robert described a situation involving an emergency supply and the ethical problem that arose because of this. A patient presented with a request for an anti-hypertensive medicine that had recently been initiated. The pharmacist identified the relevant facts as involving the legality of an emergency supply and that the patient should have been on the medicine for a certain length of time. This was not so in this case but the pharmacist also recognised the ethical value of a patient's best interests and his need to act in accordance with this value. He questioned:

‘What do I do here? Should she or shouldn’t she be on this medication? If I supply it and I’m wrong I’ve supplied a medicine without a prescription. If I don’t supply it and her blood pressure goes up and she has a stroke, then I’ve not acted in the correct way.’

The pharmacist then consulted with a local surgery (that had no doctor in attendance) and decided that a supply should be made based upon clinical evidence and also in spite of potential economic loss:

‘So if, actually, she shouldn’t have been on them then I wouldn’t have got a prescription and we would have lost twenty or thirty quid. But I did do it and I put the patient first and made the decision [...]’

Negative examples of pharmacists making an ethical decision but *not acting* upon that decision were also identified from the pharmacists interviewed. For example, Michael described an ethical problem that arose concerning a clinical decision about an interaction (as initially considered in chapter four). He had become aware that a local

GP was co-prescribing an antibiotic and a cholesterol lowering medicine and was concerned about the potential harm to the present patient and also other patients. He described his reasoning thus:

‘Is this interaction serious? Is it not? Is it ethical to let it go? Is it clinically wrong? And there you enter the minefield and that’s one of the big problems and one of my scenarios is an interaction and how far to you go with it. Do you take it to one patient? Do you take it to the whole practice?’

The pharmacist recognised the various facts of the problem in terms of the clinical interaction and the potential harm to the patient. However, he went on to note that he had contacted the GP and was told that the interaction was not a problem and that he should continue to dispense both medicines. The pharmacist did so but provided additional advice to this particular patient but the pharmacist was concerned that:

‘If that’s the GP’s action to one, and knowing the GP, that would be the action to all of them and then you’re into the dilemma of do I ring him again or do I just do as I did before [...]?’

In this ‘dilemma’, Michael was concerned about other patients in the GP’s practice and of whether he should contact the GP to protect other patient who he could not all reasonably warn. However, when asked how the ethical problem was resolved, he said that nothing had been done and that no further prescriptions had been presented to him. So, despite being aware of the potential harm to other patients and of the need to make the GP aware that he, as a pharmacist and fellow health care professional, did not think the medicines should be co-prescribed, he did not act.

In another example, Phillip was asked about the sale of confectionery in his pharmacy, a practice that is not considered professional due to issues relating to dental care and correct nutrition (Royal Pharmaceutical Society 2004). In the following quote he noted that such sales were an issue and that it is unprofessional but yet had done nothing about it:

Interviewer I mean I did spot that you have confectionery on the counter. Is that one that you've never thought of as an issue at all?

Pharmacist I have thought about it as an issue.

Interviewer Again, I'm not putting you on the spot with this issue. I'm just interested in...

Pharmacist ...I have thought about it as an issue but I haven't actually done anything about it. End of.

Interviewer Well, that's an interesting one because you've thought about it but why have you? I mean what did you see as being an issue?

[...]

Pharmacist It's more the size of the shop and I suppose also it's been quite a good line and it's...they're not next to any medicines, the P medicines are behind the counter so they're not actually situated right next to...I know, strictly speaking, that you're probably...it would be frowned upon to have confectionery in a pharmacy shop and I have thought that in the near future I'll probably be refitting anyway for this new contract and I might review it then, most probably. Yes. So that's probably where I'm at but up until now I've done nothing about it [...] Plus the fact, I suppose, they sell it next door so it's not going to stop people but, yea, we are health professionals and as a pharmacist you shouldn't be stocking stuff that is of detriment to your health. We should put it next to the Xenical [a prescription medicine used to reduce weight].'

The example is also interesting in that it represents a type of ethical reasoning involving an analogy – between sales of sweets in pharmacies and general stores – to support the sale in the former. As well as the above illustrations of considered inaction

where the pharmacist decided to do nothing, other examples involved prevarication and hence inaction but where another event or individual resolved the ethical situation and these are now considered.

5.5.1 Supervening Acts

One important theme that emerged from the interviews, and related to the last part of the decision-making model, involved examples of supervening acts in relation to ethical problems. Although examples have been provided above of pharmacists not acting ethically despite having made an ethical decision, on several occasions pharmacists identified an ethical problem but were spared having to act directly because of a supervening cause – that is, an event beyond their control had occurred that meant that they did not have to enact their ethical decision.¹⁰ However, such supervening acts were not co-synchronous but occurred because the pharmacist had not acted and it was effectively left for another individual to act. For example, although Robert was used as an example above of enacting an ethical decision, he was also involved in a police enquiry that may have required him to identify a certain medicine that was being illegally sold by an individual. He became aware that the individual was a patient of the pharmacy and recognised the ethical problem of whether he could breach confidentiality and give this information to the police. He sought the advice of the Royal Pharmaceutical Society, who advised him that it was a

¹⁰ Supervenience is used in this sense, relating more to legal causation than a philosophical concern about the dependency between two properties.

personal decision and, as regards the ethical problem of breaching confidentiality, he stated that:

‘I identified the drugs and I think eventually they caught him anyway so I didn’t actually have to do that...it was very convenient in the end, yes, but I did sweat on it for a week or two...So in a way I suppose that was shirking my responsibilities. Was that ethical? I don’t know.’

Another pharmacist, Gloria, provided an example of a nurse in a nearby practice who was suspected of consuming alcohol whilst at work. Gloria recognised this as an ethical problem, identifying that:

‘It’s about that she might need help and, you know, something needs to be done and I don’t know what it is. It’s not about getting her [the nurse] into trouble but getting her help and getting her sorted. And in no way harming patients.’

But despite recognising the ethical issues she was not sure of how to deal with the problem and eventually another nurse was informed by chance and this opportunistic, supervenient encounter resolved the ethical problem for the pharmacist.

In these two examples, the pharmacists were not ignoring the problem but, rather, felt unable to address the ethical problem decisively and relied instead upon a supervening occurrence to resolve the problem. This may be understood in terms of the isolation described by several of the pharmacists and of not having an adequate network of colleagues or peers to whom the problem could be shared or referred and this is considered in the next chapter. Of course, both pharmacists did involve others – namely, the Royal Pharmaceutical Society and another health care professional – but

in the examples given, the pharmacists appeared to have identified the ethical issue and realised what was needed to resolve each problem but did not do so.

In this final section on how pharmacists make ethical decisions, the concept of ethical action and decisiveness have been developed and it has been shown that there was variation in what pharmacists do once they became aware of an ethical problem and came to some form of ethical judgement. In some examples, decisive ethical choices were made and enacted but in others, inaction and supervenience were evident. What this final stage indicates is that, unlike previous empirical pharmacy ethics research that sought to consider simply ‘awareness’ and examples of problems (Hibbert *et al* 2000) and study how a specific ethical theory was used in practice (Chaar *et al* 2005), the present study reveals a much more complex situation where it is not at all certain that evidence of ethical understanding or application to problems or, for instance, a reading of just the second section of this chapter, would provide a full picture of how pharmacists try to resolve ethics problems in their work. Inattention, self-interest and inaction were evident and these features will now be considered in relation to the emerging concept of the ethically passive pharmacist – a description that may reflect many of the pharmacists in this study and which may be contrasted with the antonymic, active pharmacist but for which far less examples emerged.

5.6 CONCLUSIONS

The intention in this chapter has been to answer the question of how pharmacists try to

resolve ethical problems in their community pharmacy work. Hopefully, this has been achieved by the application of a broad analytical framework based upon four key areas of ethical decision-making (Jones 1991). To summarise, ethical attention has been shown to be a relevant and even under-studied aspect of empirical and normative ethics but has provided valuable insights into what emerged negatively as pharmacists' frequent inability to 'see' ethical problems and values. Ethical justification was varied and reasoning that may be approximated to normative approaches such as consequentialism and principles did emerge but, significantly, pharmacists appeared also to rely upon simpler ethical resources such as the golden rule and unqualified appeals to experience, commonsense and also religious faith. Formal forms of ethical assistance were found lacking in relation to ethical problems although communicating with friends and peers helped in a process of reflection for some. Pharmacists' legalistic self-interest has been identified as significant and, finally, variation in pharmacists' enactment of their ethical decisions has emerged. The relative space devoted to each stage of decision-making has varied in this chapter and this is not unintentional. As was noted, the importance of the first stage – of pharmacists being able to not merely *bemerken* or take notice but actually use Murdoch's 'just and loving gaze' – is a vital step and required much consideration, especially given its relative neglect in the philosophical literature. The task of explaining how ethical attention is relevant but generally lacking amongst the pharmacists in this study was necessary since it frames some of the subsequent stages and discussion. The question of how one can go on to reason and act upon what one has not come to regard as being ethical is crucial in this chapter. Hence, the subsequent stages require somewhat less space to

describe and explain what emerged from pharmacists' ethical problems and decision-making in interviews. Wittgenstein's quote regarding the turning of one's spade and hitting bedrock, although related to a linguistic meta-ethical philosophy that is beyond the scope of the present study, is still most relevant to the present study. Perhaps the pharmacists in this study could only go so far in justifying something that they did not apparently believe required further justification since it is largely unseen. Hence, 'this is simply what I do' would seem an apposite response. As was noted in relation to ethical attention, what has been hard to convey in this study is the impoverished nature of some pharmacists' accounts of their ethical problems and decision-making – especially in comparison to the relative richness and articulacy of other pharmacist's ethical insights.

5.6.1 Ethical Passivity

But what may be said of the predominant figure that has emerged from this study's analysis - the ethically *passive* pharmacist? And is this emergent theme in effect a caricature of the pharmacists interviewed, cruelly exaggerating negative ethical aspects? Although the intention throughout this study has not been to assess pharmacists or compare them favourably or otherwise with normative standards, the use of the analytical framework of ethical decision-making involved what were argued to be relatively uncontentious stages – of seeing what was ethical, of being able to make an ethical decision with regard to what one sees and to then act upon that decision. As such, the emergence of negative rather than positive examples of such

stages led inevitably to a discrepancy between the empirically observed claims and descriptions offered by pharmacists and the stages of decision-making. But in addition, the variation between pharmacists could not be ignored and it was as much in the observance that, for a given stage, some pharmacists could in fact see so much more that was ethical, could develop arguments to support their ethical choices and could then enact such ethical decisions that meant that the emergence of this active ethical process could not be but contrasted with its antonym, the ethically passive. In table four, a summary of what are argued to be characteristics of the active and passive ethical pharmacist is listed, as they have emerged from the present study.

ACTIVE	PASSIVE
ethically attentive reflective communication important experience uncertainty/doubt sustained reasoning spontaneous ethical examples faith conflicts but sensitises relatively ethically articulate	ethically inattentive unreflective self-interest legalism - reliance upon law/procedure impoverished/absent ethical reasoning prompted/absent ethical examples financial motivation impoverished ethical language

Table 4 Summary of characteristics of active and passive pharmacists.

The characteristics of the generalised active and passive pharmacist bear similarity to an unpublished study by Omery (reported by Holm 1997) involving intensive care nurses that concluded that two distinct types of nurses emerged: those whose reasoning was sovereign and those that were accommodating. The former, Holm reported, could be characterised by the use of care, advocacy, respect and self-determined moral principles whereas the latter tended to use moral norms that allowed them to conform

to their peer group and were characterised by avoidance, paternalism, professional protectionism and legalism.

Although evidence of ‘sovereign’ thought was not significant in the present study, comparisons may be drawn between the accommodating nurses in Omery’s study and the passive pharmacists in the present study, especially in relation to the identification of a legalistic outlook. Of course, there are differences as well as similarities and it is perhaps the mark of qualitative research that it reveals how different health care profession’s particular features and setting provide different interpretations of ethical activity due to the uniqueness and contextual nature of each profession.

What has emerged so far is a frequently passive ethical pharmacist, one who is relatively inattentive to the ethical in their work, with a tendency to consider problems as being often legal or quasi-ethical in nature and utilising legally defensive solutions.

Whilst the intention so far has been to use ethical passivity as a descriptive term to reflect the emergent themes in this study, it may also have consequences. For example, Gilligan uses the image of passivity in *In a Different Voice* to indicate an abrogation of responsibility amongst some women but that this is a responsibility that often cannot be avoided (Gilligan 1993). Using the metaphor of water and currents and drawing upon literary heroines from Elliot’s and Drabble’s novels *The Mill on the Floss* and *The Waterfall* respectively, Gilligan argues that some of her interviewees:

Are drawn unthinkingly by the image of passivity, the appeal of avoiding responsibility by sinking, like Jane, into an ‘ice age of inactivity’ [...] but the image of drifting, while seeming to offer safety from the onus of responsibility, carries with it the danger of landing in a more dangerous confrontation with choice. (Gilligan 1993 p.143)

Gilligan's argument is that passivity does not absolve the individual but might in fact lead to further problems, and that one cannot ignore the need to make decisions since even if one is apparently 'sinking' or 'drifting' one will eventually 'land.' The imagery of drifting emerged from women's interviews and of their noting that they felt powerless between claims of responsibility and selfishness. Hence, the image of passivity and use of Drabble's dramatic 'ice age of inactivity' convey attempts to avoid ethical decisions that must balance these two claims. These echo themes that have emerged in this study – of self-interest and also the need for ethical decisions to be made. However, a further consequence of identifying ethical passivity amongst some pharmacists in this study is not just that such passivity may perpetuate or worsen ethical decisions at times, but that in contrast to Gilligan's work, there is little apparent *insight* amongst some pharmacists. Gilligan provides examples of women who are *aware* of their inaction but in the present study, insights into ethical inaction and inattention were rare. Whilst the themes of *In a Different Voice* are of arguably more emotive and personal issues such as gender, power and oppression, it may be the case that some of the pharmacists in this study are not only moving passively but perhaps do not even realise that they are in relation to issues in their pharmacy work. In this respect, ethical attention or inattention is turned inwards and, for some pharmacists, this reveals all too little about themselves.

In the next, penultimate chapter, an attempt is made to consolidate the findings of this study – of what are ethical problems for pharmacists and how they resolve them – by considering more broadly *why* it is that pharmacists often encounter problems of a quasi-ethical legal, mundane nature and *why* it is that an ethically inattentive and

passive approach is evident for many of the pharmacists in this study. In seeking to answer these questions, the focus is shifted away from what have so far been largely micro-social phenomena to more macro-social concerns – of pharmacy more generally as a profession, for example. This is all placed in the context of what is considered to be, following Giddens (1991) and Bauman (1992), a time of late modernity and the insights offered by Giddens especially are developed in relation to whether pharmacists' need for ontological security set against a background of increasing moral sequestration are inimical to their developing an ethically active outlook.

6 THE COMMUNITY PHARMACY ENVIRONMENT

6.1 INTRODUCTION

Having so far considered the questions of what pharmacists found ethically problematic in their work and how they attempted to resolve such problems, the task in this chapter is to raise the question of *why* this is the case - to consider possible reasons why pharmacists are often passive in relation to ethical decision-making and why ethical problems emerge. In order that such questions can be addressed, attention is turned to aspects of the community pharmacy environment that have emerged in the present study. Some relevant themes have already emerged, such as the emphasis on law and not ethics in pharmacists' undergraduate education, for example, but in this chapter the intention is to consider further aspects of the community pharmacy environment that are ethically relevant and these involve the emergent themes of isolation, subordination and routinization.

