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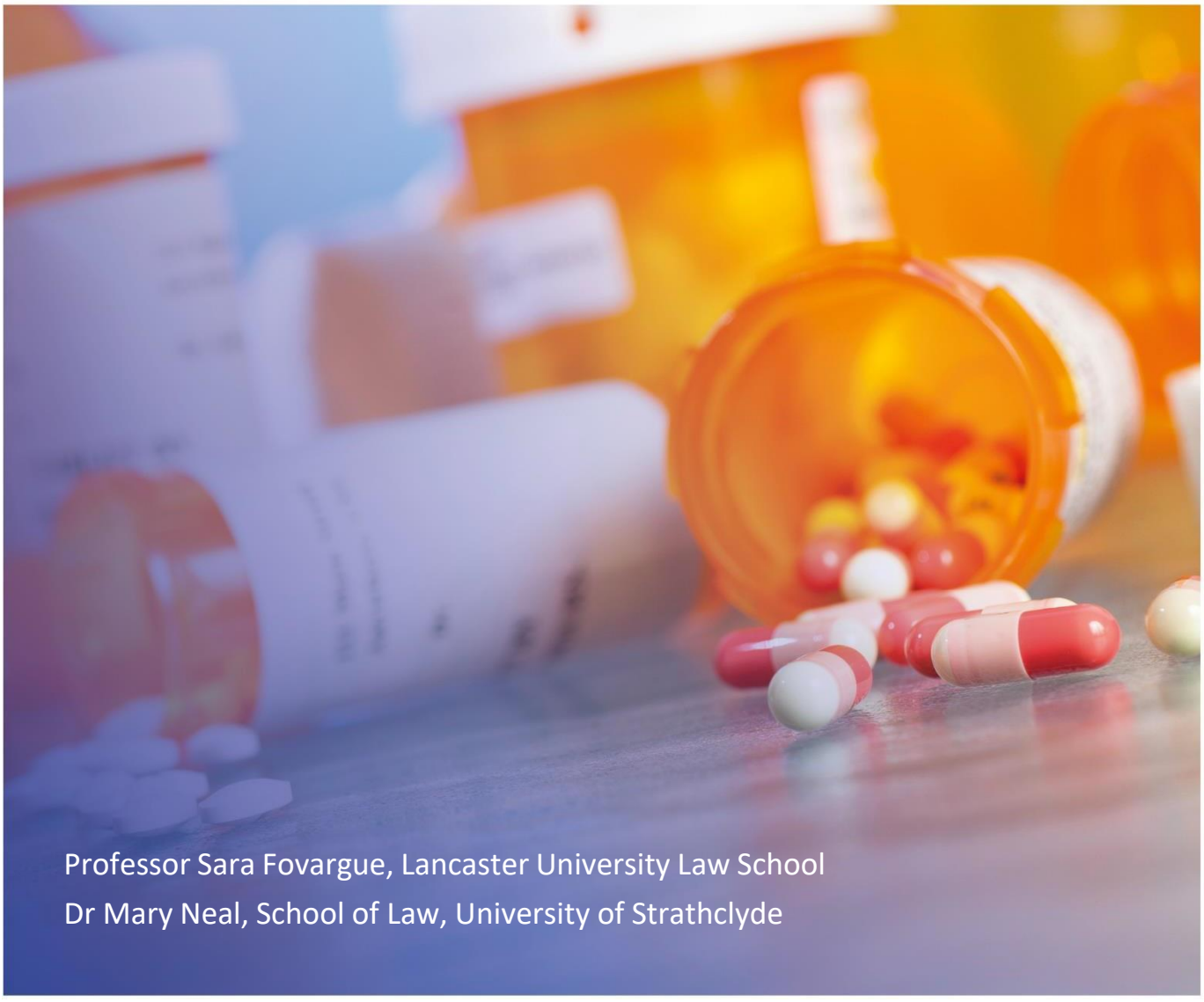
Project Report

Pharmacists' perceptions of ethical conflict and professional guidance in light of the revised General Pharmaceutical Council Standards of Conduct, Ethics and Performance

August 2021



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Contents

Acknowledgements 3
Key findings 4
1 Introduction 5
1.1 Research context
1.1.1 GPhC *Standards* and supporting *Guidance*, 2010-2017 5
1.1.2 GPhC *Standards* and supporting *Guidance*, 2017- to date 10
1.2 Our research 11

2 Research overview
2.1 Research questions 12
2.2 Research design and analysis 12
2.3 Ethical considerations 13

3 Research findings
3.1 Who responded 14

3.2 *Pharmacists' perceptions of, and involvement in, the processes by which professional ethical guidance is created (including any factors making involvement less likely)*
3.2.1 Awareness of the GPhC's *2017 Standards* and *2017 Guidance* consultation 15
3.2.2 The process of consultation 17
3.2.2.1 Pre-consultation 17
3.2.2.2 The format of consultations 18
3.2.3 Who responds to consultations? 20
3.2.4 Group responses to consultations 21
3.2.5 Post-consultation: The GPhC's response 22

3.3 *Pharmacists' sense of the role of values in their practice and the place of ethics guidance as a source of key values*
3.3.1 Values of pharmacy professionals 23
3.3.1.1 Professionals values 23
3.3.1.2 The personal values of pharmacy professionals 26
3.3.2 Role of/for values in pharmacy practice 27
3.3.3 Sources of values 28

3.4 *Pharmacists' experiences of, and views about, conflict between their personal ethical commitments and the expectations associated with their professional roles*
3.4.1 Experiences of conflict between personal ethical commitments and professional role expectations 29
3.4.2 Views on conflict between personal ethical commitments and professional role expectations 31
3.4.2.1 Managing personal and professional commitments 33
3.4.3 Views on the GPhC's *2017 Guidance* 40

4 Recommendations 45

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Data sharing

All data underpinning this publication are openly available from the University of Strathclyde KnowledgeBase at: https://doi.org/10.15129/a7f22ede-e726-43c9-a14f-2fa9dff242b5

Project documents (Participant Information Sheet, Consent Form, and Interview Guide) are available at: http://wp.lancs.ac.uk/pharmacists-ethical-guidance/project-updates-docs-outputs/.

Key findings

1. Pharmacy professionals are, generally, aware of the General Pharmaceutical Council's consultations.

2. Respondents to consultations tend to be those who have a professional and/or personal interest in the subject of the consultation (they have something to say), and/or those whose role involves writing or collating responses.

3. Factors like status within the profession ('age and stage'), confidence, time, and workload can impact upon the likelihood of responding to consultation processes and so on the range of views heard. There is a perception that individual responses do not 'count' as much as group or organisational responses.

4. Pharmacy professionals want a wide range of people and organisations to be involved at earlier stages in the consultation process; for example, when agreeing the terms of a consultation and drafting the consultation materials.

5. Pharmacy professionals want more post-consultation engagement, feedback and transparency from the GPhC. This would provide reassurance that voices within the profession had been heard and that the consultation process had been meaningful.

6. Pharmacy professionals saw their profession as values-based, with personal values (such as honesty, openness, care) having a role in professional practice. 'Person-centred care' was at the heart of professional practice, but personal ethical commitments and/or workload might affect pharmacy professionals' ability to provide this care.

7. Personal and professional values are largely derived from background and upbringing (including faith), and from experience. Education and training had a more limited role, and professional guidance was not noted as a source of values.

8. Few pharmacy professionals had experienced conflict between their personal ethical commitments and professional role. Conscientious objection was thought to be rare and it was more common to refuse/refer someone seeking care because of clinical judgement than personal ethical commitments.

9. There was general agreement that personal ethical commitments should be accommodated in professional practice because acting in conflict with those commitments can cause issues – for the pharmacy professional concerned, their colleagues, and the person seeking care. However, personal ethical commitments should not be imposed on others.

10. There was mixed understanding of the content of the General Pharmaceutical Council's *2017 Guidance on Religion, Personal Values and Beliefs*, and there was concern about professional regulatory or legal sanctions if pharmacy professionals did not provide a service to a person seeking care because of their personal ethical commitments.

1 Introduction

This report sets out the findings of an empirical project conducted between September 2017 and January 2020, funded by the British Academy/Leverhulme small research grants scheme.

We were interested in pharmacists' views on personal ethical commitments and professional guidance because this issue has received limited attention in legal and bioethical literature. It was timely to consider this because the General Pharmaceutical Council's *Guidance on Religion, Personal Values and Beliefs* focuses on person-centred care, and some of the proposed changes in healthcare could result in pharmacists being more involved in providingcontroversial care, such as assisted dying or 'abortion on prescription'.

1.1 Research context

In June 2017, the General Pharmaceutical Council (GPhC) - the regulator for pharmacists, pharmacy technicians and registered pharmacies in England, Wales and Scotland - issued new *Guidance on Religion, Personal Values and Beliefs* (the *2017 Guidance*).[1] This guidance, which is designed 'to help pharmacy professionals when their religion, personal values or beliefs might impact on their willingness to provide certain services',[2] supports the GPhC's *Standards for Pharmacy Professionals* (the *2017 Standards*), which came into force in May 2017.

Before setting out the key provisions in the *2017 Guidance*, it is important to explain the development and revision of the *2017 Standards* and *2017 Guidance* in order to understand the context within which our research took place.

1.1.1 Standards and related documents for pharmacy professionals, 2010-2017

- *Standards of Conduct, Ethics and Performance (2010)*

Since **September 2010**, the Royal Pharmaceutical Society of Great Britain (RPS) has been the professional leadership body for pharmacists in England, Scotland and Wales,[3] and the GPhC the independent regulator of pharmacy professionals and pharmacy premises in England, Scotland and Wales.[4] The GPhC published their *Standards of conduct, ethics and performance* (*2010 Standards*) in **September 2010**, which set out seven principles that pharmacy professionals 'must' meet, including 'Make patients your first concern' and 'Show respect for others'.[5] Under the latter, the GPhC said that pharmacy professionals 'must':

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[1] General Pharmaceutical Council (GPhC), *In practice: Guidance on religion, personal values and beliefs* (GPhC, 2017): https://www.pharmacyregulation.org/sites/default/files/in_practice-_guidance_on_religion_personal_values_and_beliefs.pdf.

[2] GPhC, 'GPhC Council approves guidance on religion, personal values, and beliefs' 22 June 2017: https://www.pharmacyregulation.org/news/gphc-council-approves-guidance-religion-personal-values-and-beliefs.

[3] Royal Pharmaceutical Society (RPS), 'History of the Society': https://www.rpharms.com/about-us/history-of-the-society.

[4] GPhC, 'About Us': https://www.pharmacyregulation.org/about-us.

[5] GPhC, *Standards of Conduct, Ethics and Performance* (GPhC, 2010): http://www.cps.scot/media/1695/gphcstandardsconduct_ethics_performance.pdf (reprinted in 2012). These mirror the seven principles in the RPS of Great Britain, *Code of Ethics for Pharmacists and Pharmacy Technicians* (RPS, 2007), p 4.

