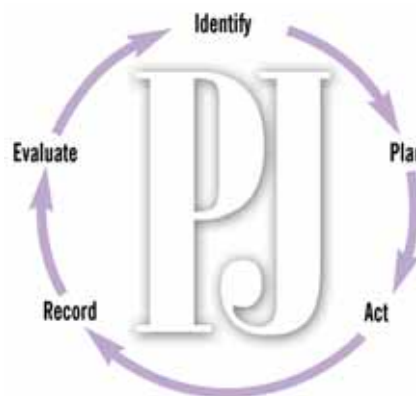


New emphasis in the code of ethics

In July, the Royal Pharmaceutical Society published a single code of ethics for pharmacists and pharmacy technicians, which was sent to every registered pharmacist and pharmacy technician, along with supplementary standards and guidance. In the first of three articles, **Joy Wingfield** explores the new professionalism implicit in the 2007 code and the concept of autonomy



The 2007 Code of Ethics for Pharmacists and Pharmacy Technicians can scarcely be described as “new”. “Revised” definitely; “improved” hopefully; and certainly modified to reflect the shifting cultures in our society and in the roles that pharmacists undertake. The 2007 code takes what has been called a “principled” approach. In other words, it identifies the ethical principles — and the inherent values, attitudes and behaviours — that characterise a good pharmacist. The highest expression of the code is captured in seven principles that can be applied to all fields of pharmacy practice and that should underpin and inform pharmacists’ decision-making processes. Each principle is supported by a number of statements.

The status and significance of the code are explained in Panel 2 (p238).

Autonomy

Seasoned pharmacists will, in some places, spot the same wording as in past codes and may assume that there is little need to learn more about a document that was studied at university and has, perhaps, remained unvisited ever since. However, there is a major shift in focus and emphasis in the revised code, which is worthy of attention: the application of the concept of autonomy. Although, to maintain simplicity, this word does not actually appear in the new text, every health professional should be familiar with its meaning and implications.

Autonomy is usually defined as self determination — the capacity to make your own decisions and to have control over how you are treated. In health care, patient autonomy is seen as the opposite pole from paternalism, whereby the health professional decides what is best for the patient. Such an approach is now deeply unfashionable, save in limited circumstances where the patient cannot make a contribution (eg, through being uncon-

Identify knowledge gaps

1. What has changed in the latest revision of the Royal Pharmaceutical Society code of ethics?
2. Panel 1 (below) contains examples of situations pharmacists have encountered. Can you identify the ethical issues and their corresponding principles (and statements) in the code?
3. Why is it advisable that decisions about the patient’s best interests should involve the patient?

Before reading on, think about how this article may help you to do your job better. The Royal Pharmaceutical Society’s areas of competence for pharmacists are listed in “Plan and record”, (available at: www.rpsgb.org/education). This article relates to “being a pharmacist” (see appendix 4 of “Plan and record”).

Panel 1: Applying ethics to real-life situations

1. In a meeting with the operations manager for a chain of residential care homes you are told: “All our inmates are on loads of medicines of course, so we will want monitored dosage packs for all supplies.”
2. You overhear a hospital porter helping an elderly woman out of a waiting room chair, say: “OK, Grandma, we are off to the eye doctor now.”
3. You visit a surgical ward that has bays for male and female patients. One of the patients complains bitterly that the lock on the lavatory door is broken and she hates having to use it.
4. A patient who appears to have been prescribed the wrong medicine says: “Well I don’t think much of that doctor then, do you?”
5. You are drawing up guidance for student visits to community pharmacies and a colleague asks what you are going to write about dressing professionally.
6. In your job as a primary care trust pharmaceutical adviser, you read the following in the medication procedures at the local prison: “Prisoners who are not authorised to be in possession of drugs must make an appointment with the medical officer for all treatment.”
7. You receive an e-mail from the pharmacist managing director of the small pharmaceutical manufacturer where you are the Qualified Person. It says you should curtail the testing process to meet immediate demand for a batch of vaccine.

scious). Today, initiatives such as the Expert Patient Programme, promotion of self-care, creation of dignity champions in hospital care — even the use of the Human Rights Act to oblige a proper respect for elderly people in care — all point to the need to involve patients, ask them and check back with them rather than assuming that you will know what is in their best interests.

However, autonomy should also be promoted in a second context: pharmacists, as fully fledged health professionals, have a right to professional autonomy. Their judgement should be valued, their responsibilities respected and their professionalism should not be compromised.