In this chapter, then, the emphasis is shifted away somewhat from micro-social events such as the minutiae of ethical problems in pharmacists' work to broader, macro-social concerns relating to pharmacists' position within the primary care setting. Theoretical insights are also considered in this chapter and, developing some of the sociological issues briefly considered in chapter two, concepts such as moral sequestration in the work of Giddens (1991), discourse ethics and colonisation of the life-world as understood by Habermas (1987, 1989) and also Bauman's description of modernity in terms of proximity and the inadequacy of individuals' increasing reliance upon laws

and codification (Bauman 1993). Although these authors differ significantly in their understanding of ethics - for Bauman, a non-universalised ontological morality and for Habermas, a reliance upon neo-Kantian universalisation, for example – they all offer valuable insights into moral and ethical matters that it is argued provide a greater understanding of the ethical characteristics and activities of pharmacists as described in the previous two chapters. Including these theoretical perspectives enhances the broader concerns that this chapter seeks to achieve, in indicating how ethical issues more generally in society are interpreted, described and also critically challenged. However, the empirical data that emerged in this thesis are not neglected and further references are made throughout this chapter to other relevant and emergent themes from the study such as pharmacists' experiences of isolation in their work, the routinization of tasks such as dispensing and their perceptions of doctors in relation to subordination. Indeed, these spontaneous and emergent themes from the interviews with pharmacists are central to this chapter and it is argued that several aspects of the community pharmacy environment are relevant to ethical issues, both generally and in relation to the emergent theme of ethical passivity.

Ethical isolation emerged as a significant issue, and was problematic in a number of ways. Firstly, it was actually perceived of as a problem by several pharmacists, in a professional and an ethical sense and it is argued that community pharmacists' isolation is inimical to ethical discourse and that opportunities for discussion with peers and other health care professionals are lacking. Habermas' theory of discourse ethics is explored in relation to the need for open forms of communication amongst individuals to facilitate ethical decision-making and isolation is argued to be a barrier

to such discourse. Secondly, several aspects of the community pharmacy environment may isolate pharmacists from the object of many of their ethical problems: customers and patients. Transitory commercial transactions are common, customer empowerment, increasing delivery of medicines to patients' homes, dispensing workload and delegated sales of medicines mean that pharmacists may lack contact and the ability to foster relationships with patients. Developing the concern that emerged in chapter four - the absence of 'relationships' for many pharmacists - the concept of proximity is explored, and drawing upon empirical and theoretical insights by Malone (2003) in relation to nursing, it is argued that proximity and isolation are relevant to ethical concerns and prevent the creation of patient and customer narratives that can better inform ethical problems. Thirdly, there is a psychological aspect that individuals tend to have more ethical concern for issues that are more proximate to them. Hence, pharmacists' isolation from patients and customers means that they may fail to consider ethically relevant issues. Such concerns have emerged in the work of Jones and also Singer. Fourthly, isolation may result from what Habermas terms the colonisation of the life-world and the increasing encroachment of formal and legal structures into individuals' lives comes at the expense of moral influences. Isolation is felt at a personal level and alienation at a broader, social level. Several aspects of Bauman's work are also argued to be relevant. He offers a description of individuals' increasing reliance upon formal legal rules and codes as a consequence of late modernity and argues that moral discourse and decision-making has become neglected. His interpretation of Levinas' radical ontological ethic is also considered and although his treatment of the themes of isolation and proximity and their relation to ethics and

morality ultimately differ from the claim made in the present study, it is argued that his *description* of modernity - of ever closer physical proximity between individuals who yet remain strangers - is fitting and may help answer the possible question as to how pharmacists could be isolated whilst being in the community and having at least some contact with others.

Further developing the emergent theme of subordination, it is argued that this is a recognised sociological feature of many paralegal professions, especially in relation to medicine. This may not only cause ethical problems to emerge but may result in an environment of ethical passivity, in which pharmacists believed a dominant prescriber was ethically responsible, obviating decision-making by some pharmacists. Although not all pharmacists deferred in such a way, the frequent emergence of atrocity stories relating to doctors' errors is argued to indicate a culture of underlying subordination. The case of EHC is used to illustrate such subordination to doctors, specifically for those pharmacists who refuse to sell EHC but who find no problem in dispensing it under the direction of a prescribing doctor.

A third aspect of the community pharmacy setting involves routinization of pharmacists' work, especially in relation to the central task of dispensing, and this is also argued to be ethically relevant. It may limit pharmacists' exposure to ethically contentious issues, which could provide the stimuli for ethical debate and thought.

Using Giddens' concepts of ontological security and the sequestration of experience in relation to pharmacy, it is argued that pharmacists may be no different from other societal members in late modernity in seeking the safety of routines that ensure they do not have to make difficult, uncertain ethical decisions. Emergent new issues, such as

the supply of EHC however may represent possible opportunities for ethical re-engagement in the area of sexuality and health which Giddens argues are being increasingly bracketed out of our lives. In areas such as supplying medicines for PAS (physician assisted suicide), the terminally ill and those with dementia, however, pharmacists do not appear to have embraced the attendant ethical challenges. Drawing analogies with Camus' interpretation of the myth of Sisyphus, it is argued that it may however be in pharmacists' attitudes to their present problems, albeit of a mundane and routine nature, that attention should be focused. In what pharmacists already describe as ethically problematic in their work, important ethical issues are present but these are currently not recognized, and addressing pharmacists' passivity may be as important as their exposure to more pressing ethical concerns.

To summarise, it will be argued that ethical passivity is a defining feature of the present study for the pharmacists interviewed and that, in addition to the emergent empirical features of inattention, self-interest, legalism and inaction identified previously, aspects of the pharmacy environment are significant, too, in explaining ethical passivity and these include the themes briefly considered above, of isolation, subordination and routinization.

6.2 STRUCTURE AND AGENCY

Before considering the above themes in turn, an initial point of clarification should be made in relation to this chapter's focus upon broader sociological issues that may be

relevant to pharmacy. At one level, this chapter involves a concern that has been central to sociology from its outset, of whether one should view society's members as free and able to exercise autonomous, rational thought and decision-making or conversely, as passive agents, and constrained by various social structures such as class, profession or gender. This is often described as the difference or even dichotomy (Jenks 1998) between agency and structure. However, the intention in this chapter and thesis is not to enter into detailed discussion of on-going theoretical divisions, no less attempt to resolve them, but to use relevant insights to understand why the participants in this research, community pharmacists, encounter, describe and attempt to resolve ethical problems as they do. It might immediately be questioned, though, whether focusing upon structures such as the pharmacy environment may in fact shift the *responsibility* for ethical action since, in seeking to understand why individuals act as they do, the emphasis moves from claims that individuals are autonomous and responsible for their action *qua* rational agents, to claims that social structures may be important in determining social action. In the context of the present study, does this then imply that a consideration of broader, social or societal structures and forces might in some respects *exonerate* pharmacists from being, what the previous chapters have argued, predominantly ethically passive, legalistic and inattentive? Philosophical and sociological insights are relevant in answering this question. Philosophically, it has often been argued since the Enlightenment that individuals are to be considered autonomous and rational agents and to admit of any influences is a failing or what Kant termed a heteronomy of the will (Kant 1998). As noted throughout this study, however, the intention has not been to adopt such a view and it has been consistently

argued that empirical, social data are relevant to our understanding of agent's ethical problems and reasoning. Sociologically, however, whilst there has been support for theories that champion both agents' individuality (phenomenology, symbolic interaction) and structural influences (functionalism and Marxism), it has also been argued that agency and structure are not antonymic and that individuals' social lives are, in fact, complementary. Giddens (1984), for example, has argued that structuration theory explains this apparently irreconcilable difference between structure and agency and argues that individuals are both enabled and constrained by social structures. The approach of the present study is not to necessarily defend a particular position but rather to use insights that can best illuminate and explain the data that emerges from pharmacists' interviews. So, as well as being sensitive to philosophical issues surrounding ethical decision-making, the influence of the community pharmacy environment is argued to provide a more complete and contextual understanding without necessarily claiming that considering such influences necessarily amount to a defence of structure. As Holm notes:

The ethical decision-making of individual health care professionals does not occur in a vacuum. It is influenced by attitudes in society at large, by the general social environment in which the professional lives, and by the organisational features of the health care institution in which the professional works. (Holm 1997 p.167)

Of course, a further criticism might be that the use of the term 'ethical *passivity*' is, by definition, an admission that pharmacists are subject to external social forces and are not active agents. Whilst this chapter will develop arguments that indeed admit of the influence of the community pharmacy environment, what must be made clear is that

the use of *passivity* is in the sense of inaction rather than that of being subject to external forces. It should be remembered that ethical passivity emerged as a descriptive term for pharmacists' frequent absence of ethical attention, ethical reasoning and ethical action and passivity properly reflects such ethical *inaction*.

6.3 ETHICAL ISOLATION

6.3.1 Professional Isolation

In concluding his analysis of ethical reasoning amongst doctors and nurses, Holm (1997) considers the context of the hospital and argued that if one ignores organisational and social factors such as culture, communication, structure and process, it is not possible to fully represent how ethical decisions-making occurs in practice. In particular, communication (or conference as he refers to it) may be relevant to how ethical problems are resolved and he concludes that greater participation from nurses and doctors in ethical conferences or fora is necessary. What may be said, though, of community pharmacists, whose work environment is significantly different from that of the hospital? In contrast to the hospital setting, where pharmacists also work of course, the community setting is solitary in comparison. This is typified in one respect by sole proprietors, who own their own businesses, but is also reflected in the majority of community pharmacies having only a single pharmacist present. So, irrespective of ownership or employee status, pharmacists often tend to work alone. This was recognised by many of the pharmacists

in the present study, who identified such solitary working arrangements but also spontaneously cited concerns about such isolation. As Gloria remarks:

‘In a way we are isolated as pharmacists and we haven’t got anybody to chat to, to ask about things, to find out what other pharmacists think.’

If pharmacists mentioned their peers, it was often to comment on the performance of locums who had worked at that pharmacist’s place of work following a day off or a holiday. Social events and professional meeting such as continuing education appeared to provide some opportunities for interaction, but during working hours, peer communication was limited. Employee status did appear to increase the opportunities for peer interaction since pharmacists who worked in larger chain pharmacy organisations tended to develop a network of pharmacist colleagues with whom they could discuss issues, even if only by telephone. However, even being part of a larger organisation did not necessarily mean that interaction with one's employer was any better or relevant in either a professional or an ethical sense. Amadika, for example, worked for one of the largest pharmacy employers in the country but when asked whether she would use those within the organisation for ethical advice or assistance, she replied that:

‘There’s the superintendent’s office at head office but then nobody at head office ever answers their phone [...and] I think the area manager is more for where the problem is more to do with staff or if the boiler’s broken or retail, you know, like we’re over-stocked, what do we do with the stock? You know, that sort of thing, but not with other issues [...] I would never, like, if I got stuck right now with something, he’s the last person I’d pick on.’

Although she identified a colleague in a nearby pharmacy that belonged to the same company that she discussed issues with, her employer remained distant not only geographically - as a nation company with a head office some two hundred miles away - but psychologically, too, and there was no-one with whom she could discuss ethical issues.

The sole proprietor appeared to fare even less well in terms of interaction with other pharmacists or those who might offer ethical assistance. Not only did the independent nature of their business concern lead to isolation but commercial rivalry also appeared to be a further barrier to communication between proprietor pharmacists. Phillip, who had owned his own pharmacies for several years, argued that this prevented any meaningful contact with other pharmacists:

‘We’re all islands and we’re all competing against each other [...]. The only time when you come into contact with another pharmacist is when there’s a conflict with something or when you want to borrow something.’

Rejecting the implication of John Donne’s poetic metaphor, Phillip claims that pharmacists are, in fact, separate ‘islands’ and are wary of interaction due to commercial sensitivities.

Interestingly, several pharmacists contrasted their isolation with what they perceived to be the case in health professions such as medicine, where they believed general practitioners would be able to seek the advice of a colleague easily. Robert, for example, believed that general medical practice offered opportunities for peer interaction and assistance, both professionally and ethically. Questioning pharmacists’

isolation in comparison to general medical practice, in particular, Robert further typified the sense of isolation experienced by many of the pharmacists in this study:

‘Why should community pharmacists have to stand in isolation and make all these difficult decisions all the time? Nobody else does it. Doctors don’t do it, do they? They have people who they can refer to – their mate next door if they don’t know.’

Such perceptions have been challenged in the literature, however, and Doyal (1999) argues that general medical practice is beset by several problems in comparison to the secondary care setting and, in particular, that ‘[...] GPs have much less opportunity for the collaborative discussion and debate which is essential for rational decision-making about ethical and legal dilemmas in medicine’ (Doyal 1999 p.45). So despite some pharmacists perceiving GPs as being interactive and having extensive networks of peer advice, it may be that the primary care setting does lead to some form of isolation, in comparison to the secondary care, hospital setting at least. But how does such isolation relate to the overall concern with ethical issues in this study? As Holm noted at the start of this section, and Doyal articulates in the above quote, ethical discussion is argued to be important even if, as Holm also identifies, practical problems in the hospital environment may impede such conferences in practice. The use of communication and shared ethical decision-making is not a new one but it is often considered from the viewpoint of philosophers assisting in particular hard cases and to the emergence of ethics committees and the role of ethicists (Moreno 1991). The question that arises in the context of the present study is whether community pharmacists’ isolation - empirically identified as a physical and professional isolation -

may also be seen as ethical isolation, and whether this offers any insights into the overall themes in the present study, of ethically passivity, the type of ethical issues that emerge and how they are resolved.

Although many pharmacists referred to isolation in a general sense, some, like Gloria and Amadika, did make specific references to their inability to seek ethical guidance. There were times when they needed ethical assistance, but it was not available and although they were aware of various possible sources of advice (their respective employer's superintendent department, for example) they claimed that in practice, they were alone in their ethical problems. However, the relevance of isolation to ethics is grounded in more than any immediate form of ethical guidance or assistance (although this is still argued to be important) but also in terms of how communication is vital to ethical understanding. This connection between ethics and communication may be seen no more clearly than in the work of Habermas (1989), where his theory of discourse ethics centralises the need for particular forms of communication that are conducive to ethical debate. Seeking to re-interpret Kant's principle of universalisation, Habermas claims that arguments can only be valid if they have been derived from a process that involves open discussion between individuals, free from distortions of power or coercion (the ideal speech situation) and allowing for the synthesis of arguments following such open discussion and reflection. Importantly:

The grounding of norms and prescriptions demands the carrying through of an actual dialogue and in the last instance is not possible monologically, in the form of an argumentation process hypothetically run through in the mind. (Habermas 1989 p. 68)

As such, the private reflections of individuals, although not rejected since they may

assist one in formulating and preparing in advance an argument in terms of the above dialectic discourse, cannot amount to a complete conception of ethics, represented as a discourse ethic. According to Crossley (2005 p. 64-65 and Nick Crossley 2006 personal correspondence), Habermas' discourse ethic is but a further development of ideas originally expressed by Mead (1967) in his short essay *Fragments on Ethics*, who argued that individuals only arrive at correct ethical decisions by reflecting upon what others believed or would do and so gain a more complete understanding of an ethical problem (but see also Habermas 1990). Pharmacists' ethical isolation, then, manifest as the relative absence of communication, can be seen to be incompatible with an approach such as discourse ethics, which values the insights offered by others. Following Mead, also, the insights offered by others are entirely relevant to one's ethical decisions, since one cannot be expected necessarily to have every experience or possible view point in a given situation.