> 3.4 Make sure that if your religious beliefs prevent you from providing a service, you tell the relevant people or authorities and refer patients and the public to other providers.[6]

In **April 2012**, an internal review of Standard 3.4 was presented to the GPhC Council, which recommended that this standard was considered as part of a wider review of the *Standards*, which was to take place during **2013** and **2014**.[7] The GPhC subsequently published a discussion paper on patient-centred professionalism,[8] and the responses to this informed the consultation on the standards for pharmacy professionals,[9] which was held between **April and June 2016**.[10]

In the draft revised standards, the GPhC proposed that nine standards for pharmacy professionals were introduced. Examples were provided under each standard to show how it could be met and the types of behaviours and attitudes expected of pharmacy professionals. Standard 1 said that 'Pharmacy professionals must provide person-centred care', and under that standard it was stated, amongst other things, that:

> People receive safe and effective care when pharmacy professionals: …
- recognise and value diversity, and respect cultural differences – making sure that every person is treated fairly whatever their values and beliefs
- recognise their own values and beliefs but do not impose them on other people
- tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers

Responses to the 2016 standards consultation predominantly came from pharmacy professionals (94% of 1,295 respondents). Of note here is that 91% of 1,122 respondents agreed that 'the new standards and their explanations make clear that a pharmacy professional's personal values and beliefs must be balanced with the care they give people who use pharmacy services'. [11]

In **October 2016**, the Council of the GPhC approved the new standards *subject to* further consultation on two of the suggested examples for Standard 1. It was proposed that the second bullet point above should be retained, but that the final one should be replaced with:

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[6] In the previous RPS *Code*, this was stated as:
3.3 Make sure that your views about a person's lifestyle, beliefs, race, gender, age, sexuality, disability or other perceived status do not prejudice their treatment or care.
3.4 Ensure that if your religious or moral beliefs prevent you from providing a particular professional service, the relevant persons or authorities are informed of this and patients are referred to alternative providers for the service they require': ibid, p 8.

[7] GPhC, 'Review of Standard 3.4 – religious or moral beliefs interim update' Council meeting 12 April 2012, Public Business, 04.12/C/01.

[8] GPhC, *Patient-centred professionalism in pharmacy: A review of the standards of conduct, ethics and performance* (GPhC, 2015), p 4. GPhC consultations between 2020 and 2014 can be found at: https://www.pharmacyregulation.org/previous-consultations#2015-1.

[9] GPhC, *Patient-centred professionalism in pharmacy – responses to the discussion paper* (GPhC, undated).

[10] GPhC, *Consultation on standards of pharmacy professionals* (GPhC, 2016).

[11] GPhC, *Standards for pharmacy professionals – analysis of consultation responses* (GPhC, 2016).

- take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs.[12]

These changes were proposed because it was said that feedback from the **2016** standards consultation indicated that the examples originally provided under Standard 1 'were not compatible with person-centred care'.[13] By contrast, the new proposals would 'shift the balance in favour of the needs and rights of the person in their care', and while referring someone to another provider might be appropriate, 'the pharmacy professional must take responsibility for the continuity and/or outcome of the person's care'.[14]

The additional consultation on the examples for Standard 1 was held between **December 2016** and **March 2017**, alongside the consultation on the proposed new supporting *Guidance* (discussed further below).[15] 3,601 responses were received, and the GPhC analysed 3,361 individual online responses in its report on the consultation.[16] More responses were received from the public (1,780) than pharmacy professionals (1,372), which was unusual for GPhC consultations. Nearly half of the respondents (46%) agreed with the proposed changes to the examples under Standard 1, including the majority of pharmacy professionals (70%) and organisations which represented the pharmacy sector. By contrast, the majority of members of the public *did not* support the changes (71%), although members of the public involved in focus groups 'overwhelmingly' supported them.

The GPhC concluded that their 'fundamental approach to person-centred care is [not] incorrect'.[17] They did not identify new or significant information that required further consideration, and said that issues raised by respondents could be more effectively addressed in supporting guidance than by changing the examples under Standard 1.

After reflecting on the feedback from the original **2016** standards consultation, the GPhC undertook a review of the law because 'the examples proposed in the initial standards consultation were too weighted towards accommodating the pharmacy professional's values and beliefs, as opposed to what the law requires of them as a service-provider'.[18] The provisions of the Equality Act 2010 and the Human Rights Act 1998 were considered, and it was determined that the **October 2016** proposals (and supporting guidance discussed below) 'strike the right balance in protecting the religious freedom of pharmacy professionals and

[12] GPhC, 'Standards for pharmacy professionals: additional consultation', Meeting paper, Council on Thursday 6 April 2017, para 1.2.
[13] Ibid.
[14] GPhC, *Consultation on religion, personal values and beliefs: First report of consultation* (GPhC, 2017), para5.
[15] The proposed revised Standards were the subject of an unsuccessful application for permission for judicial review: *R (on the application of Pitt and Tyas) v General Pharmaceutical Council* [2017] EWHC 809 (Admin).
[16] GPhC, *Consultation on religion, personal values and beliefs: First report of consultation* (GPhC, 2017).
[17] GPhC, 'Standards for pharmacy professionals: additional consultation', Meeting paper, Council on Thursday 6 April 2017, para 2.10.
[18] GPhC, *Appendix 2 Consultation on religion, personal values and beliefs: Analysis of the effects on equality* (GPhC, 2017), para 2.4.

preventing discrimination against service users'.[19] Ultimately, 'the people whom pharmacy professionals are there to serve should receive the care and advice they need'.[20]

In **May 2017**, the GPhC published their new *2017 Standards* (see section 1.1.2 below).

- *Guidance on the provision of pharmacy services affected by religious and moral beliefs (2010)*

In **September 2010**, the GPhC published its *Guidance on the provision of pharmacy services affected by religious and moral beliefs* (*2010 Guidance*), to support the *2010 Standards*. In the*2010 Guidance*, the GPhC emphasised that if a pharmacy professional's beliefs prevented them from providing a pharmacy service, it was 'essential that relevant persons are informed and that patients and the public are directed to other service providers'.[21] A list of people the pharmacy professional should inform was set out, including employers, colleagues, and a body with whom the pharmacy professional or pharmacy owner has a contract for services with. Furthermore, pharmacy professionals:

> are responsible for ensuring that the patient is properly informed about why the service they are requesting is not available. Be open and honest about your reasons for not providing a service as this will help patients understand and maintain trust and confidence in the profession.[22]

As persons seeking care might request a service from a colleague, all staff should be aware of a pharmacy professional's views and should be trained on responding to a request that their colleague could not fulfil. Employers should check whether a pharmacy professional had beliefs which affected their ability to provide a particular service, and to 'consider whether patients could be directed to alternative providers of the affected service in the vicinity'.[23] Policies and procedures should help guide staff in managing services affected by beliefs, 'so that requests are handled appropriately and patients are able to access the services they require'.[24] Information on alternative services was needed, and staff should be 'appropriately trained' and have the contact details and availability of others locally who could provide affected services.[25]

The *2010 Guidance* contained a specific section on emergency hormonal contraception (EHC), with pharmacy professionals required to refer those seeking EHC to another provider and, if referring to another pharmacy, check that a pharmacist was available to fulfil the request, including that they had the product required.

[19] Ibid, para 2.5.
[20] Ibid.
[21] GPhC, *Guidance on the provision of pharmacy services affected by religious and moral beliefs* (GPhC, 2010), p 2.
[22] Ibid, para 1.4.
[23] Ibid, p 4.
[24] Ibid, para 2.1.
[25] Ibid, paras 2.2.

As discussed above, a consultation on the guidance to accompany the proposed revised standards occurred between **December 2016 and March 2017**.[26] The proposed revised guidance was designed to give pharmacy professionals 'practical information to help them make sure they put the care of the person first', and it recognised 'the important role of employers in supporting pharmacy professionals and the wider pharmacy team to create and maintain a person-centred environment'.[27] Pharmacy professionals were to 'use their professional judgement to make sure the person receives the care or advice theyneed, when they need it', and that their decisions 'should not compromise the health, safetyor wellbeing of the person'.[28] Time limits or other barriers to accessing services should be considered, and pharmacy professionals 'should make arrangements that are appropriate tothe needs and circumstances of the person, to make sure they receive the care they need'.[29]

While pharmacy professionals' religion, personal values and beliefs were important, the GPhC wanted to 'ensure people can access the advice, care and services they need from a pharmacy professional in whatever setting, and when they need them'.[30] Thus, pharmacy professionals should consider their work location and the range of services the pharmacy they work in offers, be open with their employer about how their beliefs might affect their ability to provide certain services, 'demonstrate sound professional judgement', 'make the care of the person their first concern and in act in their best interests', and 'behave professionally at all times' ('not imply or express disapproval or judgement of a person').[31]

Employers were to have responsibilities too, including to create and maintain a person-centred environment, ensure the safe and effective delivery of pharmacy services, and consider the needs of people in their area and how best they can meet them. They should make 'anynecessary arrangements' with existing and new staff in order to provide safe and effective care, comply with relevant law and 'not unlawfully discriminate against pharmacy professionals because of their stated or perceived religion, personal values or beliefs'.[32]

Two specific questions were asked in the consultation: whether the proposed revised guidance adequately reflected the broad range of situations that pharmacy professionals might find themselves in, and what more, if anything, could be included. Of the 3,051 respondents to the first question, 56% answered 'yes', with 73% of those identifying as pharmacy professionals.[33] Responses to question two included suggestions that the guidance on referral could be more explicit – when referral would be appropriate or not, more on working arrangements (for employees and employers), and clear responsibilities especially for those considering or about to start a career in pharmacy.

In **May 2017**, the GPhC published their new *2017 Guidance* (see section 1.1.2 below).

[26] GPhC, *Consultation on religion, personal values and beliefs* (GPhC, 2016).
[27] Ibid, p 6.
[28] Ibid, p 16.
[29] Ibid.
[30] Ibid.
[31] Ibid, pp 17-18.
[32] Ibid.
[33] GPhC, *Consultation on religion, personal values and beliefs: Second report of the consultation* (GPhC, 2017), para 11.

1.1.2 GPhC *Standards* and supporting *Guidance*, 2017- to date

2017 Standards

Standard 1 provides that: 'Pharmacy professionals must provide person-centred care'. In applying that standard, the GPhC recognises that:

> Every person is an individual with their own values, needs and concerns. Person-centred careis delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs – making the care of the persontheir first priority.[34]

In applying Standard 1, the GPhC notes that:

> People receive safe and effective care when pharmacy professionals: …
- listen to the person and understand their needs and what matters to them
- give the person all the relevant information in a way they can understand, so they can make informed decisions and choices
- consider the impact of their practice whether or not they provide care directly
- respect and safeguard the person's dignity
- recognise and value diversity, and respect cultural differences – making sure that every person is treated fairly whatever their values and beliefs
- recognise their own values and beliefs but do not impose them on other people
- take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs.[35]

2017 Guidance

The *2017 Guidance* explains *how* pharmacy professionals should apply Standard 1 of the *2017 Standards*. The GPhC recognises that pharmacy professionals:

> have the right to practise in line with their religion, personal values or beliefs as long as they act in accordance with equalities and human rights law and make sure that person-centred care is not compromised.[36]

Pharmacy professionals must not, however, 'discriminate against a person based on their own – or the person's – religion, personal values or beliefs, or lack of religion or belief'.[37] They should:

- 'take responsibility for ensuring that person-centred care is not compromised by personal values or beliefs', as doing so ensures that people receive safe and effective care.[38]
- 'keep in mind' that professional clinical judgement is different to religion, personal values or beliefs.[39]

[34] GPhC, *Standards for Pharmacy Professionals* (GPhC, 2017), p 8.
[35] Ibid.
[36] GPhC, *In practice: Guidance on Religion, Personal Values and Beliefs* (GPhC, 2017), p 7.
[37] Ibid.
[38] Ibid.
[39] Ibid.

- think in advance about the type of environment and location they can work in (e.g. city/rural, solo/group, out-of-hours work), the range and types of services they can provide, the roles they can carry out, and how they might sensitively handle requests for services.
- be open with employers and colleagues about how their religion, personal values or beliefs might impact on their willingness to provide certain pharmacy services.
- work with employers to ensure that 'adequate and appropriate arrangements' are in place.[40]
- use their professional judgement to make sure the person asking for care can access or receive the services they need.

