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UK pharmacists' experiences and perceptions of conflict between personal ethical commitments and professional obligations, as set out in professional guidance

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Abstract

Background In 2017, the General Pharmaceutical Council (UK) issued new *Standards for Pharmacy Professionals* and supporting guidance, *Guidance on Religion, Personal Values and Beliefs*, to help pharmacists when their religion, personal values or beliefs might impact on their provision of services.

Objective To understand how pharmacists in the UK experience and perceive conflicts between their personal ethical commitments (matters of conscience) and professional obligations in guidance from their regulator.

Methods Twenty-four registered pharmacists were interviewed using semi-structured interviews. Interviews were transcribed verbatim and analysed using thematic analysis.

Key findings Participants were generally aware of the Council's consultations and responded if they had something to say, or it was their role to respond. Age and stage, confidence, and workload impacted on whether participants responded to Council consultations, and, therefore, on the range of views heard. The professional obligation to provide person-centred care was central to participants' practice, and personal ethical commitments were important to some. Conflict between such commitments and professional obligations were rare, and it was generally believed that the former should be accommodated, as far as possible, but not imposed on others. Personal ethical commitments could affect person-centred care and some suggested that the Council's *Guidance* was not clear on pharmacists' responsibilities in this regard.

Conclusions Clarification on the role of personal ethical commitments in professional practice, particularly in relation to providing person-centred care, would be useful. Clearer guidance on how pharmacists should manage perceived conflicts between their personal ethical commitments and their professional obligations would also be welcomed.

Keywords: pharmacists; General Pharmaceutical Council; conscientious objection; professional guidance; personal ethical commitments; professional obligations

Introduction

The role of personal ethical commitments (matters of conscience) in healthcare has long been debated, and how, if at all, a doctor or nurse's conscientious objection (CO) to a particular treatment can be accommodated is a common focus in these debates.[1-7] It has been suggested that conflicts between personal ethical commitments and professional obligations should be resolved in favour of the latter, or that only professional obligations may permissibly influence the performance of health professionals' roles.[5,8]

CO in pharmacy practice has received comparatively less academic attention, especially in the UK.[8-11] Yet, pharmacists are as likely as other health professionals to have personal ethical commitments which affect their ability to provide a particular service. Such matters are

addressed in many pharmacy regulatory codes.[12-17] However, there is a paucity of research on *how* pharmacists experience and perceive conflicts between their personal ethical commitments and professional obligations. To help fill this gap, pharmacists in England and Scotland were interviewed during 2018. The research was timely as it followed publication by the UK's General Pharmaceutical Council's (GPhC) of new *Standards for Pharmacy Professionals* (*Standards*) and the supporting *Guidance on Religion, Personal Values and Beliefs* (*Guidance*).[18,19] These were contentious and were preceded by two public consultations and two court cases - one threatened and one actualised.[20-27] Of particular concern was the proposal that pharmacists should 'take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs' (pp.10-11).[23] Over half of the consultation respondents did not agree with the proposal, and over 70% of those were members of the public. Of those who agreed with it, just over two thirds were pharmacy professionals.[24] The proposed change was subsequently included in the *Guidance*.

Codes or standards from pharmacy regulators contain the professional obligations of pharmacists, and some regulators offer separate guidance on dealing with CO in practice too.[17,19] A common obligation is to provide patient or person-centred care.[12-18] In some codes/standards, this obligation sits alongside respect for a pharmacists' personal ethical commitments, meaning that pharmacists can refuse provide services on that basis. [12-18] To facilitate this, the GPhC, for example, requires pharmacists to:

- think in advance about the environment and location they can work in, the services they can provide, the roles they can carry out, and how they might handle requests for services.
- be open with employers and colleagues about how their personal ethical commitments might impact on their willingness to provide certain services.
- use their professional judgement to ensure patients can access/receive the required services.[192]

Patients should remain at the centre of the pharmacist's decision-making and should be able to access the service they need 'in a timely manner and without hindrance' (p.7).[19] Referral might be appropriate in some situations.