Some pharmacists in this study did appear to value communication and, Helen, for example, made several references to her discussions with other pharmacists in a social context (as noted in chapter five) and also with staff, who she argued identified different view points that informed her decision-making. One member of staff, she noted, was a mother and another was a graduate from South America and the diversity of their beliefs was important in offering alternative insights. Another pharmacist, who worked both as a locum and as a prescribing adviser in a medical centre, noted that in the former role, she often felt as though she could not talk to anyone regarding professional and ethical issues or concerns but in the medical practice, discussions between health care professionals were routine and valuable in allowing differing

perspectives, including the patients, to be identified and considered. But examples of pharmacists who identified communication and the insights of other peers, staff or health care professionals were the exception and the over-riding sense was of pharmacists' awareness of making decisions alone in their working environment. What was evident, however, was that the pharmacists in this study did not identify patients and customers in relation to isolation. Whilst this would appear to be a positive sign and allow pharmacists to communicate with and gain insights from patients and customer, as a discourse ethic or Mead's conception of ethics would advance, it will be argued in the next section that empirical data suggest this may however not be the case. As noted in the introduction to this chapter, concerns about increasing prescription volume, increasing commercially driven delivery services and the delegated and consumer-driven nature of OTC transactions appear to lead to both a spatial and temporal lack of proximity and also an isolation of pharmacists from patients and customers.

But continuing with the isolation of pharmacists from peers and professionals, what this lack of communication and interaction does reveal, however, in its explicit identification by pharmacists, is that they are aware of themselves as part of a profession and as part of a health care system – even if this recognition comes at the price of knowing that they are apart in some way. This appeared to be revealed in two distinct ways. Firstly, in terms of the profession, pharmacists' sense of isolation appeared to lead to an inability to articulate, or even conceive of, what values or guiding principles the pharmacy profession should possess. Secondly, it indicates a

sense of difference from other health care professions, such as medicine in particular. Combining both of these interpretations of isolation for pharmacists, a picture emerges of pharmacists being bereft of norms and values that could be transmitted from association with a profession such as pharmacy, or as part of the health care team. Of concern, is that a lacuna may have developed in which anomie prevails, that is a sense in which norms are absent and are not capable of being transmitted via communication or interaction with others. This situation is made all the more abject, since it would appear that formal structures such as the code of ethics and undergraduate ethical training appear to have been of little influence or guidance, as emerged in the previous chapter. Although ‘anomie’ is often associated with the work of Durkheim (1952) and in particular, crises in society such as occurred during industrialisation and his famous study of suicide, it may also be used to refer less dramatically to situations in which:

There exists little consensus, a lack of certainty on values and goals, and a loss of effectiveness in the normative and moral framework which regulates collective and individual life. (Jary and Jary 2000 p.20)

In contrast to Durkheim’s understanding of morality and social structure, in which he argues that professional associations (such as pharmacy, for example) would emerge in the wake of increasing industrialisation to provide a set of collective values to counter possible anomie, the present study finds just such a value deficit in the pharmacy profession, according to the pharmacists interviewed (Cuff *et al* 1990 p.81). Isolation within the profession and between allied professions appears to lead to a form of anomie. This may be explained in another area of Habermas’ work, in which he distinguishes between what he terms the system and the lifeworld. The lifeworld

represents individuals' social and communicative activities and goals, in contrast to the system, which involves formal structures such as the economy and the judiciary. Increasingly, the latter is encroaching upon the former, according to Habermas, and colonising it with increasing legislation, for example. But systems such as legislation cannot replace the moral and social norms that define individuals' existence and give meaning to their lives and so, according to Habermas, anomie at a social level and alienation at a personal level, results. In the present study, it may be argued that isolation, and in this sense the word is used synonymously with alienation (but see Seeman 1967) and anomie with a more general absence of ethical norms and values within community pharmacy generally. Locating isolation and, more generally, anomie in the context of ethical concerns, it is possible to see that as individuals experience isolation and a resultant erosion of transmitted values or a 'moral framework', this may deprive them of a basis for ethical action. The possibility of ethical passivity then arises, in the lacuna of a profession lacking ethical guidance, unable to communicate with fellow professionals or other allied health professions and increasingly reliant upon law and procedure to provide guidance.

6.3.2 Customer and Patient Isolation

As well as the identification of professional isolation and its associated ethical problems, there also emerged in this study a concern that pharmacists were isolated from the object of many of their ethical problems, customers and patients. However, in contrast to pharmacists' frequent explicit references to a sense of isolation, the

isolation between them and patient or customer was not one that they appeared to be aware of. The emergence of such isolation arose, rather, in numerous comments from pharmacists more generally, and from which it became apparent that they were, in fact, often quite remote from patients and customers. This manifestation of isolation would appear to be somewhat paradoxical, given pharmacists' work as *community* pharmacists, and also in the light of the frequent references to customers and patients as the object of many ethical problems, as catalogued in chapter four. But it is possible to recognise that, despite being in the community setting and having to deal with problems relating to patients and customers, pharmacists are isolated. This is a recurrent theme in the work of Bauman, who notes that it is a symptom of the present times (of post-modernity for Bauman) that we are never closer to others but yet so far apart and that 'side by side may even be physically close, literally rubbing each other's shoulders, and yet infinitely remote' (Bauman 1993 p.70). Clues to this form of isolation for pharmacists were found in several different areas. Firstly, there appeared to be an ever-increasing workload, involving prescription dispensing and also paperwork. Although changes within the profession such as 'checking' technicians are due to be introduced to allow pharmacists to undertake additional roles, pharmacists presently spend the majority of their time in dispensaries, and are faced with ever increasing numbers of prescriptions (Health and Social Care Information Centre 2005). Of the pharmacies that were visited to conduct interviews, seven were of a closed variety which meant they could either not see out into the pharmacy shop itself or else had small hatches through which they could peer. In such pharmacies, the customer or patient would have found it difficult to see the pharmacist. Secondly, the use of

representatives was common, and this occurred both for prescription dispensing and OTC medicine sales. As a result, although some form of interaction could occur, it did not involve the actual patient. Of course, many factors might have made this a reasonable state of affairs and the illness of a patient or customer or various forms of disability might mean that representatives were necessary but this may still be contrasted with professions such as medicine, for example. Thirdly, in relation to OTC medicine supplies, a combination of increasing dispensing work-load for pharmacists and subsequent delegation of sales together with the increasingly consumerist nature of such transactions, means that pharmacists do not often see customers unless specific requests are made. As several pharmacists remarked, customers often viewed medicines like other consumer goods and expected transactions to proceed quickly, without questioning, with the expectation of a return policy. As Dan noted in his town centre pharmacy, customers often had answers to potential questions in relation to a prospective medicine purchase already rehearsed so that they could obtain what *they* wanted, quickly and without problem. Illustrating how increasing commodification of medicines and work pressures fuelled the situation, Robert commented on how his employer favoured open shelving to display pharmacy medicines but due to the pharmacy being busy whilst dispensing, customers would sometimes help themselves:

‘[P Medicines], they’re not for self-service but very often when you’re busy, you do find patients who go in there themselves and once they’ve got it in their hand, it’s then extremely difficult not to actually sell it to them, isn’t it?’

In some respects, it may be argued that the lack of proximity that arises in community

pharmacies may be imposed by customers, as they increasingly become *expert users* and come to reject or resent, even, the gate-keeper role of pharmacists (Hibbert *et al* 2002)

The uptake of medicine delivery services also appeared to have further distanced the pharmacist. Again, legitimate reasons exist that prevent certain patients or customers from being able to visit a pharmacy and such delivery schemes offer invaluable benefits for such individuals. However, such delivery services are often offered indiscriminately and these have the effect of further distancing individuals from the pharmacist.

Typifying these problems was a comment made by Sharon, who described an ethical problem involving a dispute about an under-supply of a hypnotic medicine with recognised misuse characteristics:

‘It got delivered that afternoon from the delivery driver and my technician answered the phone. It was the daughter of this patient, saying that she’d checked [...]

The problem was ethical since the pharmacist did not know whether to trust what the daughter (or patient?) had claimed and was concerned that they may have been mistaken or even lying to obtain a further supply of a sedative medicine. However, it illustrates clearly how divorced pharmacists can be, at times, from the actual patient and how systems of proxies prevent direct contact – the medicine was given to a driver, who delivered it and checked by a patient’s daughter, who then rang on her behalf and spoke to a member of staff. What such examples illustrate is that although not specifically thought of as such by pharmacists, there exist numerous barriers to

direct contact and these contribute to the emergence of a further form of isolation for pharmacists.

Such separation has been recognised within health care, and using the related concept of proximity, for example, Malone studied the relationships between hospital nurses and patients and identified three related forms of proximity - physical, narrative and moral (Malone 2003). It was argued that a number of trends in nursing such as organisational changes meant that instead of the necessary closeness that nursing required, a negative 'distal nursing' would emerge. The *physical* separation of nurses from patients and a resultant lack of any actual contact constituted the first type of proximity, but importantly, this was argued to lead to problems in the formation of *narrative* proximity wherein a complete understanding of patient's concerns would not be achieved. Finally, the combination of physical and narrative separation of nurses from patients was argued to lead to a lack of *moral* proximity. Moral proximity, Malone argued, was a vital aspect of nursing, since it involved recognising the responsibility that the nurse had towards the patient and involved situations 'in which nurses encounter the patient as other, recognize that a moral concern to 'be for' exists, and are solicited, to act on a patient's behalf' (Malone 2003 p.2318). Malone not only grounds proximity and the threat of distal nursing in empirical data but also identifies a range of sociological and philosophical insights into proximity and, in particular, refers to Levinas (1981) and the face to face encounter. Here, Malone recognises the phenomenological concern in Levinas' work, that in recognising the Other, we can understand our relationship and commitment in an ethical sense. In the work of Levinas, it is possible to identify a connection between proximity and distance. His

work is far from easy to grasp, not least because it reverses the common assertion that rational autonomy precedes moral commitment and claims that individuals' ethical responsibility precedes ontology – one must 'be for' rather than 'be with' the Other, as the above quotation alluded to. Proximity for Levinas, however, is not strict physical distance but one that transcends obvious physical or temporal boundaries:

The relationship of proximity cannot be reduced to any modality of distance or geometrical contiguity, or to the simple 'representation' of a neighbour; it is already an assignation, an extremely urgent assignation – an obligation, anachronously prior to any commitment. (Levinas, 1981 pp. 100-101)

Nonetheless, it does involve *interaction* and it is in the face-to-face interaction that individuals come to recognise their responsibility, their ethical charge, for others.

Levinas' conception of ethics features centrally in Bauman's work, where he argues that an ontologically prior morality is far more appealing than any adherence to an ethical or legal code, such is the state of society in late modernity (Bauman 1993). For Bauman, the present time involves unprecedented changes in relation to the organisation of space, with ever-increasing claims upon social, cognitive and aesthetic forms of space. However, whilst Bauman is concerned with the concept of proximity and, importantly, its relation to morality, his is a rather pessimistic account and one that would have to reject, for example, the arguments advanced in relation to professional isolation. For Bauman, there can be:

No universal standards, then. No looking over one's shoulder, to take a glimpse of what other people like 'me', do. No listening to what they say they do or ought to be doing. (Bauman 1993 p.53)

Despite such reticence, Bauman is not wrong to look at the concept of isolation, but in

finding what he terms ‘the moral solitude of the moral subject’ (1993 p.53) his is but a bleak account and one that can only be salvaged by approaches such as Levinas’.

Drawing these accounts of proximity together in terms of their relevance to the present study, it may be seen that there are different ways of conceiving of isolation and its relationship to ethics: in the empirically grounded work of Malone, proximity (the opposite of isolation) is important in cultivating an ethical approach to professional work such as nursing but, in contrast, that there are according to Bauman, paradoxes of proximity and that isolation may yet exist in communities, that are ethically inimical. But in developing these two arguments, it is the optimism of Malone that is favoured and although Bauman offers a sustainable *description* of modernity, his *prescription* is not necessarily correct. Again, the present study is concerned in answering specific questions in relation to pharmacists’ ethical problems and their resolution, and to offer normative critiques of moral and sociological theories is largely beyond this study’s remit. What has emerged so far is a description of the community pharmacy environment in terms of isolation that delimits pharmacists’ relationship and interaction with not only their peers and other health care professionals but also customers and patients. However, one further aspect of isolation is also relevant to ethics and this concerns appeals made to psychology.

6.3.3 The Psychology of Isolation

The concern developed above – that pharmacists might be isolated or alienated from patients and customers – is given further support by the related claim that it is

understandable that the ethical agent will have greater concern for problems or individuals that are closer to them. This claim is often expressed in terms of proximity rather than isolation but both involve a concern for the relationship between the ethical agent and others and are ostensibly psychological in nature. Such claims have been identified in the business ethics literature and also moral philosophy, more generally, in explaining descriptively and normatively, ethical action. For Jones (1991), for example, it emerged as one aspect of his theory of moral *intensity*, in relation to his synthesised model of ethical decision-making within the business environment. According to Jones, the proximity of the moral agent to a problem was an important aspect in relation to ethical decision-making and in explaining and predicting such decision-making (Loe and Ferrell 2000). Coupled with other empirical issues such as the probability of a wrong occurring, its magnitude and temporal immediacy, the proximity of an agent to what Jones terms the potential ‘victim’ is important in understanding how individuals will behave in a given moral issue. Central to Jones’ argument is the assertion that ‘intuitively, people care more about other people who are close to them (socially, culturally, psychologically, or physically) than they do for people who are distant’ (Jones 1991 p.376). Examples are then provided from the field of business ethics relating to layoffs in an organisation having more impact in a plant that is closer to the moral agent or the sale of pesticides in one’s own country being of more concern than in a distant land. Milgram’s famous obedience experiment is also cited by Jones and he argues that both the psychological and physical closeness of ‘experimenters’ to ‘subjects’ in the study was related to the propensity of the former to comply with orders and apparently inflict harm on the latter (Milgram 1974).

Singer also refers to such an effect and calls it the 'proximity principle'. In examples where the ethical concern that individuals *qua* nationals of a particular country have for those seeking help from other countries is limited, Singer argues that such individuals are simply considering those closer to them (Singer 1993). In another example, he discusses his constant surprise when each new class of philosophy students respond to the following hypothetical dilemma: on your way to class, would you stop and help a child drowning in a nearby shallow pond, even if you became wet and were late to class? The students reply that they would and then Singer asks if they would provide nominal financial help to children in another country, who may be at risk of death due to other causes. Again, they all say that they will but what surprises Singer is that few of them *actually do* the latter, despite being in a position where they *could* and where such a situation *is* actually occurring in many parts of the world. What the examples of Singer and Jones both illustrate is that there is tendency for individuals to consider those closer to them more worthy of ethical attention. Such empirical observations tend to stand at odds with normative philosophical accounts and in particular to the claim that any general ethical theory should be universalisable and not simply apply to those closer to us. What makes such descriptions relevant to the present study, however, is that they support the argument that isolation (the lack of proximity of pharmacists to others) may tend to delimit ethical responsibility. Of course, this is not to say that pharmacists *qua* health care professionals should have an ethical duty to *all* individuals but simply that a felicitous ethical environment would be one in which pharmacists were not isolated and distant from patients and customers.