If a pharmacy professional is 'unwilling'[41] to provide a service:

- they should make sure that the person asking for care is at the centre of their decision-making and can access the service they need 'in a timely manner and without hindrance'.[42]
- it may be appropriate to refer the person asking for care to another health professional, but this might not be appropriate in every situation.
- they should use their professional judgement in each case and keep a record of decisions to refer, including any discussions with the person asking for care.

1.2 Our research

We were interested in the GPhC's *Guidance on Religion, Personal Values and Beliefs (2017)* because of its focus on person-centred care, and because some of the changes being proposed in the provision and practice of health care could involve pharmacists in increasingly controversial practices. Examples include ongoing efforts to legalise assisted dying and proposals to change the nature of abortion provision.

We wanted to understand how pharmacists experience and perceive conflicts between their personal ethical commitments and their professional obligations as contained in guidance issued by their regulator. Our project was designed to be a pilot for a larger projectexploring the normative authority of professional ethics guidance.

[40] Ibid, p 8.
[41] Ibid.
[42] Ibid, p 7.

2 Research Overview

2.1 Research questions

In this project, we sought to explore three matters:

1) pharmacists' perceptions of, and involvement in, the processes by which professional ethical guidance is created, including any factors making involvement less likely.
2) pharmacists' sense of the role of values in their practice and the place of ethics 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.

2.2 Research design and data analysis

Between February and August 2018, 24 pharmacists based in England and Scotland were interviewed (by SF or MN). Interviews were held in the participants' workplace, place of study, in the researcher's office, or in an agreed public place. Most of our participants were recruited online. We posted requests for participants on the social media platform Twitter and the professional online network 'We Pharmacists', which is also on Twitter. We posted a series of tweets introducing the project and inviting participants to get in touch with us. There was also some recruitment through snowballing, by word of mouth, and through our contacts in the healthcare professions. One participant was recruited by, and interviewed together with, their domestic partner who was also a pharmacy professional (at the request of both parties). Recruitment was undertaken for five months.

As we were interested in participants' own accounts of their experiences and points of view, the interviews were semi-structured. This allowed for structured discussion around our research questions and afforded us the flexibility to follow up and discuss any important issues that emerged in each individual interview. Our interview schedule was intentionally kept broad, so that participants' experiences could be captured in their own words. Interviews generally lasted for an hour, and the longest lasted one hour and 58 minutes. With the participants' consent, each interview was digitally audio recorded and transcribed verbatim by a professional transcriber. General demographic data was collected either during the interview or subsequently by email.

Each interview transcript was read by the original interviewing researcher to check accuracy. Where there were doubts about accuracy or the transcriber could not understand what was said (indicated by a query note on the transcript), the original interviewing researcher listened to the recording of the interview. If uncertainty remained, the non-interviewing researcher listened to the recording. This process enabled the researchers to address the transcriber's uncertainty or errors, leaving only a few transcripts with inaudible words or phrases.

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 was compared and found to closely align. Once coding was complete, one member of the project team inductively thematically analysed all coded data into broad themes, in order to describe patterns in the data (SF).[43]

When data analysis appeared to be complete, all interviews were read again in order to review the themes identified (SF and MN). Not all data collected related to our research questions. Additional data covered matters such as the role of pharmacy professionals in healthcare provision and changes to that role, views on the GPhC and on the *2017 Standards*, and possible changes to the laws relating to abortion and assisted dying, both of which could involve pharmacy professionals.

This report focuses on our three research questions. Before quoting a participant, the original transcript was reviewed in order to understand the context within which the statement was made and to minimise misrepresentation.

2.3 Ethical considerations

Protecting the well-being of our participants was important to us and our project received ethical approval from Strathclyde Law School and the FASS-LUMS Research Ethics Committee, Lancaster University (FL18083/FL7010).

All participants were provided with a detailed information sheet prior to interview. This outlined the research and its aims, explained the interview process, and how data was to be collected and stored. Participants were given the opportunity to ask questions prior to the interview, and they completed and signed a consent form, which was also signed by the interviewing researcher, before the interview began. The interviewing researcher checked that there were no further questions before the interview started.

With consent, all interviews were audio recorded and the audio files were transferred into Box (Lancaster University's preferred secure storage site) as soon as possible after the interview had finished. Access to the audio files in Box were limited to the researchers and to a professional transcriber, who signed a confidentiality agreement. Once the transcriptions were complete, the transcriber's access to the audio files was removed.

The researchers only worked on password protected computers or laptops, and all interview transcripts were password protected. Only the researchers (SF and MN) and the research assistant (JG) had access to the transcripts. The research assistant only had access to anonymised transcripts. Once the transcripts had been coded, the research assistant's access to the transcripts was removed.

To protect participants' identities, all audio recordings were deleted once they had been transcribed and the transcriptions had been checked for accuracy. Interview transcriptswere anonymised and any identifying information was removed by the interviewing researcher, and double checked by the non-interviewing researcher to ensure that no participant could be identified from the text. To ensure participant anonymity, participants were assigned numerical identities (P1 to P23). One interview involved two pharmacy professionals who were known to each other and wished to participate jointly. One transcript thus reflects contributions from 2 people (reported here as (P19) and (P19(2)). For this interview, both participants signed separate consent forms and were asked if they wanted to speak privately to the interviewing researcher. Neither availed themselves of this opportunity.

[43] V Braun and V Clarke, 'Using thematic analysis in psychology' (2006) 3 *Qualitative Research in Psychology* 77.

3 Research findings

3.1 Who responded

24 pharmacy professionals were interviewed. Six were female, three were academics, two were postgraduate students and one was undertaking a PhD part-time. Nine participants were based in Scotland. Three had been qualified for under 10 years, seven for 11-20 years, 10 for between 21-30 years, and three for over 30 years. Eleven participants had experience of working in community pharmacies, 12 in hospitals, and two in GP practices. Ten participants were either not at the time of interview, or ever had been, in a patient-facing role.

Table 1: Demographic information

Participant	Gender	Qualified (years)	Working environment
P1	F	<10	Community
P2	F	31-40	Academic; community; hospital (former)
P3	M	<10	Community; hospital (former)
P4	M	21-30	Academic; hospital (former)
P5	M	11-20	Academic; hospital
P6	M	11-20	Advisory role; community (former)
P7	M	11-20	Advisory role; community
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 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

3.2 *Pharmacists' perceptions of, and involvement in, the processes by which professional ethical guidance is created (including any factors making involvement less likely)*

3.2.1 Awareness of the GPhC's *2017 Standards* and *2017 Guidance* consultation

Most participants were aware of the GPhC's consultation on the *2017 Standards* and *2017 Guidance*, and the majority of those who were aware of the consultation had responded to it - either individually and/or as part of a group response.

Three reasons were offered for responding to the consultation. First, because the participant (as an individual) **had something to say** and were **personally and/or professionally interested** in the topic. For example, *'I've always been quite interested in that, so when the consultation came out – and there was already a bit of a personal interest in that anyway'* (P3):

> *I think because I think they're* [personal ethical commitments] *important. I think they're important for us as individuals and I think it's important that we have or hold a set of values and also because I think it's very important for the profession and I think it's the interplay between our personal and professional lives that I thought was very important.* (P4)

One participant responded not because they were concerned with protecting their own personal values or ethical commitments as such, but because they **wanted to ensure that those of others were safeguarded**:

> *It's something I felt strongly about really, as I say, I've already touched upon I don't object to the service which predominates opinion and debate over this at the moment, namely the emergency hormonal contraception. However, I do feel strongly for other people's rights of freedom of their own conscience. I wouldn't like to be pressurised or forced to act contrary to my own conscience. So based on that viewpoint of mine, I therefore sympathise with a colleague whose opinions might be different to mine but who, if they were forced or pressurised to act contrary to their own conscience. So I suppose that's what's underpinned it really.* (P7)

The second reason was because **responding to consultations was one of the participant's roles in their job** – to organise or contribute to a group response. For example, *'I'm part of the* [ORGANISATION] *and that's one of our tasks we do is support consultations and that'* (P9); *'Because this organisation represents the owners, then it can affect a lot of people, whether employees or whatever, all owners, whatever they are. So we have an aspect to make sure we think they're balanced'* (P21).

Finally, some said that it was **their professional duty to respond to the consultation** - individually and/or as a part of a group response:

> *I think it's part of our responsibility as a registrant. There are those who complain about the profession but if they don't influence it, or don't take that opportunity to*

> *influence it, then they've little right to challenge the subsequent outcomes of that consultation.* (P17)

There was concern too that if they did not respond then policy could be *'misinformed'* (P3). One participant thought that the 2017 consultation had been framed in an inappropriate way and so it was their **responsibility to counter that narrative** by responding to the consultation:

> *And I think that I felt that they* [religious values] *were being put across in rather a one-sided manner by the GPhC when they first came out, there were some very clear wording that suggested, for example, that people couldn't hold a personal view on things and that might be in conflict if that was in conflict with the professional practice. So I felt that it was important that a balanced view was obtained by the GPhC.* (P4)

For those who had not responded to the *2017 Standards* and *2017 Guidance* consultation, two reasons were given. First, **a lack of time**, because of other responsibilities as well as workload:

> *It could be because of family commitments, if the majority of the profession are female, you might have a household, you've family, you've a lot of other stuff to do behind the scenes that this is seen as perhaps extraneous to what you need to do to get by. And even it's a busy job, a pharmacy job.* (P17)

> *I probably wasn't in – when the consultation documentations, I probably wasn't in a position that I would have had my head above the parapet. I wasn't in a position to respond, does that make sense? As in I was probably working based in a community pharmacy at that point and therefore like responding to a consultation like that, at that point, wasn't clear in my thought, if that makes sense.* (P23)

The lack of time available meant that **responses to consultations were more likely to be completed outside working hours**:

> *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)

The second reason was because the participant **had nothing to say** - maybe because they **agreed with the proposals** and/or they thought that they were **not relevant to them**:

> *I mean, I know the consultations generally do come round all of the staff. I have been involved in other GPhC consultations but I can't recall being involved with these. It's maybe that I've read the draft and thought, well, I agree with them anyway, so - ...* (P11)

> *Not on these ones and I can't think – I mean, I've been a pharmacist for* [xx] *or whatever it is now – no, actually, probably* [xxxx]*, so* [xx] *years this year – so there may have been times in the past but nothing that jumps out, certainly not on this sort of standards. Cos, like I said, I don't feel strongly about it. If I did, then I believe I would have but I don't feel particularly strongly about where I thought these might go, so I didn't.* (P8)

In relation to consultations generally, **apathy** was suggested too:

> *I think probably generally from elsewhere is just apathy, general apathy that people don't respond, they don't even – I mean, the publication's out there, they're well publicised, you can't ignore them, you can't claim ignorance of not being aware of it. But it's the lack of response*. (P17)

3.2.2 The process of consultation

3.2.2.1 Pre-consultation

Participants wanted to be **more involved in shaping the consultation itself**, as some were concerned that outcomes of GPhC consultations were decided before they began - they were a fait accompli:

> *I think (PAUSE) – sometimes I get a sense of how finished a document is when it comes out for consultation. I think if you're involved a bit earlier on in the process, sometimes with consultations it feels like it's almost kind of the tick box of – "well, we've consulted, so it's OK" – then it's kind of a completed document, you know. I think sometimes I'd prefer to be involved a bit earlier about – well, actually things like ethics, "well, are there any – are there any areas of ethics that you don't think are covered that need to be or that needs – you know, are 9 standards enough? Does there need to be 10 standards? And if so, what should the other say?" So something maybe a bit earlier as opposed to you get kind of – "well, we've decided there's 9 and here they are, do you agree with them, do you not agree with them", kind of.* (P11)

These views were not universal, as others believed that the **GPhC did involve stakeholders at any early stage**. For example:

> *I do accept that the first draft, what I've seen with the GPhC in particular, maybe not these guidance but it's my perception after maybe from other stuff they've done, is that they do – they sort of – so, revalidation would be a good one, they seem to do a lot of stakeholder engagement before they do anything. They seem to test it, have a draft or two, maybe so – certainly my perception of the GPhC is that they do have a - prior to consultation – they do seem to have some sort of mechanisms, maybe not for this particular one but my overall perception and I sort of trust the GPhC processes for that.* (P15)

So, **trust in the consultation process** was important.