It was in this context that the project sought to understand how pharmacists in the UK experience and perceive conflicts between their personal ethical commitments (matters of conscience) and professional obligations in guidance from their regulator. This is a matter relevant to all pharmacists, wherever they practice. The findings are thus of international significance, particularly given the services pharmacists currently do (or may be asked to) provide, such as contraception, vaccinations, early medical abortion (EMA), or assisted dying.[28-33]

Methods

Face-to-face interviews were used to capture in-depth data about pharmacists' perceptions and experiences of conflict between their personal ethical commitments and professional obligations. A semi-structured interview guide was developed (Table 1), informed by research on interviews.[34] This method enabled structured discussion around three issues:

1. Pharmacists' perceptions of, and involvement in, the processes by which professional guidance is created.

2. Pharmacists' sense of the role of personal ethical values in their practice and the place of guidance as a source of key values.
3. Pharmacists' experiences of, and views about, conflict between their personal ethical commitments and the expectations associated with their professional roles.

Table 1 Interview schedule

- Have you looked over the revised *Standards* and *Guidance*?
- Before we contacted you after you had expressed an interest in the project, were you aware of the recent consultation on the revised *Standards* and *Guidance*?
- What are your general impressions of the revised *Standards* and *Guidance*?
- Did you participate in the recent consultation on the revised *Standards* and *Guidance*?
- If interviewee has participated in this or any previous process of developing ethics guidance, what made them decide to participate, are there any particular experiences or concerns that motivated them, how would they describe the experience of participation?
- If interviewee has never participated in the creation of professional guidance, how likely are they to participate in such a process in future?
- The new *Standards* and *Guidance* give guidance on how professionals should manage conflicts between their personal ethics and the expectations attached to their professional roles. Can you tell me about any times when you have experienced such a conflict?
- How do you see the place of values in pharmacy practice?
- Can you tell me about some of the values you think are most important for a pharmacist?
- Can you describe where you think the pharmacist acquires these values from?
- How and to what extent do you make use of professional ethics guidance in your own work?
- What does the idea of 'person-centred care' mean to you?

Participants were recruited via Twitter and the professional network 'We Pharmacists' on Twitter. Participants were also recruited through snowballing, word of mouth, and via contacts in the healthcare professions.[35] One participant was recruited by their domestic partner who was also a pharmacist. Recruitment was undertaken for five months from the start of 2018 and ceased once pharmacists stopped responding to tweets or to emails following initial interest in the project. The target number of participants was 30. Participant inclusion criterion required pharmacists to be UK registered.

Interviews were held in participants' workplace, place of study, the interviewer's office, or an agreed public place. All participants were interviewed alone, bar two who requested to be interviewed together. Interviews were held between February and August 2018, were conducted by SF or MN, and lasted between 46 and 118 minutes. No participants refused to participate or withdrew from the project. General demographic data were collected during the interview or subsequently by email.

With each participant's consent, interviews were digitally audio recorded and transcribed verbatim by a professional transcriber who signed a confidentiality agreement. The interviewer checked each transcript for accuracy. Where there were doubts about accuracy or the transcriber could not understand what was said (indicated by a note on the transcript), the interviewer listened to the recording. If uncertainty remained, the non-interviewing researcher listened to the recording. This process enabled most uncertainties to be addressed, leaving only few inaudible words or phrases. To ensure participant anonymity, participants were assigned

numerical identities (P1-P23). The two participants interviewed together were assigned P19 and P19(2). Any possibly identifying information was removed from each transcript.

All text in each interview transcript was manually independently openly coded by two members of the project team (SF and JG). The coding of three interviews were compared and found to closely align. When coding was complete, SF read through all coded interviews and manually inductively thematically analysed all coded data and grouped them into broad themes, in order to describe patterns in the data.[36] Issues (i)-(iii) above formed the basis of three themes. Unexpectedly, matters relating to other issues were raised and then coded, and these resulted in other themes, including views on the GPhC and pharmacists' involvement in EMA and assisted dying. When data analysis appeared to be complete, all interviews were read again and the identified themes were reviewed (SF and MN). No new themes were identified.