Isolation may also be seen to relate to attention, as developed in the previous chapter, and that, at least in some sense, pharmacists' ability to see what is ethically relevant in their work, requires an ethical attitude that may also be hindered by isolation. The searchlight that scans the ethical terrain cannot but struggle to identify issues that are further away. But whereas ethical attention or more often inattention was considered as a characteristic of many pharmacists in this study, isolation emerges as a feature of the environment of community pharmacy. Furthermore, isolation has been argued to be not only a cause of ethical problems and also an impediment to the development of ethical norms, values, guidance and relationships. In the next section, the relationship between pharmacist and doctor is explored, as not only one in which there is professional isolation but also professional subordination.

6.4 SUBORDINATION

Subordination was introduced briefly in chapter four in relation to the ethical problem of challenging prescribing by doctors and the intention in this section is to develop the concept of subordination more fully, to reflect not only its relevance in precipitating ethical problems, as chapter four illustrated, but importantly, in leading to an environment in which ethical responsibility is shifted away from the pharmacist.

Subordination has been an important theme within healthcare and, in his seminal work, Friedson (1970) argued that the medical profession has attempted to maintain dominance and power over not only patients but also other healthcare professions. Although subsequent theories such as bureaucratization, proletarianization and

negotiated orders have challenged this monopolistic approach, it remains a significant model of how different health care professional groups are both organised and interact (Svensson 1996, Weiss 2004). In particular, nursing has often been singled out as a paramedical profession that has encountered inequalities of power in relation to medicine, but although pharmacy has been relatively ignored in terms of medical sociology and medical ethics, it shares with nursing a similar position in the division of labour in health care. Turner (1995), for example, considers not only nursing and pharmacy but also dentistry and optometry as paramedical professions and argues that three forms of medical dominance exist:

It is possible to identify three modes of domination with respect to allied occupations, namely subordination, limitation and exclusion. Subordination describes a situation in which the character and activities of an occupation are delegated by doctors with the result that there is little scope for independence, autonomy and self-regulation. Occupational subordination to medical dominance characterises both nursing and midwifery. By contrast, occupational limitation is illustrated by dentistry, optometry and pharmacy. (Turner 1995 p.138)

The consequence of limitation is a restriction upon a profession's practices to specific areas of expertise, such as the sale and supply of medicines in pharmacy, or anatomical specificity, such as dentistry or optometry, for example. In contrast to subordination though, limitation does not necessarily involve the erosion of autonomy or acting under another's orders. With respect to pharmacy, however, Turner's interpretation of professional limitation may be inaccurate and it is argued that it is not only limitation but also subordination that define the community pharmacy environment. As Harding and Taylor note:

Pharmacists take their lead from physicians who assess clinical cases from a diagnostic and therapeutic viewpoint. Both in the hospital and community context, the pharmacist is governed in part, by the decisions and judgements of the medical profession. (Harding and Taylor 2002 p. 443)

This subordinate position within healthcare may, as noted previously, lead to the precipitation of ethical problems or distress (Kälvemark *et al* 2004) but also results in an environment in which ethical decision-making is compromised. In an example considered in chapter four, Michael typified pharmacists' subordination, when he raised his ethical problem relating to challenging a local GP's prescribing. To re-cap, he was aware of a recurrent interaction between medicines that originated in the prescribing of one of the near-by doctors and although this was clinically problematic, it was ethically so too, since he believed harm may result but he also felt that he was powerless to challenge the GP. As a result, he continued to dispense such medicines but resorted to less satisfactory, practical strategies such as warning patients about possible side effects. Although Michael continued to dispense such prescriptions, other pharmacists argued that if a prescribing issue were sufficiently serious, they would not dispense it. Examples were given of medicine interactions, excessive doses and inappropriate indications such as to pregnant women. What was important in such situations, however, was that they were ethically problematic for the pharmacist concerned and pharmacists' subordination appeared to precipitate the problem. Edward was able to recall only two ethical issues during his early career - one involving reporting the illicit injection use of a methadone patient and the other, he described thus:

‘The other one was refusing to dispense a script, on a safety premise and that was a big argument between doctor and me. At the end I said to him ‘Right’, after we’d been through all the consultants and all that and whatever on this one evening, so all the pressure’s on because it’s about seven o’clock in the evening, I said ‘I’m sorry, I’m not dispensing this prescription’ and I told the patient. And the patient’s father came back in quite happily and said ‘Were you on duty last night?’ and I was expecting to get thumped. I said ‘Yes’ and he said ‘thank you very much,’ he said, ‘my daughter’s been admitted to hospital with a liver problem’ so that’s a decision and you could just go down the road – is that ethical? It’s just being professional, I suppose, but some people might have shied away from it.’

In this example, attempting to defy a doctor’s prescription instructions led to not only an argument but also the anxiety of how a relative might react, but eventually the pharmacist did act and did not supply. Interestingly, Edward questions whether this was ethical or merely professional in nature but believes that other pharmacists might have evaded the situation. Hence, subordination is still pervasive, even if in this example, it involves what a pharmacist thought his peers might *not* do. However the story has another feature that is relevant to subordination since it represents what Dingwall (1977) has referred to as an ‘atrocious story.’ These are specific accounts of work tendered by those in subordinate positions and are, according to Dingwall, a mechanism of countering the power imbalance inherent in medical hierarchy:

Atrocious stories are a particularly colourful kind of account told by lower-status people in a division of labour about higher-status people. They are often a way of redressing status inequalities by showing how the division of labour could not work without the, undervalued, contribution of the lower-status people. The implicit claims are not, however, necessarily honoured by others. (Dingwall and Watson 1995 p.124)

Many pharmacists were able to recount similar stories and it would appear that subordination may be not only explicit - in precipitating ethical problem for some

pharmacists, such as in Michael's example - but also implicit, and be detected in the atrocity stories often cited by pharmacists. Even though such atrocity stories appear to be positive examples, and represent an ethically active approach, they are symptomatic of underlying subordination that, even if not problematic in these memorable stories, may yet be problematic in other aspects of pharmacists' work. For example, in the archetypal example of the incorrectly written controlled drug prescription, pharmacists' subordinate position in the delivery of healthcare led to ethical problems for many pharmacists, as described in chapter four. Here, again, pharmacists found ethical problems because their work was effectively to comply with the authority of a doctor's prescription and if that authority was not communicated properly, as in a missed dose or the use of words and figures for example, pharmacists appeared to be unable to do anything. Their power and authority in this case, to dispense a controlled substance, was delimited by the specific rules of prescription writing.

However, subordination was not only significant in causing ethical problems for pharmacists but also appeared to foster an environment in which the need for ethical decision-making was affectively removed. This would appear to be similar to de George's concept of ethical displacement and might not necessarily be problematic for the resolution of ethical issues (1990). But whereas for de George, it may be appropriate in a business organisation to have an ethical dilemma handled more appropriately by someone else, often a superior, in the present study, some pharmacists appeared to use their subordinate position to deflect ethical problems by claiming that a doctor should be referred to or other medical attention sought. Crucially, such

problems were not of a type that could only be resolved by a doctor, as de George's form of displacement would imply, but were problems that the pharmacist would be able to assist with. This was illustrated in the example provided by Sharon of a diabetic patient with mental health problems who was discharged from hospital with new medication but not in a compliance aid and was considered briefly in chapter four. The pharmacist was asked to help and provide a suitable device for the new medication but argued that she could not perform secondary dispensing of the hospital medication or query or interpret some of the doses, which were ambiguous:

- Interviewer** The scenario you mentioned there about the patient [...] I'm just curious about that patient and would they have had any medication at all over the weekend?
- Pharmacist** Yea, about my compliance patient?
- Interviewer** Um.
- Pharmacist** Well, he did have tablets from hospital so he wasn't without any medication.
- Interviewer** Could he perhaps have self-medicated?
- Pharmacist** He, he might have self... I doubt... Well, I don't know whether he would have been without but I know they were going to call the emergency doctor out and that would have sorted him out somehow – whether they might have popped him out a few tablets just for Saturday and Sunday and because I didn't and nobody knew the dose of warfarin and nobody knew the dose of his frusemide so it all needed to be clarified [...] So I really was looking after myself there but I did say to get in contact with the emergency doctor.'

Sharon was describing problems identified by several pharmacists, including the common concern of whether to perform secondary dispensing of hospital medicines, but it was in how she dealt with the situation that subordination appeared to occur as ethical displacement. For her, it was sufficient to recommend that an emergency doctor be contacted despite the fact that they would be in a similar situation as regards the

queried doses and were even less likely to know how to make-up a compliance aid such that carers could properly administer the medication. Such abdication of ethical responsibility and displacement relates directly to the claim that many pharmacists are ethically passive, since in relying upon their subordinate position, pharmacists appear to be avoiding the need for ethical action and having to make a decision.

6.4.1 Emergency Hormonal Contraception and Subordination

Perhaps the most telling example of subordination, however, occurred for several pharmacists in relation to EHC. Specifically, this involved those who expressed ethical concerns with *selling* the product as an OTC medicine, but who did not find it problematic to have a GP prescribe EHC and then that pharmacist subsequently *dispense* it. In such examples, it appeared that the subordinate relationship of pharmacist to doctor meant that the ethical responsibility rested with the dominant prescriber. Although EHC will be considered later as a possible opportunity for ethical engagement, for some it was symptomatic of their ethical passivity. Typifying this subordinate approach in relation to EHC was Hilary, who expressed religious beliefs about not wanting to sell EHC but who conceded that dispensing it was different and acceptable. In the following extended extract, Hilary describes her position to the interviewer:

Interviewer	[...]did you think of any examples of ethical things?
Pharmacist	Yea, the one I've got is doing EHC.
Interviewer	Okay
Pharmacist	I just don't like it. It's just something... I don't mind

dispensing it – it sounds weird - but I don't want to be the one that makes that decision.

Interviewer Right, that's interesting. Okay.

Pharmacist Some people won't even dispense it. I just can't sell it. I just can't bring myself to sell it. That's how I feel.

[...]

Interviewer There's various things from that, I guess that you are happy or happier to do it on prescription?

Pharmacist Yea, I'll let somebody else make that decision - but not me. I mean, maybe that's a cop-out, I don't know, but that's how I feel.

Interviewer Right. So you mean that presumably if the doctor's making the decision...

Pharmacist Yes

Interviewer In that instance?

Pharmacist Yes, and when it became that it was coming over the counter, I thought 'Oh, no, am I going to be forced into doing something...that I don't want to do?'

[...]

Interviewer I'm just curious in your rationale there, that if the doctor gives it out or prescribes it and it's okay, then it's somebody else taking that decision. So would you...are there other occasions when something else comes in – an overdose of medicine – would you still do the same thing?

Pharmacist No, no, I'd query that. I'd check that. Yea. I mean, you could say...I mean, some people would say that perhaps by dispensing it, by giving it out, that I'm assisting in that.

Interviewer Um.

Pharmacist But I don't...well. Perhaps I am but it...that doesn't worry me. No, but actually selling it would worry me.

What the extract indicates is the distinction – one that the pharmacist is certainly aware of – between supplying and dispensing EHC. She expresses considerable concern about such sales and felt she would be 'forced' to sell it when the OTC product became available but considered the act of dispensing it to be different. Her rationale appeared to be that if someone else was 'making that decision' to supply EHC, then she was somehow not responsible, even though she admits she may be 'assisting.' This seems to typify the ethically passive approach described in this study, of pharmacists

feeling absolved from ethical responsibility since, for them, the decision to supply EHC to a patient has shifted to another healthcare professional. In some respects this could be simply seen as another instance of subordination where pharmacists attempt to shift ethical responsibility onto another professional, as in Sharon's example, but in the case of EHC for some pharmacists, subordination leads to further passivity since they then actually dispense the product, complying with superior orders effectively. Subordination and passivity similarly emerged for Chris, who again distinguished between sales and supplies. For him, the concern was religious in nature and he had struggled with the ethical issue since the introduction of the contraceptive pill in the 1960s. Like Hilary, though, he argued that if the doctor made the decision, then such supplies would be acceptable and he went further in claiming:

'But I tend to feel that when I get a prescription, coming back to your point, that it's the doctor's responsibility ultimately and that I'm just a tool of the doctor really. I'm not happy with it, I'm passing the buck and not accepting the responsibility that I should be taking...'

Being a 'tool of the doctor' perfectly describes the subordination apparent for some pharmacists and Chris realised that, in such a position, in being passive, he is displacing his responsibility. In such situations, it is possible to see how subordination then removes the need to make difficult decisions and to confront difficult issues. Similar concerns emerged in previous research involving UK pharmacists and physician-assisted suicide (PAS) (Hackett 2001 Hanlon 2000). In these studies, around a third of pharmacists indicated that they would not want to know the purpose of medicines they were dispensing if intended to assist dying. The community setting

appeared to be particularly problematic and, as Hackett points out, despite it being a professional requirement to be accountable for one's actions such as dispensing a medicine, the dearth of communication opportunities may explain what amounts to a further example of pharmacists' ethical passivity, in not wanting to know about and so become responsible for medication dispensed for PAS.

6.5 ROUTINIZATION

So far, isolation and subordination have been developed as ethically relevant aspects of the community pharmacy environment and it has been argued that both have an impact in not only precipitating ethical problems for the pharmacists in this study but also in affecting pharmacists in their very ethical decision-making – in denying the emergence of norms and assistance due to isolation and in encouraging the displacement of ethical problems due to subordination. But what also emerged from the study, especially in chapter four, was that pharmacists often encounter ethical problems of a mundane nature – they lack the drama, as Brazier noted, of other areas of healthcare such as medicine. This is argued to arise due to the generally routine nature of community pharmacy work at present and in this section, the concept of ontological security is developed (Giddens 1992) and the example of EHC, already used in relation to subordination, is considered again as an example of possible ethical re-engagement in contrast to increasing moral sequestration of experience in society. However, although Giddens' concepts offer insights into why, psychologically, pharmacists might find security in routine tasks, it does so by focusing upon 'neon light' societal issues at the

expense of ethical aspects of such routine tasks. Using the metaphor of the endless rolling of the rock in the myth of Sisyphus for pharmacists' routinized work, it is argued, following Camus, that such tasks should be considered in terms of how they are dealt with and, as such, how ethical passivity and pharmacists' attitudes towards such tasks can be changed.