Participants were clear that c**ontentious matters which might affect them professionally**, such as abortion and assisted dying which we specifically raised with them, **should be identified, discussed, and debated**. There was some concern that *'If it* [changes to abortion provision that might involve community pharmacists] *really is on the horizon, then why is this not being talked about?'* (P7).

Real consultation was essential, as was *'having a balanced discussion'* (P4). Indeed, one of the reasons why this participant had responded to the *2017 Standards* and *2017 Guidance* consultation was because they *'felt that they* [religious values] *were being portrayed as a very one-sided consultation at the time. I didn't feel it was particularly a consultation in fact, it was rather as if a decision had already been made'*. Another participant, who was critical of the GPhC generally, said *'I think that* [personal beliefs in pharmacy practice] *needs far more serious and actual real consultation and consideration, not the sort of sham of a consultation that the GPhC ran'* (P7). Notably, one participant suggested that there had been more than one consultation on the *2017 Guidance* because *'I don't think they got enough respondents and they went out again'* (P14).

P18 raised concerns about **how consultations in general were drafted**:

> *Yeah. I think people think that so called experts have written it and therefore it'll be more or less right and it'll just be tweaks from other experts. When in fact, I think that ordinary professionals have – they actually understand what's happening out at the coal face and it's often apparent that people who write these things maybe aren't quite as embedded in the coal face. So I think it's really important.*

By contrast, P17 considered that *'the GPhC are fairly active in consulting with people as to how – and a wide cross section of people – as to how the profession should be governed by the registration body'*

3.2.2.2 The format of consultations

Participants wanted consultations to be **accessible, visible, and easy to respond to**. For some, these matters were linked to their **likelihood of responding**, as well as **time and workload**, as noted above:

> *sometimes you have to read a lot of material and sometimes the questions, the way that they're asked, are very difficult to articulate in a meaningful way and sometimes it just turns you off, you just think, "I just don't have time for this, I'm not gonna do it".* (P12)

> *It depends on the questions they're asking and also with the way consultations are done, you pretty much have to have protected thinking space to do it and are you gonna get into that hole when you're knackered and all that sort of stuff, or had a hard week or whatever.* (P23)

There were mixed comments on the **ease of responding to GPhC consultations**:

> *I think it's very easy. Its refined I guess over time to be something that's quite easy to do. I don't perceive any barriers. I've never met any barriers and people haven't challenged it – others that have been part of perhaps a discussion group haven't said it's been difficult to respond to or reply to*. (P17)

> *I think there would be a better way practically of doing that where (SIGHS) – I'm not quite sure how you would do it but cos you have to scroll backwards and forwards when you're looking at these things, I'm sure you could have a sort of separate questionnaire that you could have 2 things open at the same – on your screen at the same time, that type of thing. I usually find it's a bit of a hassle*. (P18)

Helpfully, P18 suggested that **consultation processes could be improved** by giving potential respondents '*some idea of what they* [the author of the consultation] *think the contentious issues are when they put the document out'*. Providing this, and '*having kind of a bit more of an honest thing behind it of - you know, this section is the thing that we think people will have different views on because our group found it difficult to come to a conclusion, something like that'*, would **help respondents to focus on key issues** '*if you don't have enough time to really go into detail in the whole document'*.

Drawing specifically on the consultation on the *2017 Guidance*, P3 noted the **importance of clarity** in terms of proposed changes and the linked questions:

> *Yeah, roughly cos, from reading the information sheet, it was saying that initially there seemed to be – it seemed not very clear to me – but the idea was to remove the conscience clause effectively, which I was very much in support of. So I said, "oh this is a great change". The wording wasn't very clear, it didn't literally say, "we're removing the conscience clause".*

This participant was **critical of consultation processes generally**: '*But I have heard that it's almost like a bad research instrument'*.

The GPhC's **use of focus groups/workshops** as part of their consultation events was commented on by some. For example:

> *you see a lot of focus groups style events and my conclusion from what I read was that these are often steered by the host. They steer towards what they want to take from it. There's clear examples where events where they took place over a period of time, they must have had at least an hour, an hour and a half of discussion, very limited notes were taken out of it, with some quite weighty individuals in the profession and patient representative groups, representatives of technicians as well obviously … And I looked at some of the published notes from these meetings and I found myself thinking, there's no way that these individuals only had a couple of lines to say during these events.* (P7)

Concerns about focus groups/workshops were linked to ideas of **real consultation** and **involvement in the process at any early stage**:

> *So I think it's good in principle that they do conduct such workshops. However, I do feel that their responses are often – their course of action is often predetermined and there is an inherent bias in the way that they ask their questions in consultations as well.* (P6)

This participant thought that **not everyone might feel free to speak in focus groups**:

> *You can feed back and ask questions to the table that you're sat on or to the entire room. I think there are naturally difficulties in people openly saying what they think in such circumstances, but I don't see a way – I don't see that the GPhC has any way around that*. (P6)

It was also questioned whether individual responses were **anonymous**, and that this might stop some from responding to consultations.

3.2.3 Who responds to consultations?

It was suggested that certain types of people were more likely to respond to consultations or challenge proposals, and so **the status of respondents** should be considered. For example, *'this consultation was most likely an organisation's only senior people would respond to. Most of them'* because *'they would probably be the only ones that were aware that a consultation is out'* and *'they tend not to cast it out to people at the front line as often or evidently'* (P14).

The question of who responds to consultations might be connected to matters of **workload and time**, as noted above, and to **confidence** too. The suggestion that notes on contentious issues are provided as part of a consultation might help here:

> *I feel that would just be a bit more be a bit more relevant to people and give them some of the background because, to look at these things properly, unless you're an expert in the area, it's very difficult to comment cos you think your comment might actually a load of rubbish cos you just don't know enough about it. Whereas giving you some guidance – and I think that might help with the more youthful pharmacists to give them confidence in what they're contributing to.* (P18)

Where a pharmacy professional was **located and the environment** they were working in might also affect whether they responded to consultations:

> *And the people we're talking about here are those 30-40,000, so those day to day in community pharmacy. You go to Boots and speak to any chemist on the front line, they wouldn't probably have ever heard of this* [the GPhC's consultation on the *2017 Standards* and *2017 Guidance*]. (P14)

Unsurprisingly, matters of **time, workload and space to respond** to consultations generally were noted:

> *I have engaged with other similar processes but the problem is I've got an ability to do that because, of course, I've got a protected space. Whereas if you're standing in front of 500 items with lots of customers, lots of different – you don't have the ability to do that.* (P23)

3.2.4 Group responses to consultations

Some participants discussed **the process of writing a group response** to a consultation. P17, for example, talked of trying to engage colleagues in consultation processes generally, noting that:

> *it tends to be the same people possibly we tend to get the response from, although the circle is wider than that but the ones that are active tend to be the same ones that over the years have been quite active in their activity levels … It's a small pocket of people who tend to be active in things I guess that's harnessing that enthusiasm and trying to grow it.*

Others said that ***who* asked them to respond**, as part of a group, might influence whether they did so:

> *And or if one of my colleagues said, "we're putting together a group response, can I have your thoughts – excuse me – by Friday or whatever", I may be more inclined to feedback to a colleague cos he's a colleague rather than some faceless sort of entity that I don't have that similar attachment to. So if you said to me, "can I have something by Friday?", well, yeah, I'll make some time for that ...* (P8)

Interestingly, this participant, and others, believed that **responding as part of a group mattered more than an individual response**:

> *I just think they carry more weight cos it's of a group, it depends who that group is and who that feedback is from but I would expect that that is probably given more weight. Now, whether that's consciously or subconsciously than just one individual thing, "well, I don't think that's right". Whereas if it's a group of people saying, "well actually collectively we've debated this and we don't think that's right", then I think that would carry more weight.* (P8)

It was also suggested that **organisations rather than individuals were more likely to respond to consultations**:

> *I would doubt very many individual pharmacists would consult – would make comment on consultations from the GPhC I think. I don't know what – they probably have more sort of like the [NAME], [NAME], they'll have - Organisational responses than they do personal individual responses. Probably the religious and moral one, you would have*

> *more based on people's - … - felt strongly about it. But byand large it's often usually organisational responses to things rather than –*. (P23)

In terms of the actual **dynamics of writing a group response**, some participants talked of a **collaborative experience** with the GPhC's *2017 Standards* and *2017 Guidance* consultation:

> *So I read through it and then I looked at the consultation document and I said to them before, "we'll have to do this, I don't mind co-ordinating it" and they were like, "yeah, youdo it" (LAUGHS). So I wrote comments based on it and then I sent it out for check and challenge, took on board people's comments, went back out again, had a bit of a deadline and then said, "right, I'll then feed this back" and that's how I went about it and then got the boss of our* [NAME] *team at the time to say, "are you happy with this because it's coming from the team?".* (P5)

Others suggested that 'group' responses may, in fact, not be so collaboratively written:

> *More often – well, quite often I'll pull together the consultation responses by myself and then circulate them to the group, so I'm submitting on behalf of them but it's essentially all my views and I'll maybe just –*. (P10)

Some participants had tried to engage colleagues in responding to consultations, but **internal decisions could affect who respondents were**:

> *Also, in most organisations, it would be the job of the senior person to collate responses and they tend not to cast it out to people at the front line as often or evidently. So people on the front line, junior, middle, even senior people tend not to get involved in these consultations.* (P14)

Furthermore:

> *Information is filtered and no junior pharmacist 2, 3, 4 years qualified will ever really say what they think if they know their response is being filtered through a senior chain of command*. (P14)

3.2.5 Post-consultation: The GPhC's response

Once a consultation period had ended, participants wanted two things. First, **to know that they had been listened to**. Some believed this to be the case with the GPhC:

> *And I think generally the comments made are heeded to, they're incorporated perhaps in a diluted context but they are – you can recognise some of the contributions that you've made or contributed to have been taken into the context of the revised procedure or guidance*. (P17)

Others were less convinced: *'Oh, they ignored it. It's just par for the course really with the GPhC'* (P6), and:

> *my overall view of consultations by the GPhC is – I think I've already used the word that I see them as a sham really, it's a complete façade. It really is a method of paying lip service to consulting people.* (P7)

This participant also said that although they had responded to the *2017 Standards* and *2017 Guidance* consultation, *'You respond knowing that your views are gonna be disregarded …'* (P7). **Being listened to** was linked, for some, to **real consultation**:

> *No. I am a great fan of – well not a great fan, I'm a great believer that they need to listen. I don't think they're listening. They're doing but they're not listening. They're doing things that are tick box exercises because they have to do them …* (P2)

Secondly, participants wanted **more information on responses to consultations**:

> *And the more and more I respond to these consultations, the more and more I see is that outcomes – my outcomes as an organisation are probably lots of comments never heeded because I hardly ever see any change from the first situation. I hardly ever see it. So there's no explanation from the GPhC around who responded, what the response is like or it's not widely distributed*. (P14)

This participant said that the GPhC *'never published'* response rates to consultations and this meant *'So you're thinking regulation as being guided by a small minority of the profession and this affects every single profession'*.