The 2007 code includes a section (principle 7 and supporting statements) that focuses on taking responsibility for your working practices, with greater emphasis on resisting external influences that may pervert your actions and decisions. Moreover, there is a new expectation that pharmacists will remedy or, where necessary, challenge conditions that threaten either patient or professional autonomy.

What else is new in the revised code?

All seven principles of the 2007 code of ethics are of equal importance, value and relevance. The intention is that these principles express concepts that will stand the test of time and will always be principles to aspire to. As stated above, the sentiment and, indeed, wording of some of the supporting statements has not changed greatly from previous versions and almost all are expressed as positive indications of the professional behaviour to be expected of pharmacists. This section focuses on the ways in which the 2007 code differs from previous versions:

Principle 1: Make the care of patients your first concern Some pharmacists, those in academia or journalism, for example, might argue that they are not in contact with patients and their daily work makes students or readers their first concern. However, the wider purpose of their enterprise is surely to enhance the capacity of new or existing pharmacists or technicians and, therefore, ultimately to help patients. The supporting statements under principle 1 highlight the duty of all those in pharmacy to promote care, well-being and safety of patients; some practitioners are just a bit closer to patients than others.

Principle 1 is, perhaps, the most paternalistic of the principles but it is counterbalanced by the attention to autonomy expressed in principle 4 (see below). Emphasis is placed on the obligation to promote actively individual and public health and to help patients find their way around our complex health and social care systems. The importance of promoting patient safety through audit and risk assessment receives prominence alongside more familiar requirements concerning quality of products, services and records.

There is a new expectation that pharmacists will remedy or, where necessary, challenge conditions that threaten either patient or professional autonomy

Principle 2: Exercise your professional judgement in the interests of the patient and the public The need to protect your professional autonomy underpins the statements under this principle (and those under principles 5, 6 and 7). A pharmacist has to use professional judgement and discretion in determining the right way to practise and there will not always be a law or a rule to guide the way. It is here that “best interests of individual patients and the public” (statement 2.1) may inform your judgement, coupled with attention to making the best use of resources (statement 2.3). Explicit statements support a pharmacist’s obligation to take action if judgements of other health professionals, or incentives and conflicts of interest, might endanger the safety or care of patients. Such considerations extend to all fields of practice: clinical trials must be scrupulously honest; health service targets must not be allowed to swamp patient care priorities; academic research rankings should not solely depend on external funding; and marketing of pharmaceuticals should reflect global needs as well as global wealth. Finally, this principle recognises that even when professional judgement must be exercised urgently, a rapid evaluation of risks and benefits and your own competence are essential ingredients of a good decision.

Principles 3 & 4: Show respect for others; Encourage patients to participate in decisions about their care The expectations under these principles are not wholly new but are more rigorous than in previous codes in relation to the human rights and autonomy of professional contacts. The tone of these relationships is captured, in particular, by the words “respect” and “dignity”. We can sometimes overlook how our behaviour and speech ap-

Panel 2: Status and significance

Pharmacy has voluntarily had a code of ethics for over half a century but, in 2007, its existence became a statutory requirement. The Pharmacists and Pharmacy Technicians Order 2007 explicitly requires the regulator to “prepare . . . and publish . . . guidance as to the standards of conduct, practice and performance expected of registrants”. Thus the code becomes the standard of care expected by the regulator (currently the Royal Pharmaceutical Society) from pharmacists and pharmacy technicians and, by extension, the standard expected by patients, carers, Government and commissioners of services, and the standard for the duty of care expected by the courts in clinical negligence cases.

It is often said that a code of ethics sets standards over and above the law but a great deal of recent legislation codifies a social culture that respects individual autonomy and equality of access and treatment irrespective of gender, race, colour, disability, sexual preferences or faith. The civil law provides redress for individuals who suffer harm because a health professional fails to exercise a proper standard of care in their management, treatment or advice (ie, clinical negligence). Such common law rights are bolstered by comprehensive public service policy and direction, and statutory law concerning human rights, abuse of vulnerable adults, child protection, data protection, confidentiality and provisions for adults with mental disorders or who lack capacity to make their own decisions, such as people with learning disabilities or dementia.

The law cannot, however, address as yet unknown situations; its context is fixed at the time it is written and it struggles to allow for the uncertainty of the human condition and the associated need for judgement and discretion in health care. The code, therefore, attempts to define principles to be aimed at and borne in mind; it is the pharmacist (or pharmacy technician) who must interpret them in the light of practice and be held to account for the outcome.