The project received ethical approval from Strathclyde Law School and the FASS-LUMS Research Ethics Committee, Lancaster University (FL18083/FL7010).

Results

Twenty-four pharmacists were interviewed. Table 2 sets out participants' demographic details.

Table 2 Participants' demographic data

Participant	Gender	Qualified (years)	Working environment
P1	F	<10	Community locum; postgraduate
P2	F	31-40	Academic; community locum; hospital (former)
P3	M	<10	Community locum; postgraduate; hospital (former)
P4	M	21-30	Academic; postgraduate; hospital (former)
P5	M	11-20	Academic; hospital locum
P6	M	11-20	Advisory role; community (former)
P7	M	11-20	Advisory role; community locum
P8	M	21-30	Advisory; hospital (former)
P9	M	21-30	Hospital
P10	M	11-20	Hospital
P11	M	11-20	Hospital
P12	M	21-30	Hospital
P13	F	11-20	GP practice
P14	M	11-20	Office-based; hospital and primary care
P15	M	<10	Office-based; hospital (former)
P16	M	21-30	GP (20%); research/advisory (80%); hospital and community (former)
P17	M	31-40	Not in a patient-facing role; community (former)
P18	F	21-30	Hospital (office-based)
P19	M	21-30	Community
P19(2)	F	21-30	Retired; community (former)
P20	F	31-40	Community
P21	M	21-30	Office-based
P22	F	21-30	Community
P23	M	21-30	Community; office-based

1. Pharmacists' perceptions of, and involvement in, creating professional guidance

Just over half of the participants had responded to the GPhC's consultation on the *Standards* and *Guidance* - individually and/or in a group response. Respondents to those consultations were overwhelmingly either not currently employed as pharmacists or, if they were, as community pharmacists. Common reasons for responding were personal and/or professional interest, having a job role which involved organising/contributing to group responses, or perceiving that there was a professional duty to respond:

> Well, I think it's such an important thing. Professional standards, to me, they govern what we do, I thought it was important that we had a voice because, if you don't speak up about things that you are not happy with, then they can be lost and then it's easier to cry over spilt milk afterwards. (P5)

Lack of time (workload/other responsibilities), no interest in the subject, or agreement with the proposals were the main reasons for not responding:

> So if it's something I feel strongly about, I'll make the time. If it's something I feel less strongly about but want to feedback, then if I miss the deadline, it's not the end of the world. (P8)

Accessibility, visibility and ease of reply also affected whether a participant responded to a consultation. There was thus concern about who might respond to consultations and what they might say:

> I mean, the other thing really is as well, is that people are so busy and so pressured and they see that as a kinda luxury doing – responding to documents, which makes me feel that then things are more likely to get pushed through without proper consultation cos people just don't have the time to do it. (P18)

There was no agreement on whether the GPhC facilitated early input in the consultation process, helping draft and shape the consultation itself. Post-consultation engagement, feedback and transparency were important to provide reassurance that a range of voices had been heard and that the consultation process was meaningful.

2. The role of personal values in practice and professional guidance as a source of values

Pharmacy was seen as a values-based profession, and integrity, respect, honesty/truthfulness, care, kindness, and compassion were frequently mentioned values. Personal values were agreed to be important; for example, I'm a big – I think values are really important. I think if you've got sound values, you'll be a better practitioner. (P9)

A number of participants suggested that it was difficult not to impose these types of personal values on others, and that it might be a 'good' thing to do so:

> … part of being a pharmacist, your values would be to care for patients and to treat them with respect and integrity and honesty and openness and all of those good things that you would associate with being a pharmacist. (P6)

Upbringing, faith, experiences, and personal and professional role models were commonly suggested sources of personal values:

> I suppose it's my upbringing and the upbringing in society and life experiences. There are probably some values that I have now that I didn't have 10 years ago because life experience has taught me different. There are some values that I have now that I don't necessarily share with my parents, even though we are, you know, designed to take on those values but life experiences changes them. So it's probably equally important have been influential people that I've met in my life, people that I've met and respected .,, (P10)

Person-centred care (PCC) was vital to pharmacy practice, meaning 'Well, always do the best for the patient, always putting the patient first' (P19). However, providing PCC could be affected by workload or systems:

> … as a pharmacist, the patient, their care is paramount obviously to me and that's why I feel that with all the pressures that we have, it's very difficult to do that in a comprehensive way like we used to do maybe [xx] years ago when we had more time. (P20)

3. Pharmacists' experiences of, and views about, conflict between personal ethical commitments and professional expectations

Few participants had experienced conflict between their personal ethical commitments (matters of conscience) and professional role. CO was rare and refusal to provide a service because of clinical judgement was more common. It was generally agreed that personal ethical commitments *should not* be imposed on others:

> I think in any walk of life, I think to try and impose somebody's – impose your beliefs on somebody else is not right, you know. I think to recognise those beliefs and recognise that you might have different beliefs to other people is fine, but I don't think you should impose. (P11)

Nevertheless, most participants said that pharmacists' personal ethical commitments *should* be accommodated, although this might not always be easy to achieve:

> I think for this, making adjustments for people, so if you do have a large conscientious objection to something, I think employers, certainly large employers could easily - … accommodate except if it's a small independent with 1 or 2 employees might be more difficult but the large employers, there's no reason why they can't accommodate all that. (P15)

It was generally agreed that if a service was not provided, there was an obligation 'to make sure that the patient is not negatively impacted by your views' (P13). *Patient* not professional-centred care was essential. Whether referring or signposting someone because of personal ethical commitments was providing PCC was disputed: 'So you are still offering, for me, person-centred care cos you are doing the best you can for that patient' (P8); 'Even if it's against what you would – but then, that's not putting the person at the centre, that's putting yourself at the centre and that's just – that's not professionalism, that's just selfishness' (P16).

There were varied understandings of the GPhC's *Guidance*: 'it's very difficult to know what it's actually guiding you to do really if you're in that situation' (P7).I It was suggested that the *Standards* and *Guidance* were incompatible by permitting referral but retaining pharmacists' responsibility for not compromising PCC:

> So worded in that way, I think it makes it very difficult for pharmacists to refer on to another provider and they shouldn't have to warrant that somebody else won't compromise person-centred care. (P6)

Discussion

Participants responded to GPhC consultations, thereby helping to create professional guidance, if it concerned something important to them or was part of their job role. Lack of time and ease of response affected their ability to respond. Pharmacy was agreed to be a values-based profession, but professional guidance was not a source of values. Values were predominantly derived from participants' backgrounds and experiences. Most participants had not experienced conflict between their personal ethical commitments and professional obligations, but generally believed that the former should be accommodated. In cases of conflict, professional obligations should, overall, take priority because personal ethical commitments should not be imposed on others.

This is the first project to explore the experiences and perceptions of UK pharmacists of conflict between personal ethical commitments and professional obligations. It provides important insights into pharmacists' views on this matter, and complements existing research which has considered pharmacists' objections to providing specific services in the UK, commonly abortion or emergency hormonal contraception.[10,11]

The project was open to registered pharmacists throughout the UK, but only pharmacists from England and Scotland were recruited. This might be because social media was the recruitment tool, and/or because the researchers were 'outside' the profession.[37,38] The findings might also have been influenced by participants' gender, age, and place of practice.