What emerged from the interviews with pharmacists was the sense that dispensing medicines was a central task in their work and as noted previously, that pharmacies are dispensing ever increasing numbers of prescriptions. Concomitantly, what has been recognised within many professions is a trend towards increasing de-skilling and proletarianisation (Braverman 1974, Ritzer 2002) and pharmacy appears to be no exception. Indeed, community pharmacy may be more susceptible than most to claims that it has suffered a 'degradation of work' and that previously skilled tasks such as the compounding of medicines are no longer relevant as medicines are pre-packed. Although it has been argued that pharmacy can develop the role of medicine supply in such processes as the symbolic transformation of drug into medicine (Dingwall and Watson 1995), further challenges to pharmacy exist in the form of checking technicians performing many of the existing roles that pharmacists presently undertake, the erosion of pharmacists' supervisory roles as remote supervision is debated and increasing computerisation. Pharmacists were asked about positive and negative aspects of their work during their interviews in this study, and most cited the pressures and workload associated with the dispensing process. However, in addition to the pressure, there was also a sense of repetition and monotony in many

pharmacists' work. As Sharon, who has only been qualified two years, recalled:

'It gets quite boring working in community pharmacy, sometimes. Especially when you've been here nearly two years, you tend to see the same prescriptions day in, day out. So I do get bored, [...] it's fairly monotonous with the prescriptions, I sort of know...I can tell you virtually what every one is, you know, because we have a surgery next day and we get a load of prescriptions around twice a day and it doesn't really change very much, only with the acutes that come through the door.'

Such comments were relatively common and emphasized the routinized nature of community pharmacy work. But how is this related to ethical issues and decision-making? Firstly, such routine work meant that many of the problems identified in chapter four were related to the dispensing process and this has already been developed as a theme. Secondly, it is argued that an environment of such routinized work is almost anesthetic in nature, and that pharmacists are performing what Amadika terms the 'tedious' task of dispensing and, crucially, tasks with few ethical challenges. As Phillip notes, the present routine of dispensing lacks any interest:

'At the moment, it's quite monotonous. You don't go to university...but obviously you're there for safety, that is [...] So as a result of that, you probably get a little bit bored [...] I need something to motivate me or interest me and you know, I mean I'm happy in my job but I need to strive for something. I can't just sit back and tick over – I'm not made of that, I'm made differently.'

But despite pharmacists' claims that the routine nature of dispensing was boring and monotonous, such routines may be considered in terms of the security that they offer pharmacists, even if this is not apparent to them. For Giddens (1991), for example, the concept of routine is important and he argues that it is one of the mechanisms by which

individuals gain ontological security in their lives. In undertaking activities that are routine in nature, free from anxiety and devoid of the difficulty of decision-making, such activities form a 'protective cocoon' and 'buffer' individuals from difficult decisions. Although Giddens is not concerned with specific groups such as pharmacists (although they form perhaps part of the apparatus of expert systems that could, for example, communicate medicine risks to individuals), he seeks to describe how the condition of late modernity affects all concerned. Pharmacy may be simply another group for whom routine is important in their lives. Despite comments such as those above about boredom and tedium appearing to indicate that pharmacists are unhappy with their present work, such work is nonetheless *safe* - safe in the sense that pharmacists may not need to make difficult ethical decisions. Giddens refers to such instantiations of decision-making as 'fateful moments' and he further defines these as 'moments at which consequential decisions have to be taken or courses of action initiated' (Giddens 1991 p. 243) They are consequential, not in a strict utilitarian sense, but in being decisions that may have important outcomes and there is also an underlying normativity in this definition for Giddens - they require ethical action and 'have to be taken' but to do so might lead to discomfort, anxiety or what amounts to an existentially experienced angst that might ultimately threaten the safety that routines and other systems offer the individual. It can be seen that Giddens' understanding of what is not only required by the moral agent but also how this might affect the moral agent, is similar to what was described in chapter five for those pharmacists who appeared to be ethically active. It resulted in uncertainty, doubt and concern but, according to Giddens, this is simply a consequence of being a moral agent and cannot

be avoided.

Is there not an inconsistency, though, in the assertion that the routinization of pharmacists' present dispensing tasks are inimical to ethics given that it has been previously argued in this study that ethical problems did arise for pharmacists in their routine work? How can one claim that ethical issues arise in the tasks that are routinized but then subsequently argue that such routines may be important in preventing confrontation with difficult ethical issues? One answer would be that pharmacists do encounter ethical problems in their work but due to their routine nature, they are not of the same magnitude as other ethical issues. For Brazier, this would mean not having to confront the high drama dilemmas that occur at the start and end of life, for example, and for Giddens, these would be distinguished from the central moral issues of late modernity - concerning madness, sexuality, criminality, illness, death and nature. In Giddens' analysis, individuals have become increasingly separated from these key aspects of life with their attendant moral issues. A moral sequestration of experience has occurred that, importantly, obviates the need for difficult decision-making. Routinization may then be seen as a mechanism that, despite claims of boredom and tedium, helps perpetuate a sense of security in pharmacists' work that results in the avoidance of difficult ethical decision-making but that still permits the occurrence of more trivial ethical problems as have emerged predominantly in this study. The 'protective carapace' of problem-free activities such as the routine nature of dispensing may explain why pharmacists are not ethically attentive, decisive or active, since doing so may rupture the cocoon of ontological security and expose them to the potential uncertainties of challenging ethical situations.

6.5.1 EHC, Ethical Engagement and the Myth of Sisyphus

Does the identification of routinized, ethically inimical work for pharmacist imply that pharmacists should therefore engage in other work in order that they can experience other ethical issues and foster ethical debate and understanding? Although Giddens is optimistic about a return of the repressed and of society's ability to re-engage with the key moral issues of late modernity (C. Smith 2002), does this mean that routinized aspects of life should be rejected in favour of more pressing concerns? As noted above, the identification of pharmacists' ethical problems as a 'morality of the mundane', as one that lacks the drama of other areas of healthcare, should not be thought of negatively since these are, ultimately, what pharmacists find problematic in their work. But a connection between routinization and ethical passivity has been established, nonetheless, and it would seem logical to conclude that having less routinized work may lessen the tendency of pharmacists to be ethically passive. Thompson (1982) recalls an anecdote about telling guests at parties that he is a writer and having guests often reply that they wished they could write, to which he then sarcastically replies that he wished he could perform brain surgery. The joke, he tells us, is that if people want to write they should simply pick up a pen and write, but those interested in brain surgery should be less hasty! The implication of routinization is not that pharmacists should be made to sit on ethics committees or become involved in every conceivable ethical debate (although these forms of engagement may no doubt be ethically rewarding) but that in recent developments such as EHC, for example, pharmacists

may be able to engage more intimately with ethical issues. These issues, as considered in chapter four, involve not merely legal or procedural compliance but, rather, more fundamental ethical concerns about the value of life, abortion, promiscuity and sexual health. Furthermore, in EHC it may also be argued that pharmacists are confronting one of Giddens' key moral issues in late modernity – sexuality - more directly and openly. The need for direct contact with those requesting EHC sales, for example, might reduce the isolation pharmacists experience and the temporally fleeting nature of many OTC requests. Despite reservations about the physical pharmacy environment for some and concerns about privacy, EHC might offer pharmacists the opportunity to address issues that do not begin and end in what might be legally or procedurally permitted.

Of course, it could be argued that sexuality is not the only relevant morally sequestered aspects of modern life as defined by Giddens, and, for example, are not pharmacists already dealing every day with issues relating to the other areas such as illness, death and mental health? Whilst this is true in some respects, and examples have been provided of pharmacists' concerns about supplying palliative medication to the terminally ill or compliance aids to those with dementia, these appear not to have generated significant ethical debate. In relation to the terminally ill, pharmacists' concerns were often about the legality of prescriptions for their palliative medicine and, for elderly patients with dementia, concerns often focused upon policies such as re-dispensing medicines and remuneration. In this respect, pharmacists may be no different from other health and social care professionals in needing to re-address the more fundamental ethical aspects of their work and not succumb to the security of

legal and regulatory controls (C. Smith 2002, Bellah 1994, Parsons 1998).

This may also be seen in some ways as a ‘push and pull’ effect and that the failure of activities (such as supplying medicine to the terminally ill or those with mental health problems) to engage pharmacists ethically may be explained not because such issues are ethically unchallenging and lack a ‘pull’ but rather that pharmacists are not ‘pushed’ to explore relevant ethical aspects of such issues. Hence, the characteristics indicated in chapter five – ethical inattention, a lack of confidence in decision-making and self-interest - may explain why pharmacists do not engage with such ethical issues. EHC appears to be different for several pharmacists in this study and would appear to have generated ethical thought and concern and may be seen as a form of ethical re-engagement, even if for some, this is because it has represented a challenge to existing religious beliefs that stem from this, such as the perception that EHC is related to promiscuity, for example.

What becomes apparent is that it is not simply a case of exposing pharmacists to particular issues that might have ethical import but giving attention to more fundamental concerns that emerged as failures of ethical activity in chapter five. To extend Thompson’s analogy, one cannot let the would-be brain surgeon loose without giving them the skills in anatomy and surgery. As was the case with PAS, pharmacists and especially those in the community pharmacy setting, appeared to be ethically passive in relation to an issue that is of considerable ethical importance.

Although addressing fundamental existential and hence metaphysical assumptions about existence, Camus’ *The Myth of Sisyphus* (1975) has relevance to the present

concern about routinization. In an obvious sense, the myth itself invites comparisons with pharmacists' monotonous, tedious and boring work in dispensing prescriptions, as Sisyphus is condemned to roll a rock up a mountain in Hades only to have it roll back again and the task endlessly continue. One could also add that Sisyphus' blindness may be another metaphor for pharmacists' inattention, but it is in Camus' interpretation that an insight may be gained from the story. For Camus, the myth was a metaphor for life and he argued that although life may be futile and absurd, it is in one's attitude to life's vicissitudes that meaning emerges. Sisyphus was the absurd hero in his endless task in the underworld. What Camus' interpretation reveals is that it may be in pharmacists' ethical attitude to their routine tasks that one should look, rather than in trying to offer pharmacists' more high drama ethical issues to consider. Of course, Camus' claim was that the search for meaning and consciousness of another type of existence is futile but, in his conclusion that '*one must imagine Sisyphus happy*' in his task, this may be extended to a concern about how pharmacists can be ethically prepared for the tasks that presently face them.

Routinization appears to impoverish the ethical landscape and consequently negates the need to be ethically active in resolving ethical problems that arise. But it is not absolute, and ethical problems as described in chapter four still arise, even if of a predominantly legal nature, and evidence of ethical decision-making was identified, even if of a predominantly passive nature. Re-engagement with ethically relevant and significant issues is important in stimulating ethical debate and encouraging decision-making but it may not represent a panacea and may be useful only if other issues relating to pharmacists' ethical passivity are addressed. So, in considering Giddens's

use of routine as it relates to the concept of ontological security, a greater understanding and explanation of pharmacists' passivity emerges. Just as many pharmacists found legal rules and procedures to be important in resolving ethical issues since they offered a 'black and white' certainty to decisions, the prevalence of ethical issues in the routine tasks of dispensing medicines may be seen to be a further mechanism of security, in ensuring that uncertainty or anxiety – the consequences of the ethically active individual – are avoided. But, whilst EHC might offer pharmacists the opportunity to explore ethical issues and become ethically active, it does not follow that engaging in these or similar ethical problems would prevent ethical passivity. As the case of PAS showed, pharmacists' views were ethically passive and did not appear to reflect ethical engagement with such a topical and ethically significant concern within healthcare. Being more ethically aware of existing issues would appear to be just as important and, although routinization may explain pharmacists' security and passivity in such mundane tasks as dispensing, embracing such Sisyphean tasks may, following Camus, be necessary and rewarding. This does not necessarily conflict with Giddens' claim that individuals are increasingly morally sequestered in their experiences, since in the routine tasks, ethical issues are present but pharmacists merely appear to be inattentive to them. In issues relating to palliative care and mental health, for example, it may require pharmacists only to see beyond the self-interest of legalistic concerns and procedure to embrace issues relating to the care of the dying and those with mental illness.

6.6 CONCLUSIONS

In this chapter, the intention has been to offer a description of the community pharmacy environment that is not necessarily complete but rather one that offers greater understanding of the ethically relevant features as they have emerged from this study. These have occurred both in an explicit form as they were identified by pharmacists but also as they emerged from analysis of interviews to reveal aspects of community pharmacy work that were not immediately apparent. So, in the case of isolation, for example, whilst pharmacists identified a sense of professional isolation, various processes that isolated pharmacists from customers and patients became apparent over the course of the study. Similarly, the identification of subordination was recognised by some pharmacists in relation to doctors but in the identification of various atrocity stories, more widespread evidence of pharmacists' subordination also became apparent. The aim has also been to indicate how the emergent themes from the community pharmacy environment are relevant to the overall ethical concerns of this thesis and it has been a key task in this chapter to consider *why* aspects of the community pharmacy setting impinge upon the ethical activity (or more accurately, inactivity) of pharmacists. To summarise, isolation has been argued to result in anomie and lead to the community setting being an area of the pharmacy profession that may be bereft of ethical norms and values and guidance. A resultant, relative absence of communication precludes ethical discourses that could assist in ethical decision-making. Isolation, furthermore, may prevent the formation of closer relationships with customers and patients, which may in a psychological sense lead to a lack of ethical

concern and also impede the development of patient narratives that, in the field of nursing, have been argued to be necessary for ethical practice. Subordination has been argued to offer some pharmacists a convenient solution to ethical issues that they might be able to assist with, by ceding responsibility to doctors *qua* prescribers. Finally, in the routinization of tasks, pharmacists may gain a sense of security in the repetitious dispensing of prescriptions and, despite a sense of boredom, are therefore freed from confronting ethically relevant problems in their work. Ethical engagement with vital ethical issues relating to sexuality, illness and mental health may be important in generating ethical thought and decision-making but this can only occur if existing problems are addressed. Routinization may lead to ethical passivity but it is one of but several causes in the pharmacy environment. In championing pharmacists' engagement with ethically important concerns in healthcare and society more generally, the baby should not be thrown out with the bath water, so to speak, and the ethically important aspects of existing work need to be addressed by pharmacists becoming more ethically active. Ethical passivity, then, may be partly understood by these aspects of the community pharmacy environment: isolation may lead to anomie that, according to Habermas, means increasing reliance upon legal structures (or codes as Bauman understands modernity) that are not effective replacements for ethical discourse and ethical activity; pharmacists' separation from patient and customer is inimical to ethical attention and even if ethical attention requires a more sustained and comprehensive attitude to ethical activity according to Murdoch or Blum, the resultant lack of proximity is detrimental to pharmacists being ethically attentive in their work; subordination is argued to allow some pharmacists to be ethically passive and avoid

taking responsibility for some decisions and, instead, often requires doctors to take ethically responsibility; finally, routinization encourages ethical passivity since it frees the ethical agent, according to Giddens, from the uncertainty associated with difficult ethical choices, as the ethically active agent would be required to face.

What might be apparent to the reader, however, is why commercial aspects of the community pharmacy setting have not been considered as a distinct theme alongside isolation, subordination and routinization in this chapter. Firstly, this has already been done to some extent in the thesis and in chapter four, for example, several ethical issues were identified that related to pharmacists' concerns about the financial and ethical conflicts in their work. Indeed, a specific question was included in the interview schedule (appendix four) to explore whether pharmacists found the commercial nature of community work problematic. Overall, the response was a negative one and this would appear to contrast with the findings of Latif, for example, who hypothesised that community pharmacists, in displaying lower levels of CMD and DIT 'p' scores, might have undergone a socialization process in entering the community pharmacy setting (Latif 2000a). So, secondly, whilst it would appear that some pharmacists, and especially those who were proprietors, made decisions that gave primacy to commercial rather than ethical concerns, this did not appear to be a significant theme overall and indeed several pharmacists challenged the claim that pharmacists were financially driven or mere 'shopkeepers'. The commercial nature of community pharmacy is unavoidable in the sense that it *is* the environment in which pharmacists work and it was impossible to ignore, upon entering pharmacies to

conduct interviews, the promotional displays, the large range of non-medical goods and toiletries, the '99p' floor bins full of discounted items and the tills, but in relation to how this related to the ethical concerns of this study, it appeared to be far less significant than the three key concerns developed in this chapter. Hopefully, it has been shown that isolation, subordination and routinization are important issues in explaining why pharmacists not only encounter the ethical concerns that they do but also attempt to resolve them.