Panel 3: Three theoretical approaches commonly used in ethical analysis

	Deontology (duty-based thinking)	Consequentialism (goal-based thinking)	Virtue ethics
Description	Deontology identifies rules that determine what is right or wrong irrespective of outcome. It focuses on the intentions behind or the purpose of the act in question.	Consequentialism considers that the ethical value of an action depends on its outcome or consequence.	Virtue ethics seeks to assess the character traits or virtues, such as courage, wisdom, compassion and trustworthiness, that are demonstrated by the act.
Rationale	<i>A particular act or omission could be regarded as ethical or unethical depending on:</i>		
	Whether or not you believe that one should always follow one's duty and do the "right" thing regardless of consequences.	Whether or not you believe that the outcome is the most important factor.	Whether you believe that the act is characteristic of a virtuous person or is disreputable and unworthy of a professional.

pears to others. This is best addressed by consciously being aware of what considerations should be borne in mind and focusing on how you would feel to be treated in the manner that you treat others. These two principles also contain exhortations to be polite, considerate, non-discriminatory and unprejudiced.

Whereas pharmacists have pioneered the concept of concordance to reflect patient autonomy in the taking of medicines, we may be less familiar with notions of respect, dignity and the maintenance of professional boundaries in our dealings with patients. Reflecting the clinical "hands-on" roles the code mentions, for the first time, the need to maintain professional boundaries and to consider the need for a chaperone in certain situations. Much is said about consent and the duty of confidentiality and privacy in health care (these will be covered in more detail in further articles in this series).

Principles 5 & 6: Develop your professional knowledge and competence; Be honest and trustworthy Principle 5 needs little expansion. Principle 6 is an expression of the virtues expected of pharmacists (or pharmacy technicians) in their professional practice and, to a large extent, in their private lives (see "virtue ethics" below). The boundaries of what behaviour should be regarded as unprofessional or disreputable are fluid; much depends on the circumstances and culture of the day. Adultery, for example, might have been unacceptable in the past but would probably be met with a shrug of the shoulders today. Other behaviour, such as accessing internet child pornography, would probably be unacceptable. Principle 6 emphasises a personal obligation to have integrity; the final principle (below) extends this to challenging situations where others may compromise your integrity.

Principle 7: Take responsibility for your working practices Few pharmacists can deliver a professional service on their own. Most work with others; many work within large organisations, public or private, which determine their working practices to a greater or lesser extent. Again, much of the wording under this principle is not new and embodies con-

cepts of risk management and complaints handling, which are now parts of our commitment to clinical governance in our practice. However, two requirements are new: first that all pharmacy practitioners should actively develop the professional competence of others and, secondly, an expectation not only that pharmacists will resist, in the interests of their patients, any perverse effects of their environment but that they will speak out and challenge them if need be.

Thinking ethics

In the unenlightened days of the mid 20th century (as followers of the television series "Life on Mars" will have noticed), it was commonplace to use sexist and racist terminology in conversations about and even with women or black people. Similar observations could be made about society's attitudes then towards people who were homosexual or disabled. Today such attitudes are viewed as unacceptable — indeed unethical — but correction requires first that we can identify what is wrong with them. Recent research findings¹⁻³ indicate that pharmacists do not always find it easy to identify and describe ethical issues. In other words, they have low ethical sensitivity and literacy.

To achieve greater ethical literacy, it is helpful to be familiar with some of the terminology and ways of thinking used by philosophers to analyse and criticise the moral behaviour and actions of humans, that is, ethical theories. Panel 3 sets out a simplified summary of the three theoretical approaches that are most commonly used in ethical analysis. There are others, such as "rights based morality" or an ethic of care, but all are an attempt to understand how humans arrive at judgements and decisions as to what is right and wrong in their behaviour towards each other. For example, using duty-based thinking, the supply of oral contraception could be considered unethical, because it frustrates the natural purpose of sexual intercourse, or ethical, because the intention is to enhance an existing life. Alternatively, one could focus on the consequences: avoidance of teenage pregnancy is good, because the adolescent girl has the opportunity for a full education, or bad, because ready availability

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of contraception may encourage promiscuity. And, applying virtue ethics, the virtue of chastity in young girls could be the solution but, on the other hand, a caring health professional should show the virtues of compassion and forbearance, even when confronted by a lifestyle of which he or she disapproves.

