DISPENSING PRACTICE AND COMMERCIAL INTERESTS AMONG MALTESE PHARMACISTS: ETHICAL ISSUES

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A thesis submitted in partial fulfilment of the requirements for the Master of Arts in Business Ethics.

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Abstract

Objective

This dissertation presents the findings of a qualitative study that asked a sample of Maltese community pharmacists to describe their living experiences of ethical issues during dispensing and the ways they resolved or dealt with these problems.

Method

Semi-structured interviews were carried out with twenty-three Maltese community pharmacists. The content of these interviews was qualitatively analyzed for emerging themes.

Key Findings

The fear of losing customers was the central theme which emerged from the pharmacists' interviews. Most participants were ready to bend rules to please patients. They were ready to put their professional autonomy in subordination to that of the physician in order not to irritate the doctor and lose prescriptions. The Pharmacy of Your Choice (POYC) system was an important way to retain and gain customers. Hence, the pharmacies were accepting more POYC applications than they could handle. This resulted in isolation which led to a decrease in pharmacists' proximity to colleagues, patients and the medical profession. This daily tension of retaining and winning over new customers to increase sales created day-to-day conflicts with ethical professional behavior.

The author witnessed a general lack of ethical awareness and ethical literacy in most participants. Most pharmacists relied on experience and common sense to solve these ethical problems during dispensing and participants never consulted the Code of Ethics.

Conclusion

Findings of this study indicated that Maltese pharmacists felt torn between maintaining professional standards and commercial interests. Also, of significance in this study was

the finding that financial pressure coming from the highly competitive business environment and the pharmacies' owners' race for more profits, had a negative impact on ethical decision making. The primary interests of the pharmacist to seek the best interest of the patient could be unduly influenced by secondary interests of financial greed. This conflict of interest would threaten the quality of pharmaceutical care and decrease the public's trust in the pharmacy profession.

Keywords

Pharmacy Ethics, Incentives, Isolation, Patient best interest, Conflict of interest.

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Date

Dedication

To my family, for without their constant, unwavering support

I would not have made it this far.

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I am most grateful for the constant support of my wife. It is to her that I dedicate this thesis, and for good reason. Not all have been as fortunate as I. Without her constant support I would not have gone far.

I would like to thank all my tutors during these last three years. A special thanks to the Master's in Business Ethics course coordinator, Rev. David Cortis and to the lecturers Rev. Prof. George Grima, Rev. Dr Mark Sultana and Rev. Dr Ray Zammit.

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To all those who have shared these experiences with me: Cheers and good luck!

Abbreviations

CMD	Cognitive Moral Development
COI	Conflict of Interest
EDM	Ethical Decision Making
OTC	Over the Counter
PBI	Patients' Best Interests
PEO	Population, Exposure, Outcome
POM	Prescription Only Medicine
SSI	Semi-Structured Interview

Introduction

The status of pharmacy as a profession has always been the cause of an ongoing debate among health care professionals.[1]

The essence of a professional status is the possession of esoteric knowledge: knowledge which is particular to that profession. Not every person has the knowledge and training of compounding medicines. The apothecary was perceived as having this knowledge of formulating remedies. This role, however, was severely diminished through the mass production of premixed medicines. Soon, the pharmacist's role was often perceived to be the selection of medication, counting of tablets and putting them in a bag. Hence, the profession assumed a marginal status. In 1968 it was described as a profession in transition and lost much of its prestige, power and function.[2]

In recent years, however, there has been a migration in the service delivered by the pharmacist, gradually moving towards more patient-focused health care, with increasing clinical and advisory roles.[3] Pharmaceutical care reflects this transition to a more patient-focused profession.[4] This has given rise to more responsibilities as the pharmacist has more decisions to make and the patient expects more, making encounters with ethical issues evermore frequent.[5] It is becoming more important to put pharmacists' values and ethics under the social lens. This attention for ethical

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1 Betty Chaar, Jo-Anne Brien and Ines Krass, "Professional Ethics in Pharmacy: The Australian Experience," *International Journal of Pharmacy Practice* 13, no. 3 (2005): 195-204.

2 Norman K. Denzin and Curtis J. Mettlin, "Incomplete Professionalization: The Case of Pharmacy," *Social Forces* 46, no. 3 (1968): 375-381.

3 David Latif, "Ethical Cognition and Selection Socialisation in Retail Pharmacy," *Journal of Business Ethics* 25, no.4 (2000a): 343-381.

4 Pharmaceutical care is defined as the "responsible provision of drug therapy for the purpose of achieving definite outcomes that improve patient's QOL." David Latif, "Providing Patient-Focused Care Within a Managed Care and Pharmaceutical Care Environment: A Person/Situational Interactionist Model for Community Pharmacists," *Journal of Managed Care Pharmacy* 6, no.3 (2000): 233-239.

5 *Ibid*.

behavior is crucial since the profession is still perceived by many as a pure business entity. The community pharmacist gives service to patients as customers and as patients receiving complex therapeutic regimens.[6] The pharmacist needs to possess high ethical competence to deal with the increasing challenges of delivering complex medicines in a business environment.