In the next and final chapter, an attempt is made to bring together the findings and emergent themes of this thesis and to present not only some conclusions but also indicate the relevance and significance of these to pharmacy and health care more generally.

7 CONCLUSIONS

7.1 INTRODUCTION

In this final chapter, I will summarise the main findings of this thesis, offer several conclusions and consider the implications of this research for not only pharmacists and pharmacy practice but also healthcare and society more generally. I will identify possible limitations to the thesis, indicate areas of further research and provide further reflexive insights into the research.

It is hoped that this thesis has provided unique and important insights into the nature of ethical issues in UK community pharmacy and that these offer a significant contribution to the pharmacy literature. The main conclusions of this thesis are that community pharmacists encounter a range of ethical problems in their work but that these often involve the routine, legal or procedural minutiae of community pharmacy practice. As such, it may be more appropriate to consider these as quasi-ethical problems rather than dilemmas since they often involved an ethical value and a legal, procedural or financial issue rather than rival ethical values or normative conflicts. The centrality of law for many pharmacists in this study was striking and law appeared not only to be synonymous with ethics for many but it also defined and decided many problems identified in pharmacists' practice. The concept of ethically passivity emerged as an appropriate description of pharmacists who were ethically inattentive, concerned with self-interest and who did not engage in ethical action. However, aspects of the community pharmacy environment, such as pharmacists' isolation from

peers, professionals and public, subordination to doctors and routinized work, appeared to precipitate ethical problems and contribute to ethical passivity.

Before considering a number of specific conclusions, limitations and ethically relevant potential changes to pharmacy practice from this thesis, I want to first of all reflect upon the overall research process and consider several additional insights that will offer a transparent and reflexive account of this research.

7.2 REFLEXIVITY

This thesis has involved an attempt to be reflexive about the research process and in chapter one, for example, I indicated how my own experiences of community pharmacy practice influenced the research and research questions and, in chapter three, how decisions, changes and revisions to the research process occurred. In this section, however, I want to focus upon a number of additional experiences from the research and reflect upon how these reflexive concerns had relevance to the overall research process, too.

In particular, I want to address the issues of my own development during the research and also how the findings from this thesis could be located within my own understanding of ethics and pharmacy practice. As noted in chapter one, I do not subscribe to the notion of value neutrality in the research process and believe that it is important to recognise how my own educational and professional background and assumptions about ethics and the construction of knowledge have shaped and, significantly, been shaped by this research.

Developing the first point about how the findings of this research could be accommodated in my own experiences, a reflexive concern emerges - and one that may be apparent to a reader comparing, say, chapter one with chapter four of this thesis, for example – that my own ethical concerns as a practicing pharmacist did not appear to be reflected in those of the cohort pharmacists interviewed. It may be questioned, therefore, whether I was surprised or even disappointed in finding legalistic and procedural ethical problems amongst many of the cohort pharmacists, for example, or in often identifying only basic forms of ethical argumentation and justification. To return to the analogy with Conrad's *Heart of Darkness* briefly (although I will make further comparisons at the end of this thesis), was there a concern similar to that experienced by Marlowe, when he realises that his search for Kurtz revealed something less than he had expected? He admitted that:

There was a sense of extreme disappointment, as though I had found out I had been striving after something altogether without a substance. (Conrad 1902 p.67)

For Marlowe, this disappointment arose because of the disparity between what had been reported about Kurtz and what he actually saw. To some extent, this perception mirrors my own concerns and surprise and this may have arisen because my review of the empirical pharmacy ethics research literature had revealed studies that had *not* asked questions such as: how do pharmacists understand ethics issues, and were there different approaches to resolving such issues in their work? What the published literature did not indicate, for example, was whether pharmacists were forthcoming or not in their responses and their ability to talk about ethical concerns. Hence, an initial

sense of disappointment did arise in relation to some of the interviews in this research since several were very difficult to conduct in terms of eliciting the participating pharmacist's experiences of ethical concerns in their work and to having them reflect upon how they dealt with problems. Although this will be considered later in terms of study limitations, I did consider using not just prompting about possible areas of ethical concern but actual hypothetical vignettes. Looking back at this decision in the research process, despite the difficulty of some interviews, I believed it was important to continue to ask what did pharmacists understand by, and experience as ethical issues in their work, and that this was justified since it revealed hitherto unidentified issues such a legalistic conception of ethics and self-interest.

In the earlier interviews, my sense of disappointment with an interview was perhaps more noticeable but I attributed this to anxiety about my research skills, manifest in a number of concerns: since my research background prior to this had been quantitative, laboratory-based pharmacy studies, I was worried that my skills at qualitative techniques such as semi-structured interviewing might have led to interviews being difficult; I also recall feeling an impatience and that I wanted obvious themes to emerge following interviews, which in hindsight I think resulted from an anxiety about the analytical stage of the research since this, again, was not a research approach I had previously used. Looking back over the research process, these anxieties were probably misplaced and occurred as a result of my initial inexperience: later interviews did not necessarily lead to increased responses from interviewees, despite my becoming more confident and experienced at interviewing as the research progressed, for example, and, as the next reflexive concern hopefully indicates, understanding how

the theoretical literature was of value in interpreting and analysing the interview data was an important stage in the process for me.

In addition to my developing skills in qualitative techniques during the research process, a further reflexive concern involved my increased theoretical understanding of the ethics literature. In particular, I want to consider how this knowledge informed but was also informed by, the research and data over the course of the three years of this research. I was conscious at the early stages of the research (before beginning recruitment and interviewing) of holding onto a more rigid understanding of ethics and moral philosophy generally because of my training in what could be described as the normative Enlightenment traditions in medical ethics. These are reflected in some of the theoretical positions considered in the first part of chapter two and, specifically, the centrality of rationality and typified by the influence of utilitarian and deontological ethical positions, for example. However, it was obvious early in the research that in undertaking this empirical ethics research that I would need to consider not only the direct empirical literature but also a meta-ethical concern about the place of empirical research. This was, in part, an intentional intellectual task that was informed by a review of the literature but it was also driven by the emergent data and by the need to account for themes such as the influence of law, for example. But conversely, I believe that the commentaries on 'late modernity' offered by writers such as Bauman, Giddens and Habermas, for example, were an influence upon the research and the further interpretation and understanding of the data. In recognising the influence of these accounts of the place of ethics (and law) in society, I do not mean to suggest that they

fully explained the data or accounted for my disappointment but simply that they revealed to me additional insights that were relevant in analysing and interpreting the data.

A further example of where my reflexive concern for the influence of the theoretical literature was relevant to the research concerned my decision *not* to rely upon CMD, despite its popularity in the empirical ethics literature. My reservations about the often neglected but fundamental normative assumptions upon which CMD is based - that a justice-based form of reasoning was the ultimate stage of development according to Kohlberg - led me to doubt whether this theory could be used solely as a basis for this research. Of course, I was also concerned that using this approach would not fully answer the research questions in terms of revealing more situated and subjective insights but, like Holm (1997), I doubted whether this approach could offer a comprehensive account of ethical reasoning. But not focusing upon CMD also influenced how I analysed and contextualised the data and emergent themes and this was apparent in the case of pharmacists' legal problems and legalistic self-interest. I recognise that I have not referred to CMD in explaining the significance and influence of law for many pharmacists, despite this being a feature of the lower, pre-conventional and conventional stages of moral reasoning of CMD, involving egoistic self-interest and a concern for law. Considering the similarities between this research and the lower stages of CMD reasoning could perhaps have been explored more but given the scope of the thesis, I made a decision during the analysis of the interview data not to engage in what I considered to be a more theoretical line of discussion. However, I recognise that this could be pursued in further research, perhaps at the level

of meta-ethical discussion.

By considering the reflexive concerns identified above and in other parts of this thesis, I hope that this will provide a transparency to the research and help illuminate stages of the research such as the framing of the research questions and the analysis of interviews. In the next section I want to consider some of the implication of the research for pharmacy practice and then, in the remainder of this chapter, go on to identify in terms of praxis, a number of more specific changes, followed by the limitations of the study and opportunities for further research.

7.3 EDUCATION

The findings in this thesis have relevance to several issues in ethics education for pharmacists. Many undergraduate professional courses now include some form of ethics instruction (Illingworth 2003, Doyal and Gillon 1998) and the RPSGB, too, recognises that pharmacy teaching should involve ethics so that ethical problems in pharmacists' practice can be dealt with appropriately. In the pharmacy undergraduate course, for example, one of the pharmacy degree accreditation 'outcomes' is for a pharmacy graduate who:

Is able to recognise ethical dilemmas in healthcare and science, and understands ways in which these might be managed by healthcare professionals, whilst taking account of relevant law. (Royal Pharmaceutical Society 2003)

Furthermore, the Quality Assurance Agency for Higher Education document (2003)

relating to benchmarks in pharmacy education similarly refers to ethics and makes several references to the need for pharmacy graduates to gain an understanding in ethical issues and decision-making.

The findings of this thesis may be relevant to the teaching of ethics in pharmacy in a number of ways. In one respect, it may allow those involved in teaching ethics to be more aware of the ethical problems that actually occur in practice. This, according to Holm, might make ethics instruction more effective and he notes that ‘knowledge about the types of ethical problem that students are to meet in their daily practice is also important [...]’ (Holm 1997 p.32). This may be achieved by including realistic scenarios in ethics teaching that have been derived from empirical ethics research, such as this thesis. This has, in fact, been one of the main aims of previous research such as Hibbert *et al* (2000 and Derek Hibbert personal correspondence 2004). The importance of exposing students to what are thought to be ethical problems that relate to practice may, however, be potentially problematic. A number of the more recently qualified pharmacists in this thesis noted that they were provided with scenarios and asked to make an ethically justified decision about them but what were often recalled were the emergency supply scenarios or, as Julian noted in chapter four, the paradigm incorrectly written controlled drug prescription. Perhaps there is a danger of the self-fulfilling prophecy (Merton 1957) in the use of such situations and that, in only being able to offer student pharmacists a limited number of scenarios, might these therefore come to dominate and shape how they ‘see’ ethical problems in practice? Hopefully, this thesis has illustrated not just the range of ethical issues experienced by pharmacists but, importantly, argued that many are quasi-ethical problems and may not

be the most appropriate type to use in undergraduate pharmacy ethics education. But this thesis has also identified examples of ethical problems that *do* involve conflict of rival ethical values or concerns and these may be of relevance to ethics education.

In another respect and perhaps more importantly, however, the findings of this study might be used to consider whether changes to pharmacy ethics teaching are required. Although specific educational reforms will be considered later, in the section on praxis, two general points are relevant here. Firstly, this thesis reflected existing attempts at teaching ethics, as identified in the comments made by pharmacists about their undergraduate education. These comments were almost always negative, unfortunately, and as was indicated, pharmacists either recalled little specific ethics instruction or noted that what was provided was of limited relevance to practice and was often legal rather than ethical in nature. Secondly, in addition to these direct reflections on pharmacists' ethics education, could it not be argued that the emergent theme of ethical passivity that characterised many pharmacists in this research might be, even in part, attributable to how pharmacists were taught as undergraduates?

Unfortunately, the questions of how effective ethics teaching is and how it could be measured have been problematic and there appears to be little consensus about how ethics education could actually be assessed in terms of its success in influencing practice (Molyneux 2001). Approaches such as measuring ethical knowledge skills (Sulmasy *et al* 1997), sensitivity (Mitchell *et al* 1993), confidence (Molyneux 2001) and problem solving ability (Savulescu *et al* 1999) have all been proposed but this may be an area that requires further research. In spite of this potential difficulty in assessing the effectiveness of ethics teaching, it is argued that the findings in this thesis and, in

particular, the emergent theme of ethical passivity and pharmacists' synonymous understanding of law and ethics may reflect problems in how pharmacists come to understand ethics. In presenting some of the findings of this thesis to academic pharmacy audiences (Cooper *et al* 2006), there has been considerable discussion and interest in how the emergent themes of this thesis may be used to develop or change how pharmacists are taught in relation to ethics, particularly in terms of how legalism and isolation could be avoided and these are concerns that I will address more specifically in terms of praxis later in this chapter.

One further pedagogical issue that emerged was that none of the pharmacists in this thesis had undertaken any post-graduate ethics education and, given the lack of any substantive ethics education as undergraduates and especially amongst older pharmacists, a resultant lacuna in terms of ethical instruction may exist. Hence a further implication from this thesis is that an assessment of ethical educational needs is required at a post-graduate as well as undergraduate level. Post-graduate ethical training has been used with doctors (Molyneux 2001) but although a continuing education course – *Evidence-based practice: dealing with dilemmas* – is provided by the Centre for Pharmacy Postgraduate Education (CPPE), this course does not appear to be widely available (2006 Dave Dunning, CPPE personal correspondence). Interestingly, in the course's description, a number of RPSGB competencies are used but one that is surprisingly omitted is that of 'making decisions and solving problems' (CPPE 2006 p. 27).

7.4 PHARMACY, HEALTHCARE AND SOCIETY

It is also possible to reflect on whether there is something more fundamental involved in why pharmacists recall little ethical education and why ethics is frequently understood as law and legalistic self-interest and also why ethical passivity was identified. It would be naïve to assume that ethical understanding and decision-making ability could be completely gained by education alone and so it would be inappropriate to single out education. Perhaps just as relevant may be the more general sociological claims that, as were described in chapters two and six, individuals in society are being increasingly regulated for in terms of legislation (Habermas 1987) and codes (Bauman 1993) and that these result in a predictable, secure ‘black and white’ approach to practice that avoids the need for pharmacists to confront ethical problems and make ethical decisions. Education is not necessarily exonerated in this alternative view, and it may be that if such philosophical and sociological accounts of the increasing erosion of the ethical in individuals’ lives are correct - as not only Bauman and Habermas but also Giddens (1991) and C. Smith (2002) suggest - then education may perhaps have some role to play in developing re-moralization or stimulating value awareness (Cribb and Barber 2000).

Considered in this way, this thesis and the ethical passivity and legalism identified may be representative of, and support claims that, late modernity – and perhaps particularly Western liberal culture – is a time of ever eroding ethical relevance. It is beyond the scope of this thesis to comment more fully upon the attendant socio-political issues that might arise from this - about what Habermas (1987) terms

juridification (verrechtlichung) and Giddens (1991) argues requires *life politics* - but what this thesis perhaps illustrates in pharmacists' passivity and legalism is a microcosm of broader social trends.

It is also hoped that this thesis and the emergent findings may be relevant to healthcare and in particular to concerns about the relationship between pharmacists and doctors, for example, and also to whether primary care is sufficiently integrated. Again, these are not inconsiderable issues that go beyond the scope of this thesis but the emergence of subordination and isolation as being inimical to an ethical approach to community pharmacy may be of concern to the most effective delivery of services to patients and the public. Potential changes to pharmacy practice and healthcare generally are considered later in this chapter but it is argued that subordination may be relevant to other paramedical professions and ethical isolation may affect not only pharmacists but also other primary care practitioners who work alone. In England for example, 6.2% of general medical practitioners work 'single handed' without a medical partner (Department of Health, 2005) and this research raises the possibility that some practitioners may be, like pharmacists, ethically isolated 'islands', too.