Interestingly, it was **questioned whether responses to consultations generally were representative of pharmacy professionals**, and **a way to address this was suggested**:

> *I don't know whether (PAUSE) – you know, with these consultations, is there any attempt to say, "well, if we don't get anything from any junior hospital pharmacist, then that's a problem and we need to go back to them?" I don't think there is anything like that. I think it's just if you contribute, you contribute and, if not, then it goes through.* (P18)

3.3 *Pharmacists' sense of the role of values in their practice and the place of ethics guidance as a source of key values*

3.3.1 The values of pharmacy professionals

3.3.1.1 Professional values

The idea of providing **person-centred care** (*'putting the patient first'* (P1)) was mentioned by the majority of participants, with P5, for example, saying that:

> *For me, it's always been about the person or the patient because, at the end of the day, they're the end user, they're the person that it benefits and even from when I came into this profession or before that when I was a student or pre-reg, it's always been about that person, that patient. You do something – I was always taught, whatever you're doing, pretend you're doing it – think about the person you love most in the world and think about doing it for them. So you would never do anything to harm the person you love most. You've got the person that you love most in the world, you want to give them the best care. So for me, that was just a no brainer.*

Providing person-centred care had a number of elements, including **seeing the person seeking care as a person** (*'it isn't all about medicines, you know, see the person behind them'* (P4)), **valuing** them and **giving and respecting their choices** *('it wouldn't be what I would choose but the outcome's unlikely to be so severe that it will be very detrimental to the patient's health or whatever'* (P21)) as **recipients of health care**:

> *So I would like to think and I hope (PAUSE) – that if I value – like values as a general perspective of valuing people allows you to do maybe a better job, you go the extra mile, you'll try and do a wee bit more for that person because you value (PAUSE) – to value them, to value what you think you can bring to the situation but also as well know your limitations but to (PAUSE) – so I think the values are core to it because I would like people to treat my mother in the healthcare system the way that she would like to be treated or my ageing relatives, can they do their best for them. If it's me, "can I do my best for them?" So there is – that's kinda value driven.* (P16)

Some participants, however, suggested that their **workload** might **hamper their ability to provide person-centred care** and is it prevented them from seeing persons seeking care '*In the context of their life and I don't think we necessarily do that and I think we have a difficulty in the ability to do that because of the workloads'* (P18).

Person-centred care did **not mean that those seeking care always got what they wanted** when the pharmacy professional's **clinical/professional judgement** suggested otherwise: *'I wouldn't be doing my job if I did exactly what the patient wanted, which might not exactly be what is best in my professional opinion'* (P19). This participant said that while pharmacy professionals should exercise their **professional judgement,** this might mean having to *'stand in between the patient and treatment'* if they had requested something that the pharmacy professional thought was inappropriate for them. Indeed, *'As a trusted health professional, you've got to try and do what's best, you've gotta use your judgement in an appropriate way'* (P4). And in **exercising their professional judgement**, pharmacy professionals should be **non-judgemental and not discriminate:**

> *who am I to tell another human being what's right and wrong? Sorry, I don't think that's for me to make that judgement. It's for me as a professional to give them all the advice and all the information and to ensure they've made an informed decision and a decision that hopefully they won't regret.* (P8)

Some participants saw the person seeking care as **giving the pharmacy professional responsibility** to act in their **best interests**, so that they **benefitted from and were not harmed** by the care they received:

> *somebody has come to you for advice. They put their health in your – excuse me – in your hands. Now, that's more responsibility than if you are a financial adviser or you're a lawyer, you know. The consequences potentially are death … That's the responsibility we take on. So your values, your behaviours have to reflect that responsibility that patient often abdicates to you. "You're the health expert. I'm gonna give you this ball of responsibility for my care. I don't know what I'm doing, you're the expert".* (P8)

As part of this, the **values of the person seeking care** should be recognised:

> *It's very much to each, each - each patient is unique, is different and you've got to have the time and the ability to get to know what their values are all about, to get the best optimisation of the care and the advice you give to them. Absolutely.* (P2)

Others noted the position of the **person seeking care and their family** too:

> *So person-centred care may – I don't know whether the definition includes the carer, the partner, the father, the mother. But actually, if we're talking about ethics and morals and what have you, I don't think you can ignore the wider family circle or the wider carer circle in what judgements you are making and engaging with*. (P8)

Being professional, including **being a healthcare professional** (*'we're a healthcare professional'* (P6)), was mentioned by many participants. For example, *'I think – I mean, I have quite high standards and I hold myself to a high standard as a pharmacy professional …'* (P1) and *'You, as a healthcare professional, you're there to support them* [persons seeking care]*'* (P9). P14 suggested that **healthcare professionals had different values to others**:

> *These are human values. We're talking about human values. These are values which would benefit us all if we all practised that across human civilisation, which we seem to forget we're part of sometimes. And I think that is where when you have a conversation with a healthcare professional, it's a very different conversation compared to a non-healthcare professional, cos we see things differently cos of our value, believe, our value base is different to those other ones.*

Being a healthcare professional was linked with person-centred care: '*… you're sort of part of the deal of being certainly a healthcare professional is you're there to serve the public and going back to patient-centred care, the patient is your first concern …'* (P15). It was also connected to ideas of **responsibility** and values more broadly:

they're giving you that responsibility and you, as a professional, your values have to all be about understanding that responsibility you've been given and doing the best for the patient, the person, client, whatever the terminology you want to use is or the parent or the carer. (P8)

3.3.1.2 The personal values of pharmacy professionals

Perhaps unsurprisingly, the same personal values were mentioned by many of the participants:

- **integrity:** *'I think like having integrity is quite important for me and being quite – like being quite – sticking to my principles of what I think matters'* (P1); *'integrity and trustworthiness is very important, absolute key of their professionalism, whatever that means in various contexts'* (P14);

- **respect:** *'So clearly values of respect, clearly values of kindness, values around being generous with our time, being willing to go the extra mile for people when they need us to, values that I hope don't judge people'* (P4);

- **honesty/truthfulness:** *'You treat someone in the same way you would want to be treated, fairly and honestly'* (P5); *'I suppose kind of honesty and being realistic, and letting people know what the benefits of treatments are but being realistic about side effects and about the negative side of it'* (P18);

- **openness/transparency:** *'Well, things like honesty and transparency and consistency and all those ways that you would want to be treated yourself and I think the same applies if you're the recipient of healthcare. You would want to be have your healthcare delivered by people who you felt had those kinds of values and I do think a big part of that is being non-judgemental'* (P10);

- **care**, **comfort**, **kindness**, **compassion**, **empathy:** *'I think more the case, if you drill down to what your personal values are, you know, be nice, looking after people, understanding and caring and being compassionate and empathetic and all that sort of stuff …'* (P9); *'The right values again would be around – I don't know how to describe this (PAUSE) – again, it's about you only go into healthcare if you want to care for patients*' (P12).

P20 spoke for many:

What values? Well, I think we have to be patient, we have to be caring, understanding, respectful, knowledgeable obviously clinically competent, but we have to have these softer skills as well. We have to be able to manage someone, to speak to someone, to advise someone with the best of grace because, as we've said before, it's not always just the clinical side of things. Sometimes it might be a mental anguish that they have and you have to be able to support somebody.

Other personal values included being **intuitive** and having **insight** *('reading between the lines and understanding what that means'* (P14), **seeing others' points of view**, **tolerance**, **flexibility**, **speaking up (for self and for persons seeking care)** and **authenticity** *('You have to show authenticity all the time, you have to show integrity all the time and be able to speak up, as it were, to say if there's a concern, you raise that concern'* (P12)). **Personal values might be linked with the values of the NHS**, for example:

> *I've always believed in being kind and considerate and compassionate and, funnily enough, they are the same kind of values that are in the NHS, which is probably why I went into the NHS because it shares the same values that I do*. (P5)

3.3.2 The role of/for personal values in pharmacy practice

Many participants stated that personal values were **important** to, and in, their practice (*'You have to have values, you have to have morals, you have to have strengths in your profession.Obviously it's really important*' (P20)). **Personal values needed to be recognised and acknowledged**, as they might **affect behaviour**: *'Well, I think that – I mean, attitude and values, undoubtedly drive our behaviours, don't they? And they will drive our health failures and the approach that we take to patients'* (P4).

Overall, there was a sense that personal values were linked to **being a good professional**, in terms of **professional morality and expectations**. Perhaps because of this, for some participants **personal and professional values** were, or should be, **the same**: *'My professional values and my personal values are pretty much the same. How I am at home is how I am at work and how I am at work is how I am at home and it's the same'* (P5).

For some, values were so important that **value-based recruitment** was, or should be, employed. For example:

> *Yeah, absolutely. I mean, we actually – when we interview – so I head up the recruitment for the department and when we interview the interviewees, we have sort of practical tasks, pharmacy related tasks but we also have a value based interview. So actually all of the questions – well, I don't ask questions around, you know, clinically what's this drug or this, I ask things on their values. So I'll ask things around what their views are on mental health and physical health and very much our organisation is value based recruitment, so we make sure that, fundamentally, everybody we employ holds the same values as we do. So, you know, the honesty, transparency. We don't ask values around things that may sound religious or, you know, values like that but actually that would come out because we want people to be honest, transparent and want staff to feel they can have those conversations with us when they come on board if they have any issues around sort of religious beliefs. But, you know, we do strongly believe that values and that – again, that's in all of our strategies that we want staff to feel they can come forward.* (P11)

This participant's position on personal values was clear: *'I think you've got to have good values to work in the NHS'*.

Personal values were linked to creating **relationships**, which were essential for **trust** and providing **person-centred care** (*'I think having a good relationship with the patient leads to good trust and I think you having reasonably good values leads to that, doesn't it?'* (P9)), and some talked of **values as being important for both the pharmacy professional and the person seeking care**:

> *I think your values and your feelings are important both for the carer and - the giver and the receiver. So you have to have a balance where my feelings are taken into account as well as the patient*. (P20)

Most participants said that pharmacy professionals' **personal ethical commitments should be accommodated** (see section 3.4.2.1 below), and that **balance** was required but was not easyto achieve:

> *it's difficult to accept everybody's view and there may be people on the vast extremes that are just one or two individuals that hold a completely different viewpoint … But, you know, for the majority, there will be a variance in their beliefs and their moral ethical standpoint that I think you should accommodate that is generally acceptable*. (P8)

P14 questioned why it was **appropriate to recognise external but not internal values** - those of the person seeking care but not those of pharmacy professionals:

> *So why do we have to take external values into consideration when we can't really take internal values into consideration as strongly as that? We can do to a point but then after that point, we can't. Whereas where the patients are external people to us, we have to take all of their values and recommend something based on all their values.*

3.3.3 Sources of values

Unsurprisingly perhaps, very few participants said that their personal values came from **guidance or codes**, and some specifically noted that the GPhC's guidance was not a source *('I don't think any of them come from the GPhC, I have to say'* (P6)). Rather, participants said that there were various sources of personal values, with **background** (including family, education and religion) noted by the majority of participants, and **experience** mentioned by many too. P5, for example, said that:

> *my values are shaped on my own experiences, my faith, my family, my friends, stuff that happened at school – that's how I've become who I've become. So my values and morals have shaped me and I try and have good positive values because that's how I want to be treated*.