The conflict of interest between ethics and business is present in every dispensing practice decision.[7] The pharmacist may focus on a *homo economicus* model where the only objective is to maximize utility in terms of profit.[8] "The business of business is business," as Milton Friedman famously pointed out.[9] Business is seen only through the euro lens. Human relations are reduced to simple transactions. Morality takes a subsidiary role to profit, thus strengthening the concept of radical individualism.[10] This *homo economicus* model gives a dismal idea of personhood, quite opposite to the Catholic Social position that "the business of business is the human person."[11]

What are the objectives of this research?

This dissertation aims to answer two questions from an empirical and philosophical perspectives: *What ethical dispensing practices issues are experienced by Maltese community pharmacists* and *how are they resolved or dealt with?* The author is convinced that ethical issues are best understood by analyzing them in real life situations

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6 J. Wingfield, P. Bissell and C. Anderson, "The Scope of Pharmacy Ethics: An Evaluation of the International Research Literature, 1990-2002," *Social Science & Medicine* 58, no. 12 (2004): 2383-2396.

7 Ethics in this study is used to indicate a concern with determining what ought to be done in dispensing practice.

8 Another word for *homo economicus* is 'economic man' who attempts to maximize utility as a consumer and economic profit as a producer.

9 Milton Friedman, "The social responsibility of business is to increase its profit," *New York Times Magazine*, September 13, 1970.

10 Scott Vitell, Mohammed Rawwas and Troy Festervand, "The Business Ethics of Pharmacists: Conflicts Practices and Beliefs," *Journal of Business Ethics* 10, no. 4 (1991): 295-301.

11 Lloyd Sandelands, "The Business of Business is the Human Person: Lessons from the Catholic Social Tradition," *Journal of Business Ethics* 85, no. 1 (2009): 93-101.

and listening to persons who have experienced them.[12]

Why is this research important?

There has been little international research on ethics in pharmacy practice. In the early 21st century, David Latif, who obtained a doctorate in social, behavioral and administrative pharmacy at Auburn University and is currently professor and chairman of the School of Pharmacy at the University of Charleston, was actively researching this topic in the USA, using postal questionnaires. Recently there have been three Ph.D. theses on empirical pharmacy ethics in the UK by M. Alisa Benson,[13] Zuzana Deans[14] and Richard Cooper.[15] Such a study can identify ethical issues occurring in the local community pharmacists and be able to compare these findings with those arising in the UK and other countries. In this way, this study can add knowledge to the present literature on empirical ethics within pharmaceutical care.

This qualitative study can also throw light on how pharmacists' ethical behavior can be manipulated by corporate business culture since Malta, like other European countries, is experiencing a takeover of pharmacies by a few pharmaceutical wholesalers whose major objective is to maximize profits. Furthermore, the study can discover themes that may be relevant to other medical professions. Finally, this study may recommend changes in pharmaceutical practice which may be of benefit to the pharmacy profession and patients' welfare.

This research is of interest to a large audience. These include individual community pharmacists, the pharmacy professional body, policy makers, researchers, philosophers,

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12 B. Hoffmaster, "Can Ethnography Save the Life of Medical Ethics?" *Social Science & Medicine* 35, no. 12 (1992): 1421-1431.

13 M. Ailsa Benson, "Pharmacy Values and Ethics: A Qualitative mapping of the perceptions and Experiences of UK Pharmacy Practitioners" (Ph.D. thesis, King's College University, 2006).

14 Zuzana Deans, "The Ethics of Pharmacy Practice: An Empirical and Philosophical Study" (Ph.D. thesis, Keele University, 2007).

15 Richard Cooper, "Ethical Problems and their resolution among UK community pharmacists" (A qualitative study PhD thesis, University of Nottingham, 2007).

and educators of pharmacy students.

Why is the topic of interest to the researcher?

The source of interest in this topic comes from the researcher's educational background. A pharmacist by profession, the researcher has worked as a medical representative and product manager in Malta and in the Middle East. The nature of this job brought him in daily contact with many community pharmacists.

During these relationships with pharmacists, the researcher became aware that pharmacists face several ethical issues during their work and, unfortunately, many of them lacked ethical attentiveness. These issues were several and consisted of conflicts between profits and customers' welfare; increasing consumerism and commodification of medicines which have given more voice to customers who may demand needs which the pharmacist may consider as inappropriate; rival professional autonomy; confidentiality issues and isolation. All these concerns aroused the author's curiosity and this dissertation is an opportunity to research these issues locally.

Thesis Outline

The first chapter will describe the literature reviews carried out by Copper *et al*.[16] and Wingfield *et al.*[17] covering studies of pharmacy ethics between 1986 and 2004. This is followed by the author's own literature review between 2004 and 2018. The chapter will then describe T. M. Jones' ethical decision making (EDM) model which will offer practical and pragmatic advice of how a community pharmacist can deal with ethical dispensing issues.[18]

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16 R.J. Cooper, P. Bissell and J. Wingfield, "A New Prescription for Empirical Ethics Research in Pharmacy: A Critical Review of the Literature," *Journal of Medical Ethics* 33, no. 2 (2007): 82-86.