Literature on professionals' involvement in regulators' consultations is limited, but the findings on pharmacists' involvement in creating professional guidance reflect existing research on public consultations generally.[39] The need to involve parties at early stages, recognise and value consultation responses, clarify how participants will benefit from participating, and being attentive to matters of representation and the voices being heard have been noted elsewhere.[40-42] Similarly, it is widely recognised that pharmacy is a values-based profession, with providing PCC a central obligation.[43] The findings largely supported the common argument that conflict between personal ethical commitments and professional obligations should be resolved in favour of the latter.[5,8] Most participants had not personally experienced such conflict but generally believed that personal ethical commitments should be accommodated, thereby supporting Wicclair's position that CO is *not* incompatible with being a healthcare professional.[6]

Notably, accommodating CO has been endorsed by Savulescu, a trenchant advocate of 'the incompatibility thesis', that CO is incompatible with being a healthcare professional, where doing so does not 'compromis[e] the quality and efficiency of public medicine' (p.296).[5,6,44] Accommodation in codes/standards often comes in the form of referring patients to other healthcare providers.[12-17] The GPhC, for example, recognises that referral is appropriate in some but not all situations, with accessibility, time, and vulnerability amongst the matters to be considered.[19] Yet, as some participants and others have acknowledged, referring patients may not be straightforward because some pharmacists with personal ethical commitments equate referral to complicity in the objected-to service.[44-48] Other participants, however, questioned whether the 'conventional compromise' of referral or signposting were

incompatible with providing PCC, and some were unclear about *what* was required of them if they had a CO.

The findings echo those of Maxwell and colleagues, who explored UK pharmacists' views on CO to abortion.[11] They found general agreement that CO could and *should* be accommodated in pharmacy practice, but that doing so was 'riddled with complexities' (p.262).[11] Despite these similarities, it is important to note that the majority of participants in the current project had not personally experienced conflict between their personal ethical commitments and professional obligations, and so their views on managing such conflict were, effectively, views about what other people (those who do experience such conflict) should do. This is noteworthy because it may be easier to make statements about not imposing personal ethical commitments when it is the commitments of others that are at issue.

With PCC as the central professional value, if regulators such as the GPhC are serious about accommodating personal ethical commitments, professional guidance must be clear about *how* pharmacists should manage perceived conflicts between these commitments and their professional obligations. Without this, vaguely expressed guidance merely 'passes the buck' to individual professionals. The GPhC's *Guidance* could, thus, usefully be reviewed to minimise existing confusion and uncertainty about accommodating pharmacists' personal ethical commitments in practice, particularly in relation to providing PCC. Ultimately, the projects' findings offer further support to Maxwell and colleagues' conclusion that there are 'a number of shortcomings concerning accommodating CO in pharmacy practice, which include lack of training around the subject, unclear guidance to work with and lack of knowledge in relating to referral and signposting' (p.262).[11]

Conclusion

The project aimed to understand how pharmacists in the UK experience and perceive conflicts between their personal ethical commitments and professional obligations in guidance from their regulator. While most participants had not personally experienced conflict, it was widely accepted that some pharmacists might have personal ethical commitments that conflicted with their professional obligations. In this situation, there was a willingness for such commitments to be accommodated where possible. For this to occur and for PCC, an internationally recognised professional obligation, to remain central to pharmacy practice, clear guidance on the specifics of doing so are essential.

Indeed, if regulators permit pharmacists to not provide certain services because of personal ethical commitments, it must be clear *how* pharmacists (including employers) can manage perceived conflicts between those commitments and professional obligations. In order to ensure that the needs of pharmacists *and* patients are attended to, further research on the practicalities of accommodating and managing personal ethical commitments within pharmacy practice is recommended.

In addition, as GPhC consultation processes can generate standards and guidance that become sources of professional obligations, the processes must be robust. Consultations should be designed so that a representative range of people and organisations are involved at all stages, possibly including agreeing the terms of reference and drafting consultation materials. Consultations should be easy to respond to and, because age and stage, confidence, and workload may affect whether an individual responds to a consultation, there must be genuine attempts to truly engage a range of respondents in order to reflect the spectrum of views within

the profession. Those devising and instituting consultations must thus be attentive to existing research on how to do this effectively.

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