Many participants said that values were **innate**, and **role models** were a source of values for some. A number of participants actively sought to pass their values on to others – to act as role models, but very few said that values could be taught. P10's comments captured the views of many:

> *… Well, 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 and* – [role models within the profession] *… Yeah, often they are. Often they are. Certainly with regards to my professional life, yeah, absolutely. There's probably 3 or 4 people that I would put into that category who I've worked with or worked alongside over the piece that have changed the way that I look at things and the way that I value things.*

3.4 *Pharmacists' experiences of, and views about, conflict between their personal ethical commitments and the expectations associated with their professional roles*

3.4.1 Experiences of conflict between personal ethical commitments and professional role expectations

Most participants had **not personally experienced conflict** between their personal ethical commitments and the expectations of their professional role; however, a number said that **their personal ethical commitments or values did not come first** (*'there are many values that I stand for in my personal life that I have to put aside and accept because I have to understand patients are different'* (P14)). Notably, one participant suggested that **conflict was more likely to relate to something that they wanted to do but could not**, rather than not wanting to do something: *'I mean, there's a lot of times where you think, this is (PAUSE) – a lot of times you will feel that, yes the patient should be getting this but your professional responsibility says no. So there is a conflict within yourself for that as well'* (P19).

Conscientious objection was not thought to be common (*'a small proportion of pharmacists hold a very firm belief'* (P4)), and only **a few participants knew pharmacy professionals who had refused to provide some services**. One participant had **had patients referred to them** by another pharmacy professional, and others had been asked to dispense for a colleague and had no problem with this (*'that's how you work as part of a team'* (P13)). Another recounted their experiences of being the subject of (local and national) protests because of setting up a sexual health clinic.

Very few participants said that they had refused to provide services because of their personal ethical commitments, but an example was given by P14:

> *So there's been times where I have said to patients or have advised them without saying directly that "this advice, this service that you're looking for can't be provided here but can be provided at X, Y and Z". One or two times they ask "why not" which I say, "today, we can't provide this service" and sometimes we've gone into it – once I've gone into it actually and said, "really, this goes against what I stand for, I don't provide this service but part of my duty to you is to tell you who does" and they've accepted that. That's only ever happened once to me. Most of them are people just accept, "oh you can't do this but I can do it here, great".*

This participant agreed that they **would not have felt as comfortable doing this earlier in their career**: *'Yeah, of course not. I would have just – I would have given them or provided the service if it was appropriate for them'*.

Another participant **reluctantly provides emergency hormonal contraceptives**: *'It's not a red line in that it's a grey line, if you like, so I will do it - so I will do it but with a heavy heart, shall we say'* (P20). This participant would signpost someone seeking care if they had safety concerns about providing a service but would not signpost for moral reasons. And they worried about the **consequences of not supplying** emergency hormonal contraception: *'I think it's worse if it's a young girl and I'm thinking, she's gonna have a baby if I don't do this or it could be worse, it could be worse for the child'* (P20).

In fact, a number of participants had refused to provide services to, or referred on, persons seeking care on the basis of their **clinical judgement**. Indeed, it was suggested that *'probably every pharmacist has probably been in a situation where they've had to refuse a sale of co-codamol or Nurofen Plus'* (P7). Another participant said that they had suggested or would suggest that persons seeking care went elsewhere if they felt that those persons were not opening up to them:

> *But if I'm really uncomfortable because I'm not – if I feel not trusted or anything like that or if I feel that, you know, I'm not getting something, I'm not getting anywhere with – by speaking and the person is not opening up to me, then I would say – I would actually say to that patient, "go to somewhere where you feel comfortable talking" ... And I'm allowed now to do that ... But before, when we weren't … - that's where I found it quite difficult … But it was very, very – it was very infrequent – don't get me wrong – but I understood it. I actually understood why I was doing it, I was comfortable with it.* (P2)

This participant had specific areas that they were personally uncomfortable discussing or had limited knowledge of, and so would look for **support** on these from colleagues (*'we've got a circle of friends where I can open up and sort of professional friends as well as good friends'*). Interestingly, a number of participants said that **different levels of support** were available **for community and hospital pharmacy professionals**. P4, for example, talked of those working in hospitals being *'surrounded by health professionals and other pharmacists'.* By contrast, *'when you work in community pharmacy, sometimes you do feel as if you're by yourself'* (P16), and this **might affect responses to conflict with personal ethical commitments**.

As well as **painkillers**, **emergency hormonal contraception** was commonly mentioned by participants as a service that some pharmacy professionals may refuse to provide, with other examples being **contraception**, **homeopathy and alternative medicines**, **methadone**, and **needle exchanges**. Notably, some participants suggested that **conflict in community pharmacy** consistently existed between ***'patient and profit'*** (P4) and that values had a role here too:

> *'it is all down again to values and ethical behaviours and they probably apply as much to business, or they should do and perhaps they don't, but they should do, as they do to other decisions'.* (P4)

3.4.2 Views on conflict between personal ethical commitments and professional role expectations

The overall sense was that while there could be **tension between personal ethical commitments and professional requirements,** '*The occasions where that tension comes into conflict I think are quite few and far between*' (P4). Most participants thought that **personal ethical commitments <u>should not</u> be imposed on or shared with those seeking care and/or colleagues** (*'I have religious beliefs but they're my religious beliefs, they're not someone else's religious beliefs'* (P5)). P3 provided an interesting analogy:

> *… I think – this may sound quite strange but the teaching I do, I use the example of healthcare professionals as construction workers in that we are not – we don't have a higher authority, we're not moral arbiters. We provide a service. That service is care, obviously, but when you have a builder coming to your house and there's a house round the corner from where I live who's got these massive pillars which I think – "oh God, they're gaudy and gauche", but actually the builder may think that but that isn't – the builder's been asked to build something and as long as it's safe in terms of the architecture, it will support the house, it's not dangerous, it's environmental safe it's not gonna pollute, it's not a dangerous thing to build. But the builder provides that for the customer and I think that's similar with what we're doing. We, as a society, deem that it is ethical to have – I'm focusing on EHC* [emergency hormonal contraception]*, things like EHC and those sorts of services – so as a society, that's our – that's OK, it's not for individuals then to decide what you can and can't do.*

Different perspectives on imposing values were also offered, with some participants asking whether **positive values could/should be imposed**:

> *… what if you've got positive values and beliefs, that should be – we talk about sharing health and wellbeing and positivity and all that good stuff, so if you've got these positive values and beliefs, then why would you not impose them? … And I agree, you shouldn't impose your own values and beliefs on other people if they are values that go against being good and being moral and being kind and caring and anything that goes against that, well why should you impose that?* (P5)

Another said:

> *I think it is important for people to recognise their values might not be shared by other people. I think there's the converse of that is – yes, but the GPhC can't be imposing their values and beliefs on to the pharmacists (LAUGHS).* (P15)

This, they suggested, could be how the *2017 Guidance* was interpreted by some.

For some participants, if **services were legally approved** then that was the end of the matter, and **not providing lawful services <u>was</u> imposing values**:

> *So if it's lawful, if it's available to the patient, then I think the decision around the ethics and the morals is for the patient to decide. For me as a professional, it's about – … It's* [Law's] *a safety net and an enabler I guess.* (P11)

> *So I think – well, certainly the way I'd approach it – I think if something was legally approved by law and the majority of our profession was doing that, you disagree with it and made that person, patient, whatever not able to avail of that service because of your values or beliefs or treated them in a manner that something's accepted by most people - legal, fully legal - and you've made them feel stigmatised or contribute to stigma* [then you have imposed your views on them]. (P15)

Similarly, **pharmacy professionals' views could be imposed** on that person by **not signposting/referring** the person seeking care to another provider:

> *Well, if you just leave the patient hanging because of your moral or ethical views, then you have, in a way, passed on your views on to the patient because you've left them with nowhere to go.* (P19)

A number of participants recognised that **separating personal ethical commitments and professional values might not be easy or possible** but said that it was **necessary to do this as a pharmacy professional**. As P3, for example, said:

> *But I think we should be more a mirror rather than (LAUGHS) – I don't know what the opposite of mirror is but (LAUGHTER) – rather than say, this is my belief, there you go – it should be – well, there are several beliefs about this and try to be as non-judgemental as possible because, by saying, no I won't supply it – I keep focusing on EHC* [emergency hormonal contraception] *but no, I won't supply EHC, there is no room for manoeuvre there, that's – you have to – the pharmacist has decided that.*

One of this participant's concerns was that if a pharmacy professional's personal ethical commitments predominated, then power was taken from the person seeking care and **person-centred care was compromised**. As P10 said:

> *when you're delivering healthcare, you're delivering it for the benefit of the person you're delivering it to, not for the benefit of the person who's delivering it. And so the values and beliefs that are important are those of the recipient of the healthcare rather than the provider.*

Some participants said that the pharmacy professional had **chosen their profession**, and that this had an impact on whether their personal ethical commitments should be accommodated:

> *I think people go into professions knowing what to expect and that's why we teach law and ethics in university is to give them that get out clause – well, potentially, the get out clause if you're not gonna practise in this environment, then you shouldn't practise at all. (*P12)

Not all shared this view:

> *I don't think that that's an appropriate approach because – for several reasons. One is that pharmacy is constantly evolving and assisted dying will become part of – treatment for assisted dying will become part of practise and I don't think it would be reasonable to say to someone who's had 20 years' service as a pharmacist that you can't work as a pharmacist any more because you're not providing this service. Two, I think to do – to say that to an entire healthcare profession of 54,000 people would be (PAUSE) – it would be very damaging to that profession and to the public alike if they were deprived of the services and care of a very good pharmacist who held a particular belief. And three, I don't think it strikes a fair or reasonable balance in human rights and doesn't – and wouldn't respect the human rights of the pharmacist.* (P6)

One participant had a more fundamental concern:

> *You've got to have an open ear and I think – I do worry that sometimes people's own views and values and beliefs block out listening, just listening, cos every situation is very, very different. Every person is different.* (P5)

3.4.2.1 Managing personal ethical and professional commitments

As noted in section 3.3.2 above, many participants said that **compromise and balance** were needed in order to **accommodate** personal ethical commitments and professional commitments and to **manage any tensions/conflicts**:

> *So I mean, I was reflecting back to when I was a newly qualified, a junior pharmacist, I would wholeheartedly put everything to a side and look at the patient. Now, as I get older, I understand there's an important balance there and I can make the judgement of not imposing but sticking close to what I believe what my values are and still be a patient, person-centred professional.* (P14)

Different perspectives were offered, for example:

> *But I think they need to be and I think if you go into a profession delivering healthcare, then you have to be prepared that that will be difficult sometimes and that you will meet people who are vulnerable who are in situations that you don't agree with and wouldn't have chosen to get into but that's part of the deal you're taking on when you do it I think*. (P10)

Accommodating personal ethical commitments was, largely, seen as important because there was **empathy for pharmacy professionals who objected to certain treatments**, and concern for the **impact on them** if conscientious objection was not permitted:

> *Well, do you know, I think what I come back to is (PAUSE) – no, I wouldn't want any healthcare colleague to feel compromised and therefore to impact on their emotional wellbeing if they had to operate in a way that was totally against what they believed in.* (P22)

Thus, being a pharmacy professional did **not mean having to put personal ethical commitments to one side** but, instead, **telling employers** and **devising processes** to ensure that **person-centred care** was provided *('I think then the relationship with the employer, the discussion with the employer is key and any employer manages those issues is really important'* (P10)). Some participants suggested that both **employers and employees**, including locums, had **roles and responsibilities for accommodating personal ethical commitments**. For example:

> *And I'd expect the employers in them cases – I think people join the profession, they expect more of an onus on the individual not to put yourself in that area where this is now accepted practice. But say for example the EHC* [emergency hormonal contraception] *when it came in for people who were doing that job for ages and never thought it would be an issue, then they object – I think it's more of a responsibility on the employer there, slightly more. I don't know. I don't know really why I think that, where there should be at least be a lot more facilitative in trying to place them somewhere else.* (P15)

> *So, for example, if I had a locum, if I had somebody coming into the pharmacy I work in on the days that I'm not in it and they had some beliefs and values that would not allow them, for example, to deliver the morning after pill, I believe it's their responsibility to let me know before they're in my pharmacy to say," just to let you know this is kind of, I wouldn't be able to do this, how could we work this together?"* (P22)

Pharmacy professionals had a responsibility to consider the **location and environment** in which they were working in or hoping to work in:

> *Well, you need to be aware of the situation which you're going into. If you're gonna take up a post or a job, you should do so knowing everything that's gonna be expected of you and I know you can't know everything but – and again, I'm gonna use EHC as the most common example. If you are going to work in community pharmacy and you do not and you fundamentally, morally, religiously believe in that and contraception, you need to really consider which community pharmacy you're going to work in.* (P5)

And it was suggested that if they have *'such strong convictions'* that they cannot refer someone elsewhere, and if they were unable to provide a service *'then you're possibly in the wrong part of the pharmacy'* (P8).