7.5 CODE OF ETHICS

Another implication of this research concerns the code of ethics for pharmacy and, in particular, the debate as to the relevance of a code (Deans and Dawson 2005) and whether a change from a rule-based code to a principle-based one is needed (Royal Pharmaceutical Society 2006b). As noted above, education is not the only way in

which ethical values and guidance can potentially be communicated and transmitted and it is also a function of professional codes of ethics, which have proliferated and gained popularity in recent years (Veatch 1978, Gorlin 1995). However, in addition to the normative claim by Bauman that increasing codification is a negative societal attribute, the findings in this thesis represent a further, empirical claim that may undermine the relevance and use of a code of ethics for pharmacy. It appeared that the present pharmacy code of ethics was, rather like ethics education, both unhelpful and unmemorable for the pharmacists interviewed. As chapter five indicated, little of the content of the present code could be recalled and few pharmacists identified it as being of any assistance in ethical decision-making or in guiding their practice. The findings from this thesis, coupled with similar findings in other studies (Holm 1997, Hibbert *et al* 2000, Chaar *et al* 2005), suggest that codes, in general, may not be an influence for pharmacists and other health care professions.

However, it may be argued by supporters of a change to the pharmacy code of ethics that evidence of the code's unmemorable and unhelpful nature, such as has emerged from this and other research, simply reflects a problem with its *present* form and hence a change to the code – such as to a principle-based code, for example - is necessary to make it relevant and beneficial to pharmacy practice. It is argued that the findings of this thesis do not support even a *revised* code since many pharmacists in this thesis struggled to identify and also articulate ethical concepts or values and an overall ethical illiteracy and inarticulacy appeared to limit many pharmacists' ability to discuss ethics issues or reflect upon the decision-making process. Hence, the content of an ethical code simply may not be understood and subsequently used in practice. The

work hands in John Irving's *The Cider House Rules* (1993), for example, were unable to understand the list of rules made for them because of basic illiteracy and for them to 'read' the rules would have meant acquiring fundamental skills. The analogy to pharmacy is that comprehension of a code may be limited by a lack of understanding of the basic concepts contained within it. A further concern relating to the relevance and use of a code of ethics that emerges from this thesis is that, especially in the form of a principle-based code as the RPSGB proposes, pharmacists must be able to balance and choose from potentially competing principles and this ability was not identified in this thesis. The RPSGB note that a revised code would include 'basic ethical principles which practitioners would apply to their own circumstances in accordance with their professional judgement' (Royal Pharmaceutical Society 2005b p. 466). However, this statement assumes that pharmacists can 'apply' the principles correctly and can engage in the appropriate balancing of rival principles. Even if pharmacists were able to recall or even understand a principle in a code (which appears not to be the case with the present code), the findings in this thesis undermine the case that pharmacists may be able to successfully balance potentially competing principles – as can often occur in practice – and so apply them appropriately to ethical problems in pharmacy.

So, despite the popularity of codes of ethics for many professions and, increasingly, organisations (Stevens 1999), they may be undermined by empirical research such as the findings of this thesis. One frequent claim, however, is to suggest that codes have a place but *alongside* other forms of ethical communication (Stevens 1999) or ethical argumentation (Pellegrino 2001). These claims may be more compatible with the findings of this thesis, which has identified a dearth of ethical communication that may

be related to pharmacists' isolation and also ethical reasoning. In recognising the importance of more fundamental issues relating to how ethical values and norms are communicated in a profession such as pharmacy and to addressing more basic claims about how professionals like pharmacists come to reason in an ethical way (as opposed to a legalistic way, for example), it may be possible to find areas of potential change to pharmacy practice that would avoid the pessimism of, say, Bauman's post-modernity and an absolute distrust of codification.

7.6 ADDITIONAL ROLES

One further and significant implication for this thesis concerns the current changes to practice in UK community pharmacy. Although this research was undertaken at a time when the new NHS contract for pharmacy in England was being introduced, it was unfortunately perhaps too early to identify ethical concerns with the enhanced and extended roles that are proposed for pharmacy. All empirical research and even longitudinal studies are located within a particular time frame and need to be understood in terms of this temporality. However, this does not mean that they cannot have relevance or offer insights into later or proposed issues and it is argued that this thesis may be relevant to the possible new roles and services for UK community pharmacists. In one sense, this research threatens possible changes to practice because, in the proposed roles that might involve supplementary prescribing, medicines use reviews (MURs) and access to medical records amongst other developments, pharmacists' ethical passivity, subordination and legalistic approach may not be

conducive to undertaking such tasks. Issues relating to distributive justice, confidentiality and professional autonomy are immediate ethical concerns that might arise in the new roles identified but, as this thesis has considered, ethical inattention and a propensity to identify with legal rather than ethical issues may mean that pharmacists do not identify or deal with the additional ethical responsibilities of these new roles.

In another sense, however, it has been argued that the routinization of existing community pharmacy tasks may be preventing pharmacists from engaging in ethical issues fully and that, in what might appear to be a contradiction to the above point, pharmacists should try to undertake less routinized and more ethically challenging work. But as the previous chapter illustrated, the apparent contradiction in this statement can be avoided, however, if attention is focused upon more fundamental concerns in relation to pharmacist's ethical understanding. If this can be addressed and ethical passivity avoided, then not only might existing pharmacy tasks be seen to contain hitherto unseen ethical aspects but also that the additional role for pharmacy may be dealt with in an ethically sensitive and appropriate way.

7.7 PRAXIS

As noted in the introduction to this thesis, much health service research is directed at potential policy change and although this thesis did not set out to study changes to practice, it may be helpful to consider how and where ethically relevant changes could be made to UK pharmacy practice. In this section I want to argue that, in addition to

the concerns already noted about education, codes and new roles, a number of more *specific* changes to UK pharmacy should be considered that might be ethically significant. These build upon the issues already identified such as pharmacists' education and communication but with a focus upon increasing the amount of interaction that occurs and promoting ethical debate more effectively.

7.7.1 Integrating undergraduate ethics training

Concerns have already been raised in this chapter about how ethical understanding and awareness could be developed pedagogically and it was argued that a less legalist approach was needed to avoid the propensity of pharmacists to see legalistic problems and solutions in their work. In addition to these concerns about the *content* of a pharmacy course is the more general claim, and one that relates to the emergence of isolation in this thesis, that pharmacy undergraduate training should be more integrated with other healthcare professions' training – such as medicine, nursing and dentistry, for example. By doing so, pharmacy students would have the opportunity to interact with students of other allied disciplines at an early stage and gain insights into not only ethical problems that occur in other areas of healthcare but also how these may be ethically debated and resolved in other disciplines. Increasing interaction specifically in the area of ethics is by no means a new idea and Hanson (2005), for example, has argued using American nursing and medical student cohorts as an example, that three key benefits would result: increased awareness of different healthcare professions' unique insights into ethical problems, increased collaboration and, significantly given

the emergence of subordination in this thesis, a reduction in ‘deference’ and the ‘desire to avoid making difficult ethical decisions’ amongst nursing cohorts (Hanson 2005, p.174). In practical terms and of relevance to how this might be achieved in pharmacy, Hanson notes that barriers to educational integration exist in terms of distinct ethical textbooks for different healthcare professions that encourages separateness and the logistical difficulty of trying to organise two curricula that might teach ethics at different stages of training and with different staff – staff, furthermore, who may not have specialist ethics or philosophical training. Although the former point may be challenged by the availability of many general health care ethics textbooks, the latter point may be significant and was one of the recommendations made by Wingfield, Wilson and Hall (2006) who argued that, like BMA proposals for medical education, recruiting a specialist healthcare ethics lecturer (or utilising those in a philosophy department) could develop and enhance the teaching of ethics.

Integrative approaches to healthcare education have become more accepted and these have increasingly challenged a tradition of education along ‘discrete occupational lines’ (Elston 2004). An important aspect of this integrative approach is that it may be significant in the professional socialisation process and may even help develop a healthcare culture that recognises the interdependency of different professions such as pharmacy, medicine and nursing and may inculcate a greater desire for interaction and communication. Whilst this is argued to be ethically beneficial to pharmacy students, practicing pharmacists would not gain but there may be other changes that could be ethically relevant and these are now considered.

7.7.2 Increasing professional interaction and communication

Linked to the concern about isolation and an associated anomie and lack of communication identified in the previous chapter, how can pharmacy practice be changed to facilitate more interaction and communication? One possibility would be to change the work arrangements within pharmacies and, specifically, encourage more than one pharmacist to work at a pharmacy at one time, as is currently the norm.

Although perhaps at odds with the current debate about supervision and developments such as remote supervision (Bellingham 2004), having pharmacists working together rather than in separate pharmacies may allow for greater debate and assistance - clinically, professionally and ethically. This would help allay the concerns of many pharmacists in this research that they were alone in their work and ethical decisions and had no one to discuss ethical issues with.

Although it was recognised that pharmacists who had already qualified would not benefit from integration of undergraduate ethics training, changes could be made to post-graduate education and specifically ethics. In addition to promoting a specific continuing education ethics course, as already noted in this chapter, developing continuing education ethics programmes that were suitable not just for pharmacists but also doctors, nurses, social care workers and others working in primary care may allow for increased communication and perhaps the benefits that Hanson (2005) noted. The ability to gain insights into the ethical perspectives of other healthcare professionals and how they try to resolve ethical problems could be valuable for pharmacists'

decision-making. In addition, it could offer insights into complex issues such as medical subordination by allowing dominant medical professionals to see how ethical problems result from hierarchical healthcare arrangements.

One further opportunity for postgraduate ethics training exists in the form of taught courses in healthcare ethics offered by several universities. Perhaps more could be done to make pharmacists aware of such courses by advertising in publications such as *The Pharmaceutical Journal* or in pharmacy departments or through employers and for such courses to be accredited for continuing professional development.

7.7.3 Raising the profile of ethics in the pharmacy literature

A final form of praxis, and once that is related to the point made above about advertising, is that more should be done to increase pharmacists' understanding of ethics and encourage debate and thought through the available literature. Although publication such as *The Pharmaceutical Journal* and *Chemist and Druggist* have previously included occasional articles on ethical 'dilemmas' (Royal Pharmaceutical Society 2001), more should be done to provide a regular feature, focusing upon ethical debate and even normative philosophical approaches. *The Pharmaceutical Journal* does provide an occasional 'Law and Ethics Bulletin' but this often focus's upon practical and legal or procedural aspects of pharmacy practice rather than ethical issues or broader ethical concepts and theory. An allied concern is that pharmacy lacks a dedicated ethics journal (in contrast to medicine and nursing, for example) and this is an area of change that could be ethically relevant. Although it may be argued that

practicing pharmacists would not have routine access to academic journals, creating a literature forum such as a pharmacy ethics journal would provide the catalyst for not only more pharmacy ethics research but also the ability of such research to inform practice in relation to ethical concerns.

7.8 LIMITATIONS AND FURTHER RESEARCH

Having considered several reflexive concerns, the relevance of this thesis to pharmacy practice and possible changes, I want to consider a number of limitations of the study and also indicate where additional research may be required as a result of this thesis.

Two limitations, in particular, which I want to consider and which I believe will allow the data and themes of this thesis to be understood and contextualised more fully involve the decision not to use hypothetical ethical scenarios in interviews and the possibility of more positive responses amongst the eventual pharmacist cohort.

In relation to the first limitation, my research questions were about the actual ethical problems that community pharmacists encountered in their work and how they tried to resolve them but I realise and want to make clear the possibility that pharmacists might have resolved *different* ethical problems (to the ones they actually identified in interviews) in a *different* way. The emergence of a legalistic and ethically passive approach to decision-making may only reflect the fact that this is how the pharmacists in this study would try to resolve problems of a quasi-ethical legal and practical nature, as was often the case in this research. This raises the question of whether hypothetical ethical vignettes or scenarios would have resulted in different findings and could have

been used to explore ethical decision-making more fully. As noted, such an approach was used by Holm (1997) and other research has also suggested that the type of ethical problem might determine the type of ethical reasoning used by individuals (Walker *et al* 1987). But such research arguably only offers insights into how decision-making or reasoning occurs in relation to these, different, ethical artifices. This does not make the present research better, however, and I recognise that what emerged from interviews in this research were perhaps reconstructions and re-interpretations of ethics concerns and reasoning (Haidt 2001). What I think it is important to make clear is that the emergence of ethical passivity – inattention, legalistic self-interest and inaction – should be seen only in the context of the study design and the research questions of this thesis and that it leaves open the possibility that pharmacists might have dealt with different problems (such as hypothetical scenarios) in a different way. Focusing upon pharmacists’ actual understanding and construction of their problems and their attendant decision-making I believe remains an important feature of this research despite this limitation and has offered unique insights into decision-making and the understanding of ethical problems. One possibility for future research, however, could involve using a decision-making model such as that of Jones’ (1991) to analyse how pharmacists would try to resolve hypothetical ethical scenarios.

A related limitation is that this research was explained to participants as being about ‘ethical problems’ (appendix two) and it must be recognised, as noted in chapter four, that a framing effect may have occurred and that the frequent citing of legal and procedural problems in the minutiae of practice represented pharmacists’ attempts at offering what they thought should be said. Although I left open - and indeed wanted to

know - what pharmacists understood initially by the terms ethics and ethical problems, I realise that I did prompt pharmacists about some areas of community pharmacy practice. This was done particularly in interviews where a pharmacist was finding it difficult to provide unsolicited examples of ethical concerns but I also used it to direct other interviews into areas that I wanted to cover, such as possible commercial and ethical conflicts. Hence, I recognise that there may have been a tendency not only for pharmacists to assume that all the questions related to ethics but that they *must* offer at least some response, such as what they found ethically problematic. Unlike Holm's research (1997), I did not offer a deliberate non-ethical hypothetical scenario to explore whether pharmacists would try to frame such a vignette as being ethics but this limitation should be recognised in relation to the findings of this thesis.

A further study limitation that I want to address relates to the pharmacist sample and, specifically, whether the pharmacists who participated represented a more positive cohort than pharmacists who did not want to participate in research about ethical issues. Hence, despite the emergence of ethical passivity and quasi-ethical legal issues, the pharmacist cohort in this thesis might represent those pharmacists who felt most able to contribute and amongst the non-respondents, this situation may be worse again. As noted in chapter three in relation to sampling and the recruitment process, a number of pharmacists were approached and asked to participate in the research but declined and some of these argued that they could not recall a single ethical issue in their work and hence believed that they would not be suitable pharmacists to be interviewed. It can only be speculated whether there might be a 'dark figure' of pharmacists who were even less ethically attentive than those pharmacists who were prepared to talk about

ethical issues in their work and the findings of this thesis should be considered in relation to this possibility.