Ethical analysis is neither easy nor particularly satisfying. One is still left with uncertainty as to whether something is always right or always wrong in every situation. In medical and nursing education four bioethical fundamentals have held sway for several decades, although they are not without their critics. Two American philosophers, Beauchamp and Childress, first proposed that clinicians should group together four fundamentals in evaluating ethical aspects of professional-patient relationships. These are:

- Beneficence — always aim to do good for the patient
- Non-maleficence — always aim not to harm the patient
- Respect for autonomy — promote autonomy
- Justice

Scope for “acting in the best interests of the patient” is embedded in beneficence and non-maleficence but respect for autonomy means that this should not be paternalistic — the patient should be involved and concur to the maximum extent possible. So when thinking about the best interests of the patient, pharmacists should also think “have I tried asking the patient?”

Autonomy fluctuates according to the individual and the decision to be taken. Most of us are autonomous individuals when it comes to buying, for example, a shampoo — we know what kind of hair we have, what price we are prepared to pay, what shops we trust and what smell we like. We may be less so when buying a medicine for a sudden unexpected illness or electing for surgery and we may need help to reach our decision.

The fourth fundamental, justice, may seem a little out of place. In fact, Beauchamp and Childress were not thinking of legislative justice but distributive justice. In the context of health care, this is the concept of resource allocation or, as the media prefer, “rationing” or “postcode prescribing”. The equitable distribution of scarce health resources implies a need for fairness or even-handedness in dealing with patients and an absence of discrimination. Resource allocation can raise the most intractable of ethical dilemmas when attempting to balance the interests of an individual patient against the needs of a specific population. Yet many pharmacists are involved in this process when helping patients choose their medicines or treatments, when devising prescribing guidelines or controlling drug budgets.

Often there is a balance to be struck between the applications of more than one principle. Principles can conflict (eg, patient confidentiality against the public interest or

Resources

- Wingfield J, Badcott D. *Pharmacy ethics and decision making*. London: Pharmaceutical Press; 2007.
- The Code of Ethics for Pharmacists and Pharmacy Technicians and supporting standards and guidance are available at www.rpsgb.org

fully informed consent when urgent treatment is needed) and only the health professional on the spot can decide what really is the right course of action to take. To fully appreciate the character of the 2007 code of ethics, there really is no substitute for reading it with careful attention. Its drafting took two years, drawing on the expertise of many outside the profession — ethicists, lawyers and patient groups — as well as practising pharmacists and technicians at many levels and in many fields of practice. Consultation responses were copious and constructive, and were acted upon.

Further guidance, particularly on the ethical obligations of pharmacists and others in positions of authority, elaborating on the concepts of consent and confidentiality also supplement the code. Mostly, however, the 2007 code of ethics seeks to reflect what many would agree are the professional values, behaviours and attitudes expected of everyone involved in pharmacy.

The second article in this series, to be published on 13 October, will look at consent.

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2. Cooper R, Bissell P, Wingfield J. Dilemmas in dispensing, problems in practice? Ethical issues and law in UK community pharmacy. *Clinical Ethics* 2007 (in press).
3. Benson A, Cribb A, Barber N. Respect for medicines, respect for people: mapping pharmacist practitioners' perceptions and experiences of ethics and values. 2007 Available at www.rpsgb.org.uk (accessed on 15 August 2007).

Action: practice points

Reading is only one way to undertake CPD and the Society will expect to see various approaches in a pharmacist's CPD portfolio.

1. The first question in the “identify knowledge gaps” panel on p237 asked you to look at Panel 1 and identify which principles in the revised Code of Ethics might be at issue in the situations illustrated. Try doing this exercise again. Did you identify more the second time around? Suggested answers can be found at: www.pjonline.com/CPD.
2. Download a copy of “Human rights in healthcare — a framework for local action” from the Department of Health website (www.dh.gov.uk). Read the executive summary, introduction and section 1. What are the five principles underlying the human rights based reform of health and social care and the five principles underpinning a human rights based approach to health care? Looking at your own field of practice, write down three actions that you will now take to reflect the human rights of those with whom you come into contact.
3. The Dignity in Care Campaign aims to eliminate tolerance of indignity in health and social care services. To date, the campaign has focused on older people and is being extended to include people with mental health needs. Read the reports of events held in Birmingham and Leeds (available at www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Socialcare/Dignityincare/DH_065418) and hold a short tutorial for your staff. Identify at least one change that you will implement to improve respect or dignity for those with whom you come into contact in your practice.

Evaluate

For your work to be presented as CPD, you need to evaluate your reading and any other activities. Answer the following questions: What have you learnt? How has it added value to your practice? (Have you applied this learning or had any feedback?) What will you do now and how will this be achieved?