Another participant, however, suggested that **too much responsibility was placed on employees**:

> *there seems to be disproportionate onus on employees than there is on employers and employers have more power, they have more facility to make it easy or not easy for individual employees to take action. And (SIGHS) – …* (P15)

It was suggested that **systems should and could be established to enable those seeking care to access all services** and P8, for example, said: *'I find it difficult to believe or to think of a scenario where you couldn't accommodate that'*. Another participant, speaking from the perspective of an employer/manager, talked in terms of a **contract between colleagues to accommodate personal ethical commitments**:

> *So I think it's a contract of 2 colleagues, one who has a view on something that prevents them delivering a service, to work together to sort it out. I don't believe I should be sorting it out on my own and I feel then as a responsibility after that conversation to communicate to the rest of the team and say, "look guys, this is what the situation is, this is what we're gonna put in place, any problems give me a shout". This is what I would normally do.* (P22)

This participant also noted the **effect of refusing to provide a service on other healthcare professionals** and the importance of **taking responsibility**:

> *But the reality is, where possible, we need to take responsibility as much as possible, for what's within our control so we minimise the work with another healthcare professional.* (P22)

P11 spoke of how they would **act as an employer**:

> *I would respect that and I'd say, "OK, we'll find somewhere else for you to work where you are comfortable in what you can provide the patient's service without having that ethical dilemma every day and the moral dilemmas that you've obviously got".*

Their concern was not having people *'working in areas that they didn't feel comfortable or that they couldn't provide the service we wanted them to'*. This would have to be considered on a case-by-case basis, and P11 was clear that they did not want *'a pharmacy robot'*.

Some participants thought that **accommodation was likely to be common but hidden**: *'And I would generally imagine – I imagine that there's a lot of this already going on that we don't know about that's dealt with informally because – but not very visibly'* (P18). For a number of participants, the primary concern was **service provision**:

> *Well, it's service provision. That's my point of principle. Cos someone has made a conscious choice to access a service or a treatment and, for me then, I'm in a healthcare profession, they've chosen to access that. Now, whether I agree with what their choice is – … That's a different thing for me.* (P21)

Personal ethical commitments could be accommodated by the pharmacy professional **signposting or referring those seeking care** elsewhere, although by doing so some suggested that *'you're not really helping that person, are you? You're helping yourself …'* (P9). Thus, **person-centred care might be at issue**. Nevertheless, **referring** was thought by some to be:

> *one of the most simplistic and most timely ways to do it because, if you start putting in other things, then it makes it harder. Time delay might be really important and - … And it's kinda like – off the cuff – right, you can do that and it's easy to remember. Rather than a whole process of bureaucratic shenanigans.* (P16)

It was widely agreed that what mattered was **how referral occurred** (*'a polite refusal'* (P6); *'in a timely manner'* (P13)). It was important to be **respectful**, **responsible**, and **non-judgemental**:

> *… I don't think it's our place to make judgements about people. We may have our personal views on things but we mustn't use those to judge other people or their situation. On the other hand, we could use those values that are important in terms of caring for people to not necessarily conflict with our belief about that but to actually arrange for somebody to see somebody else, to make contact with them, to explain why we may not be in the best position to help them or why we feel that somebody else may be able to provide better support and care for them.* (P4)

P11 spoke for many: *'what you don't want is the patient to go away thinking they've done something wrong'*.

'A polite refusal' might include **telling those seeking care why the service was not being provided**:

> *I think it's appropriate to say, explain to someone why you don't do it. I think you have to do it in the right (LAUGHS), like, if you say to someone, "I don't do this, you're a dirty so and so for even wanting this" – that's not an appropriate way to explain to someone. I think it's appropriate to say, "I understand you've come in for this, this is available in most places, personally, I morally disagree with this, I'm actually – there is an exemption for this, I'm really sorry about that" – or maybe you don't want to apologise for your views but, "look, we have a couple of – you have a couple of options. You can ring the out of hours GP, you can go to the pharmacy 100 metres down the road". I think that's sort of, the best approach from a professional.* (P15)

But, as P11 said, *'what you can't do is say, "well, no, I'm not gonna provide that service and leave the patient with no alternative". That wouldn't be ethical'*.

For P5, referral should be **akin to primary-to-secondary care referral**:

> *Well, in the same way if you refer – if I were referred by my GP to a consultant, there'd be a letter, there'd be an introduction, I am referring you to. And it's the same sort of thing. Hello, I've got somewhere here, are you able to see them? Oh right, in 20 minutes, right OK, I'm going to tell them.*

Another participant said that **more than just signposting or referring was required**:

> *I think it's – well, for me, it's about making sure it's a hand over and the service gets delivered. Cos if someone comes in – if we just use the example of emergency contraception. Someone would come in, then I think I now have a responsibility to ensure that person receives the service. And just by saying, "someone down the road is likely to do that", I don't think that's enough cos you know someone has desired to access a service and just by saying, "well someone down the road will do it", doesn't quite – guarantee's maybe the wrong word but you've no knowledge of whether that your action resulted in the service being delivered.* (P21)

For them follow-up was required too: *'I think they have an obligation to make sure that X knows the patient's coming, follows up that the patient has been and that they were treated'.*

There was no agreement as to whether it was **acceptable to lie** to a person seeking care **about not providing a service** by, for example, saying that a medicine was 'out-of-stock', rather than explaining why the pharmacy professional would not supply it. This might be appropriate: *'I would just say, "sorry I don't have this available today, I can – I'll ring another pharmacy and check that they have it in and they can provide it to you". That's what I'd do'* (P1); but others disagreed: *'That's the cheat's way out'* (P5). This participant questioned the reason for lying, implying that this might make a difference to whether it was appropriate: *'But what is their motivation? I mean, if somebody says that, are they doing it because they want it for the patient's good? Or are they doing it just to give themselves an easy time?* (P5).

Signposting and/or referral was recognised to be difficult for some pharmacy professionals who viewed it as tantamount to **complicity** in the objected to service:

> *I can see how that individual would say, "I don't agree with this, why would I facilitate someone getting it through other means? It's exactly the same as me carrying out the act by facilitating that".* (P15)

One participant's response to that was:

> *if that's the case and they're not even willing to signpost, then they shouldn't be a pharmacist. At the end of the day, if you're not providing, you're not a healthcare professional, you're not sticking to the code of ethics, you should look for another career.* (P13)

An interesting perspective on complicity was provided by P14:

> *The way I look at it is that I don't drink, I don't eat pork, for example. If I said to somebody, if somebody asked me, "where's the off licence?" "It's over there". Does that mean I'm facilitating it? I don't think so. If somebody's gonna do whatever they want to do, it's up to them.*

Yet another participant thought the complicity argument *'could be challenged by the GPhC'* (P17).

The **practicalities of refusal and referral** were discussed, which were important because the types of services that those seeking care were likely to be referred to others for, especially emergency hormonal contraception, meant that not only might **time** be an issue, but also that referring someone on might affect **if and where services are accessed** in the future. Referral, though, might be problematic or not possible depending on the **location and/or environment** in which the pharmacy professional was working:

> *For them* [the person seeking care]*, yeah, it* [referral] *might not be the best thing if they can't get to the other service, the other service isn't open, typically, these things always happen on a weekend or late or at night.* (P14)

If a pharmacy professional did not/could not refer in that situation, then they would either have to *'put your feelings to the side and provide that service'*, or not do that and then *'you are putting the patient at a disadvantage'* as well as leaving themselves open to a complaint or *'more litigation of some kind'* (P14). There, thus, might be **serious implications if a service was refused**, including to the person seeking care themselves:

> *But I always think, if someone comes to you for EHC* [emergency hormonal contraception]*, I know nothing about them, they might have been raped and I always think about, "what if they've been raped, what if it was an unfortunate incident and you're saying to them, I can't help you because of my religious beliefs?" You don't know what could be the ramifications of that. What if they go away and kill themselves? What is the bigger sin?* (P5)

It was important, then, that **people were not put off from accessing services**: *'And we really have to try and do the best for the individual so they don't get scared not to access treatment'* (P23).

Employment issues were noted here too, and it was suggested that if it was not possible (either personally or because of location) for a pharmacy professional to refer on someone seeking care and they were **seeking employment**:

> *Then I don't think they should be taken forward for the job cos they can't meet the criteria if they're really that – if those views are that strong that they will not provide a service, then that's like – you could argue it's the equivalent of saying, "well I don't believe in cough remedies or something", like it's just – it's cutting out a part of that business. It doesn't make sense for the employer to employ somebody who won't do what they're – …* (P13)

If the pharmacy professional was **already in employment**, some suggested that their options were either to leave the profession, *'Or go to a different part of pharmacy that wouldn't have that involvement. There's plenty sorts of pharmacy you could do'* (P19(2)). Ultimately, it was important that *'… you really have to have a think about where you practise and, as you say, putting safeguards in place and stuff like that and I'm not sure how many people have done that'* (P23).

Many participants recognised that **employment opportunities might be limited** if they had conflicts between personal ethical commitments and professional expectations:

> *So I guess like you risk basically don't – not having employment if you – maybe in some places – if you decide to stick to your – stick solidly to everything. I think it depends on the circumstances as well.* (P1)

Because of these matters, **some pharmacy professionals might not say that they would not provide a service for fear of not being employed**. However, **personal ethical commitments and possible conflicts should be considered when considering entering the profession**:

> *But I think they really need to be very clear about that when they come in because they're gonna face it. Sorry, if we know what we know at the time of entry, then I think people need to be very clear that that could be an issue for you in the future. If, in these particular circumstances, people will consider. So as long as you're aware of that. (P21)*

There were concerns about **record keeping**, and **complaints** and the **law** too. While some participants said that they would tell the person they were referring that they have *'the right to complain'* (P5), others were worried about the GPhC if they prioritised personal ethical commitments over professional obligations, especially when they were at an **earlier stage in their career**:

> *So belonging to my profession, I knew my regulator, I knew what they stood for, I knew how either ruthless or strongly they feel the standards should be met, I knew what a regulation meant widely. So it* [prioritising professional obligations] *was almost a fear aspect that you don't want to do anything that goes against that.* (P14)

Some of the personal and professional values noted in section 3.3.1 above, were also discussed by participants in relation to managing personal ethical commitments and professional role expectations, including in relation to refusing a service or referring a person seeking care. For example, **person-centred care** was commonly (directly or indirectly) referred to: *'So, you know, I think it's important that we take on people's views but I think as long as it's clear that – yes, we accept that people have different views but the patient needs to be cared for'* (P11). Others said: *'You can't not compromise person-centred care if you're thinking about your own values and beliefs'* (P18). And while P8 commented that when referring or signposting someone seeking care, *'So you are still offering, for me, person-centred care cos you are doing the best you can for that patient'*, P16 thought otherwise: *'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'*. There was thus **no agreement on whether signposting or referring someone seeking care compromised the provision of person-centred care**.