A further limitation, already noted in this chapter was that this research was conducted over a period of three years with interviewing between 2004 and 2005 and hence occurred just as the new NHS contract for community pharmacy in England was being introduced. Hence, the examples of ethical problems identified do not reflect several changes to UK pharmacy practice. One obvious opportunity for further research might involve a study of the aforementioned new roles for community pharmacy and whether these lead to ethical problems for pharmacists. Furthermore, this thesis did not set out to consider in detail what ethical impact the changing work patterns in community pharmacy might have. Issues relating to the increasing ownership of pharmacies by large corporate organisations and, indeed, the recent merger of two of the main retail pharmacy companies in the UK, may require research into what ethical impact there might be for pharmacists as employees not only in larger organisations but also in ones that may have their own ethical codes and values.

In terms of other areas for additional research, the role of education in how pharmacists come to understand and apply ethical reasoning and decision-making was an area that this thesis was unable to explore more fully. Questions arise as to how best to educate pharmacists in ethical matters and how to assess this but perhaps more fundamentally, to whether it is education alone that can inculcate ethical activity and understanding.

This point, allied to concerns about the effectiveness of pharmacy's code of ethics, may lead to questions and further research opportunities in relation to how values and

ethics are transmitted as norms within community pharmacy and to a consideration of the issues about the community pharmacy environment identified in this thesis. Are isolation, subordination and routinization of work barriers to ethical activity in community pharmacy that can be changed or removed? Further study is required to consider whether this is possible.

7.9 A HEART OF DARKNESS?

In the introduction to this thesis, an analogy was made with Conrad's *Heart of Darkness* and, in particular, my reflexive concern throughout this research about representation and reputation and of how this thesis would be received by my fellow pharmacists and other audiences. For Marlow, a lie was necessary because the truth of his search for what might be moral and good was ultimately 'too dark – too dark altogether'. Does this thesis's identification of ethical passivity, legalistic self-interest, subordination, isolation and routinization reflect something that is altogether 'too dark'? Raising this question by no means implies that I would change or present the findings from this research in any other way but I am aware that, in undertaking this research and seeking to understand in more depth and more contextually UK community pharmacist's ethical problems and how they dealt with them and by considering not only pharmacy but also ethics in relation to other social concerns, that a somewhat bleak account has emerged. The intention throughout this research, though, has not been to assess or rate pharmacists in an ethical sense and it is hoped that the emergent concepts of ethical passivity and legalism can be used to consider

key issues in a positive way. Considered in this way, concerns about how can ethical attention be developed, how ethical passivity and legalist self-interest can be avoided and how isolation, subordination and routinization in the community pharmacy setting may be challenged, can be addressed positively.

Hopefully, this thesis has contributed to what is understood about ethical issues in UK community pharmacy and to how pharmacists try to resolve such problems and that it may be of relevance to future practice and research.

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APPENDIX ONE: CONSENT FORM

*Centre for Pharmacy, Health and Society
School of Pharmacy
University of Nottingham
Nottingham
NG7 2RD*



ETHICAL PROBLEMS IN COMMUNITY PHARMACY

Name of Investigator: **RICHARD COOPER**

Study Participant's Consent Form

Please read this form and sign it once the above named or their designated representative, has explained fully the aims and procedures of the study to you

- I voluntarily agree to take part in this study.
- I confirm that I have been given a full explanation by the above named and that I have read and understand the information sheet given to me which is attached.
- I have been given the opportunity to ask questions and discuss the study with one of the above investigators or their deputies on all aspects of the study and have understood the advice and information given as a result.
- I authorise the investigators to disclose the results of my participation in the study but not my name.
- I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 7 years after the results of this study have been published.
- I understand that I can ask for further instructions or explanations at any time.
- I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing.

Name:

Address:

Telephone number:

Signature: **Date:**

I confirm that I have fully explained the purpose of the study and what is involved to:

.....
I have given the above named a copy of this form together with the information sheet.

Investigators Signature: **Name:**

Study Volunteer Number:

APPENDIX TWO: INFORMATION SHEET

Centre for Pharmacy, Health and Society
School of Pharmacy
University of Nottingham
Nottingham
NG7 2RD



ETHICAL PROBLEMS IN COMMUNITY PHARMACY

Name of Investigator: Richard Cooper

Study Participant's Information Sheet

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. If you decide to take part you may keep this leaflet. Thank you for reading this.

Background

The aim of this study is to investigate what ethical problems arise for pharmacists in their community pharmacy work and to gain an understanding of how pharmacists attempt to deal with such ethical problems.

What does the study involve?

The study involves conducting what are known as semi-structured interviews. These will involve the investigator asking you a number of open questions that allow you to talk about issues for as long as you want and to express yourself fully. A suitable location will be required for the interview – this might often be your place of work if there is a quiet period such as during a lunch break, for example. If this is not possible, an alternative venue can be mutually arranged. The interview is not formal and you may ask for clarification about anything during the interview and at the end you will be given the opportunity to ask any questions. The interview will be recorded unless you request that it not be. The recorded interview will then be anonymously transcribed into written form to allow the researcher to understand the interview better. A form of qualitative data analysis will then be used to explore the issues raised in the interview.

Why have you been chosen?

You have been selected to help in this study because you are a community pharmacist working in the UK and are registered with the Royal Pharmaceutical Society of Great Britain. You are one of several pharmacists asked to help in this study to provide a representative sample of UK community pharmacists.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

As a participant in this study, you will be required to take part in what is known as a semi-structured, in-depth interview. This will usually last between 30-50 minutes and involve the investigator asking you several questions about your work and, in particular, ethical issues. Such interviews are quite informal and are not tests. Prior to the interview, it would be helpful to think about a couple of what you consider to be ethical problems that you have encountered in your pharmacy work and to be prepared to discuss such ethical problems at the interview. The investigator may ask you why you thought the problem was ethical and ask how you dealt with the problem.

It is important, however, that you respect the confidentiality and anonymity of any patients/customers/employees/employers/health care professionals such as doctors or nurses and not allow any such individuals to be identifiable during any interview.

What are the possible disadvantages and risks of taking part?

There are not thought to be any disadvantages or risks in assisting in this research. If, however, you feel that you have been affected by the interview or any of the issues raised, you are welcome to discuss these with the researcher or another appropriate person. The study follows the ethical guidelines of the British Sociological Association and the Social Research Association.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

You may request a copy of your interview transcript if necessary.

What will happen to the results of the research study?

The results of this study will be used primarily as part of a PhD thesis which is expected to end in 2006. Results from this study may be subsequently published or presented at conferences. However, all results from this study will be anonymised and participants will not be identifiable in any way.

Who is organising and funding the research?

The study is organised and funded by The Centre for Pharmacy, Health and Society within the School of Pharmacy at the University of Nottingham.

Contact for Further Information

Should you require any further information or want to discuss any aspect of this study, please contact the researcher, Richard Cooper, by:

Telephone: 07889932626;

E-mail: paxrjc@nottingham.ac.uk;

Post: 1, Wesley Terrace, Rodley, Leeds, LS13 1JJ.¹¹

Thank you once again for offering to help in this study

¹¹ This address has subsequently changed to 27, Swallow Drive, Pool in Wharfedale, Otley, Yorkshire, LS21 1RS

APPENDIX THREE: PHARMACISTS' BACKGROUND DETAILS

In this appendix, relevant details of the pharmacists interviewed in this research are presented. Pseudonyms are used throughout to protect anonymity and some information is left intentionally vague (such as exact work location, job description or employer) where this was considered a threat to the pharmacist's anonymity.

Gloria is a female manager of a pharmacy (owned by large multiple) in a location next to health centre. She has been qualified for over 20 years. She has a pre-registration student and about seven staff. The interview was conducted in January 2004, in the dispensary during a lunch break whilst the pharmacy was closed. A pre-registration student was working in another part of the dispensary for some part of interview. The interview lasted approx. 60 minutes.

Clare graduated in 2002. She is a pharmacist manager in a pharmacy based in a high street suburban location. She is employed by a large multiple and has about six staff. The interview was conducted, in the spring of 2004, in empty staff room during the pharmacist's lunch break and lasted approximately 45 minutes.

Andrew, who was a newly qualified pharmacist at the time of the interview in 2004, presently works as pharmacy manager of a quiet community pharmacy. He is employed by a medium sized multiple pharmacy group and has four staff working at his branch. Before qualifying, he completed his pre-registration in hospital and has previously worked for another large multiple pharmacy whilst a student. He was interviewed in my home after work and the interview lasted around sixty minutes with no interruptions.

Robert works in academia and also as a community pharmacist. He has previously been a pharmacy manager. The interview lasted 42 minutes with one small interruption.

Michael is the owner of a single pharmacy in small, semi-rural location, which has been family owned for several generations. The interview took place in the pharmacist's shop in an office on a day when a locum was providing pharmacy cover and when the owner would usually attend to paperwork. The interview lasted around seventy minutes with minimal interruption. However, after the interview proper had ended and the tape recording stopped, the interviewee continued talking and raised one particular example of an ethical problem spontaneously. This was written down as promptly and as accurately as possible by the researcher after the interview had finally ended.

Philip is the owner and superintendent of two suburban pharmacies and presently works in one of the shops. He qualified in the early 1990's. Prior to his present role, he was also a locum. The interview was conducted in early 2005 in the pharmacy stockroom, during a quiet period in the day, although there were a couple of small interruptions. The interview was fully recorded and lasted around 40 minutes.

Shahid, who is in his mid-thirties, and of Asian background, presently works part-time as a manager of a pharmacy, owned by a small multiple organisation. He also worked for a local PCT (although this aspect of his work was not discussed in the interview). He had previously worked for a large multiple and also as a locum and had worked extensively in a number of supermarket-owned pharmacies. The interview occurred during a lunch break in the pharmacy and, because the interview lasted about 70 minutes, there was a small interruption as the pharmacy re-opened. The interview was fully recorded and was completed in 2005.

Hilary, a female pharmacist in her forties, had until recently been a part-time locum pharmacist but about a month prior to being interviewed became the part-time manager of a small health-centre pharmacy. She was interviewed in the dispensary whilst the pharmacy was closed over lunchtime and the interview lasted about 45 minutes and was fully recorded.

Edward is a male pharmacist manager, employed by a medium-sized organisation. He qualified in 2001 and had also worked as a locum. The interview took place in the spring of 2005 in a university office and was foreshortened unexpectedly and only lasted around 25 minutes. It was fully recorded.

Clarissa is a research student who also worked as a locum pharmacist. She had been qualified only around four years at the time of the interview and had never had a managerial role in the community. The interview was fully recorded and lasted around 45 minutes without interruption.

Amadika, a female pharmacist who originally qualified in Africa, was in her late twenties at the time of the interview. She worked as a pharmacist manager for a large, national company. She intended to leave this post and begin working as a locum in the near future. She was interviewed during her lunch break whilst the pharmacy was open and there were no interruptions. The interview was fully recorded and lasted around 40 minutes.

Stuart, a pharmacist in his late forties, was a superintendent of a medium-sized company. Although he worked in the company's head office for most of his time, he still work regularly as a pharmacist. He was interviewed in the company's head office.

James was interviewed in the autumn of 2004 and had three work commitments. He was primarily a hospital pharmacist at the time of the interview, but he also worked occasionally as a locum and was a superintendent. He was interviewed in the pharmacy on a quiet Saturday morning and the interview was tape recorded. The interview lasted about 50 minutes but there were several interruptions as James was called to dispense prescriptions.

Jane, a female pharmacist in her mid-thirties, was interviewed in April 2005 in her

capacity as a pharmacy manager of a small company. She was also a superintendent. She was interviewed in a quiet stockroom area of her pharmacy and the interview lasted for around uninterrupted 60 minutes.

Sharon is a pharmacy manager of a medium-sized company. She had been qualified only around four years at the time of the interview and had not worked at any other pharmacy or in any other role. She was interviewed during a lunch break whilst the pharmacy was closed. The interview lasted about 50 minutes and was fully recorded, digitally.

Tanvir, a male pharmacist in his mid-thirties, worked part-time as the manager of a late-opening supermarket pharmacy. The interview took place in a quiet area of the supermarket's cafeteria, although Tanvir asked that the interview not be recorded. Extensive notes were taken during the interview, with his permission, and the interview lasted around 35 minutes. Tanvir did not want to be recorded since he believed one the ethical 'dilemmas' he had chosen to talk about involved him acting illegally in supplying a controlled drug on a doctor's telephone request rather than from an actual prescription.

John and **Simon** are owners of a busy pharmacy and John was the superintendent. The interview was different from many of the others in this research since it involved my working as a locum at their pharmacy in late 2004, with the understanding that I could ask them questions throughout the day. Both declined to be recorded but notes were written as the day progressed.

Larry is the pharmacist of a very busy health centre pharmacy, which was part of a medium-sized company. He had worked as a community pharmacist for more than thirty years in a variety of roles. The interview lasted around 90 minutes, was digitally recorded, and occurred after the pharmacy had closed.

William, a pharmacist who had been qualified for more than thirty years, is the

manager of a quiet suburban pharmacy. He was also the company superintendent. He was interviewed during a quiet period and there was only one interruption. The interview was recorded and was undertaken in November 2004.

Dan, a pharmacist in his early forties, is the manager of a busy city centre pharmacy. He had also participated on LPC and PEC committees. He was interviewed whilst the pharmacy was open, during a quiet lunchtime, although other members of staff were present in the dispensary. The interview lasted around 50 minutes and, although digitally recorded, suffered intermittent recording faults. Hence, after the interview, further notes were made about the interview like almost all the other interviews, but in more detail. Following transcription of the interview, Dan was contacted by e-mail and asked to provide written responses to some of the questions which the recording problem had not captured.

Julian, a male pharmacist in his late twenties, is joint owner of two suburban, family-run pharmacies. He worked in one of the pharmacies and was responsible for around twelve staff. He was interviewed on his day off, in a private consultation room and the interview lasted around 40 minutes and was recorded digitally. He was interviewed in May 2005.

Christopher is a pharmacist manager nearing retirement, who worked in a quiet suburban pharmacy for a national company, for whom he had worked for over ten years. He was interviewed whilst the pharmacy was closed for lunch and the interview lasted for about 80 minutes and had to be stopped some time after the pharmacy re-opened after lunch. The interview was recorded digitally in the autumn of 2005 and was the last interview of this research.

APPENDIX FOUR: INTERVIEW SCHEDULE QUESTIONS

- 1) What has been your career path to date?
- 2) What do you find are the positive, rewarding aspects of your pharmacy work?
- 3) And the negative aspects?
- 4) This interview is about ethical understanding and problems, what does ethics mean to you? And an ethical problem?
- 5) What values do you think are important within pharmacy?
- 6) Can you recall a specific ethical problem that you were forced to resolve in your work?
- 7) What about it made it ethical?
- 8) What were the values involved?
- 9) How did you decide what to do?
- 10) Do you think you resolved it satisfactorily?
- 11) Do you ever think in terms of needing to justify your choices to others?
- 12) Would you consult anyone or anything to help resolve an ethical issue?
- 13) Have you consulted the MEP code of ethics in relation to ethical problems?
- 14) Are you aware of any of the principles? Are they useful?
- 15) Regarding your work environment, do you find any aspects of your work conflicting with a professional, ethical service?
- 16) Are financial or commercial pressures ever a problem?
- 17) Are there pressures from other/senior staff which might compromise your ethical choices?
- 18) How do you feel about conscience clauses?
- 19) Do you think that ethics or morality in your work is the same as that of your personal life?
- 20) Do you think that the ethical values within pharmacy are or should be the same as those in other professions such as medicine or nursing?
- 21) Overall do you feel confident in resolving ethical problems?
- 22) Any other questions?