Notably, one participant discussed **person-centred care in different referral situations**:

> *We often have silly examples, we get things like with the prescription items just now there's a huge problem with supply issues and sometimes it's difficult to get an item at a price that the pharmacist will be adequately reimbursed for, so they might be out of pocket. In some cases, it could be quite a large sum and some pharmacists will say that they can't get it and others will say – and then, end of story, they won't try and get it. Others will do their damndest to try and get it. Others will get it and absorb the cost. It's the same with extemporaneous products, it's a lot of hassle sometimes – so, "no, we don't do that". Then they're moved on to another pharmacy. Some patients report having been to 5 or 6 pharmacies before they can get the product which could have been obtained in the first instance if the pharmacist had been so inclined and been more patient-centred.* (P17)

Ideas connected to **professionalism** and **being a professional** were evident too; for example:

> *I think as a professional, your duty of care is with the patient, so you either support that patient to do what is needed or you ensure very quickly that they get somebody who can help them and you take a side step.* (P9)

> *And I think if a professional or somebody puts a barrier up to something, the chances are they're not going to re-present and that's a real concern for me around your – by you having those difficult religious beliefs – difficult's the wrong way of putting it – you may well prevent someone – you may well make somebody's life choices for them inadvertently.* (P23)

3.4.3 Views on the GPhC's *2017 Guidance*

Many participants shared their views on the *2017 Guidance*, with some seemingly undecided as to **whether such a document was needed**:

> *So I think putting this guideline – if pharmacists are gonna be objecting, then I think they do need guidance as to how they do that. The other side of it I think is that I think it almost condones it, it almost supports it and I … By producing – I mean, this is an official document produced by a big body, I worry about public perceptions – I mean, primarily about pharmacy but also the health service because what are they gonna think about what we do and I think if that's undermining patient faith – there's already enough in the news about undermining faith in doctors and professionals, I worry that this could almost be a ticket to do that further, if you will.* (P3)

This participant was concerned that the very existence of a document on personal beliefs and moral values would **undermine the public's trust** in pharmacy professionals and **stop people seeking care**: *'My worry is that it will put patients off coming to see us and it will affect people's health cos they'll think, "well they're just gonna judge me, they're just gonna say this, they're gonna say that"'*. At the same time, they recognised that if personal ethical commitments were to be accommodated, then guidance was required.

While **separate guidance was, generally, thought to be useful**, some questioned **whether it would be read**:

> *… I think another document – are people gonna read it? Probably not. Are people gonna understand everything in it? Probably not. Do you need to discuss around it? Yes, you probably do because it's ethical and the only way you can teach ethics or the way you can understand ethics is to talk about it or be in those situations.* (P5)

As the *Guidance* had to be *'really woolly … because you can't predict every single eventuality'* (P5), there were concerns that pharmacy professionals **might not understand the wording in it**. Indeed, some participants thought that they were now required to explain why they were referring on a person seeking care. And while some of the *Guidance* was *'helpful'* and *'useful'* (P6), there were **questions about its applicability in practice**: '*looking at the guidance, it's very difficult to know what it's actually guiding you to do really if you're in that situation'* (P7).

Some participants had, in fact, **only read the *2017 Guidance* because it was relevant to something they were dealing with**:

> *… are individual pharmacists thinking about the guidance enough? I'd be interested to know how many pharmacists have actually read the guidance from end to end. Now, I've read the guidance because I had a bit of a situation. Something I was thinking about ... So I'd read the guidance, if you know what I mean. So I've read the guidance but I would really, really doubt how many of my colleagues have read it end to end, if that makes sense, based on scenarios and all that sort of stuff* - (P23)

This participant also asked **whether guidance was enough**: *'But I'm not sure (PAUSE) (SIGHS) guidance is guidance. It's guidance. At the end of the day - … I think we possibly need something a bit more rigorous about it … something stronger'*.

Unsurprisingly, there were mixed responses to the **content** of the final *2017 Guidance*. Some participants noted the **changes from the draft to final version** of the *2017 Guidance*: '*I think it's trying to and I think it got challenged and I think it was improved as a result of that. So things that were quite radical to take out'* (P4). Others thought differently: *'So my first observation is that the final wording of this guidance document appears to be a fudge. It has changed from the draft version which was put out to consultation …'* (P7).

There was **speculation as to why those changes were made**, including because of pressure from religious and pressure groups, legal challenges to the draft version, and the need to adhere to other legal requirements, such as the Equality Act 2010. One participant, who was generally critical of the GPhC, said that the consultation on the *2017 Guidance 'really took things to a new level really because the whole thing was sold as being patients are pressurising for this, they need this change to be made'* (P7). However:

> *And it turned out that, actually, the patients more often than not according to the GPhC's own figures in their findings were actually saying, "well no pharmacists, you can – let's leave the clause as it is"*. (P7)

Another was concerned that in its *2017 Standards* and *2017 Guidance* consultation, the GPhC *'was being put under extreme pressure by very vociferous quite militant groups'*, and so they emphasised the importance of *'having a balanced discussion'* in consultations (P4). Specifically, they said that:

> *And it seems as though, in this day and age, you can talk about almost everything, apart from your faith and your religion, which actually, interestingly, is so protected you can't even talk about it in the public domain.*

Some participants questioned whether the ***2017 Guidance*** **and the** ***2017 Standards*** **were incompatible**:

> *I think the second one – take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs – that's very difficult if a pharmacist wishes to refer a patient on to another pharmacist or another healthcare provider because of their own personal values and beliefs. That pharmacist can't warrant that the other person will not compromise patient care, which ultimately the root cause of that would have been because of the referral. 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)

This participant thought that *'better balance'* in the wording was needed, and they wanted the rights of both pharmacy professionals and those seeking care protected *'to the highest possible extent and I don't think that the GPhC's guidance does that ...'*

The **practical implications** of the requirements in the *2017 Guidance* were considered, and it was suggested that if a pharmacy professional could not refer a person seeking care on because it was, for example, late at night and there were no alternatives available, then *'they're going to get into trouble in essence, that this new wording of take responsibility means that they've got no choice but to provide the service'* (P7). As such, *'clearly the push has been to try to force the healthcare professional to provide the service, regardless of whether they want to or not'* (P7). This participant was concerned that the *2017 Guidance* could be **used against pharmacy professionals** by the GPhC or employers (*'to punish a pharmacist'*), and asked whether refusal of a service using **clinical judgement might be 'misconstrued' for a personal value**.

Others said that the *2017 Guidance* meant *'actually, I think the balance still lies with the patient receiving the service'* (P21), but this participant was **worried about interpretation**: *'… But my concern is that someone won't interpret it that way. That's my interpretation of whereit still sits'*. Many agreed with the *2017 Guidance* that **personal ethical values should not be imposed on those seeking care**. This was '*extremely important'* (P10), but was:

> *easier said than done and can bring individuals into conflict predominantly with their employers but also with patients. And so I think the guidance that – that that should be recognised but managed in an appropriate way in a manner that doesn't impact upon the patient I think is extremely important …* (P10)

Some believed that the rules for pharmacy professionals were **different from those for other healthcare professionals**:

> *Yeah, it was disappointing because other regulators don't have this view … So other regulators like I think the medics, they're allowed to say that, "this is my belief and this is why I can't do this, but somebody else can". And I didn't see the reason why they changed it … Because the system wasn't broken in the first place, it worked well enough, so why did it need changing?* (P12)

This participant questioned whether the wording in the *2017 Guidance* meant that **signposting could be interpreted as compromising person-centred care** and suggested that *'legal challenge'* might result over this. They believed that the conscience clause had been removed from the GPhC's guidance.

P4 was also concerned about any differences with other healthcare professions in relation to personal ethical commitments, and thought that there had been a **substantial change in the *2017 Guidance***, but read the previous version in a very different way to P12:

> *Previously it was if you held this sort of view, you couldn't possibly be employed – (a) you couldn't be a registered pharmacist for holding a view like this – that was the previous iteration and that actually it was unacceptable for you to be employed as a pharmacist. So it was almost saying, if you hold a view like this, you cannot practise as a pharmacist and I would question why.*

Another participant made similar comments: *'So there's still no clarity around if you decide to refuse to provide a particular service based on religious backgrounds, where do you stand?'*, and *'The question is, is imposing refusing? Are those two synonymous with each other or not?'* (P14).

One participant expressed **surprise that the GPhC had not been <u>less</u> accommodating of personal ethical commitments** in its *Guidance*: *'I kinda thought the GPhC might be more blanket about it thistime and I was surprised they weren't'* (P23). Others **wanted more from the *2017 Guidance***:

> *So there should be a statement around, if you refuse, you are in your right to do so on your religious grounds but your duty still remains to the patient, so you should – you know, there should be some questioning or discussion around that which is one of the key things that I put in to our response to the consultation.* (P14)

In commenting on the *2017 Guidance*, participants also reflected on **whether and how personal ethical commitments should come into professional life**, how **person-centred care** might be affected, and what it meant for them as **professionals**:

> *I think they are (SIGHS) – I think they* [the provisions in the *2017 Guidance*] *are appropriate. I think you have different ways – I think the first one about not imposing values on other people is really key and I think that was – I suspect that was probably the most controversial part. My own personal view is that when you're delivering healthcare, you're delivering it for the benefit of the person you're delivering it to, not for the benefit of the person who's delivering it. And so the values and beliefs that are important are those of the recipient of the healthcare rather than the provider. So I think that's extremely important and I think there are patients that shouldn't be made to feel as though somebody else's values or beliefs are being imposed upon them.* (P10)

> *Yeah. So when I first read – when I read the first one* [recognise your own values and beliefs but not impose them on other people]*, I've got nothing wrong with that at all. I think you park what you think at the door when you walk into your professional setting and I've always believed that whether it's selling the morning after pill or whatever the situation might be. I totally get that.* (P9)

4 Recommendations

1. To increase trust and confidence in consultation processes, a wide range of people and organisations should be involved at earlier stages of the process, such as when agreeing the terms of a consultation and drafting consultation materials.

2. Consultations need to be easy to respond to, and their results should be shared in an easily accessible and visible way, including information on the numbers involved. The responses of the General Pharmaceutical Council to consultation processes should also be shared accessibly.

3. Consultation responses should be proactively sought from those whose views might not otherwise be heard because of barriers to participation, including those with caring responsibilities, those whose professional roles do not often involve responding to consultations, and those at earlier stages of their careers. It should be made clear that individual responses are as valued as group or organisational responses.

4. Consultation calls could draw potential respondents' attention to the issues that have been identified (in the early stages of the process) as likely to be areas of controversy, while also leaving people free to identify and respond to whatever elements of the consultation they themselves regard as deserving of focus. This would make the process more streamlined and user-friendly.

5. Consideration should be given to the most effective way to consult with and engage stakeholders, including taking into account research on conducting focus groups and other forms of consultation.

6. The General Pharmaceutical Council, and other related bodies, should promote a clearer understanding of the role of personal ethical commitments in professional practice, particularly in relation to providing person-centred care. This could be built into the ethics training provided to those preparing to join the profession and included in continuing professional development too.

7. Professional guidance should be clear about how pharmacy professionals should manage perceived conflicts between their personal ethical commitments and their professional obligations. Vaguely expressed guidance 'passes the buck' to individual professionals.

8. The General Pharmaceutical Council should clarify its 2017 *Guidance on Religion, Personal Values and Beliefs* to minimise existing confusion and uncertainty about how personal ethical commitments can be accommodated by pharmacy professionals.

9. Professional bodies should undertake 'horizon-scanning' consultations on issues that have the potential to raise values-based conflict for professionals in future. For pharmacy professionals, this might include efforts to legalise assisted dying and proposed changes to abortion provision.

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