17 J. Wingfield, P. Bissell and C. Anderson, "The Scope of Pharmacy Ethics: An Evaluation of the International Research Literature, 1990-2002," *Social Science & Medicine* 58, no. 12 (2004): 2383-2396.

18 Thomas Jones, "Ethical Decision Making by Individuals in Organisations: An Issue-Contingent Model," *Academy Management Review* 16 (1991): 366-295.

The empirical investigation of pharmacy ethics will be the main objective of Chapter two. This process will involve several steps. It will start with the research strategy and the reasons for the author's choice of a qualitative method using semi-structured interviews (SSI). This will be followed by the research design where the author will describe the sampling method and how practical and logistic issues will be solved. The author will then explain in detail how the interviews will be conducted and the objectives behind each question. The last two sections will describe the data collection and data analysis.

The next chapter will aim to examine the participants' narrations of their living experiences of ethical problems during the dispensing practice and to gather major themes which emerge from these stories. This third chapter will therefore answer the first part of the research question.

Chapter four will address the second part of the dissertation question, that is, how pharmacists deal with ethical problems faced during their dispensing practice. In particular, the author will focus his attention upon the several theoretical stages in the decision-making process, following the widely used model by Jones. This process will start with the evaluation of the participants' ethical awareness. The next stage in Jones' model is that of ethical reasoning and the author will try to identify the participants' main ways of ethical reasoning. The third stage is that of ethical intent and the author will try to identify the participants' central intent. Finally, the chapter will conclude by describing the participants' ethical enactment.

In this final chapter the author will summarize the findings and conclusions of the study. These will be compared with findings from other pharmacy ethics research. The author will then consider the several implications arising from the dissertation's conclusions and their management. The dissertation will conclude by identifying limitations of the study, suggesting areas of further investigation and the author's final reflexive insights.

Chapter One: A Review of the Literature

1.1. Introduction

The main objective of this chapter is to document studies which will answer the research questions put forward in the introduction. These studies will be obtained from three literature reviews on empirical pharmacy ethics between 1986 and 2018. The first two literature reviews belong to Cooper *et al.* and Wingfield *et al*. covering empirical pharmacy ethics studies between 1986 and 2005. The third literature review is that of the researcher covering years from 2006 to 2018. The author hopes that these literature reviews can help to evaluate the best possible methodology for the research study. Finally, the author will describe the framework for ethical decision making proposed by Thomas M. Jones, Professor Emeritus of Management at the Foster School of Business at the University of Washington, to evaluate the way the Maltese community pharmacist is dealing with ethical problems related to the dispensing of medicines.

1.2 Literature Reviews

It appears that pharmacy ethics research has attracted little attention from researchers, despite the visible attempts by the pharmacy profession to embrace more challenging roles in patient care. Cribb and Barber remark that "there has been very little literature produced on the subject of ethical values in pharmacy at all."[1]

This lack of interest in pharmacy ethics can be due to several reasons. First, there is the obvious fact that pharmacists do not encounter dramatic ethical issues and dilemmas as do physicians and nurses. Secondly, although the impact of the pharmacist's work affects all, many barely notice its importance. Many perceive the pharmacy profession as only a minor component of the health care team. Undoubtedly, however, pharmacists

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[1] Alan Cribb and Nick Barber, *Developing Pharmacy Values: Stimulating the Debate. A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain, 2000).

do encounter ethical dilemmas considering that they are in contact with many stakeholders. These include the patient, the physician, the medical representative, the distributors' salesmen, the health authorities and the owner of the pharmacy. All these stakeholders have their agenda and moral convictions.

1.2.1. Cooper *et al.*'s Literature Review

The literature review undertaken by Cooper and colleagues extended from 1986-2005 and identified around twenty empirical pharmacy ethics research.[2] Table 1 gives a summary of the studies identified in this literature review that fit the objectives of this dissertation's research.

[2] R.J. Cooper, P. Bissell and J. Wingfield, "A New Prescription for Empirical Ethics Research in Pharmacy: A Critical Review of the Literature," *Journal of Medical Ethics* 33, no. 2 (2007): 82-86.

Table 1: Cooper's literature review studies

Study	Sample	Methodology
Hibbert *et al*.[3]	6 community pharmacists	Qualitative SSI
Wingfield *et al*.[4]	11 community pharmacists	Qualitative SSI
Cooper *et al*.[5]	11 community pharmacists	Qualitative SSI
Chaar et al.[6]	25 Australian community pharmacists	Qualitative SSI
Latif[7]	113 US community pharmacists	Quantitative DIT
Latif[8]	114 US community pharmacists	Quantitative DIT
Latif[9]	113 US pharmacists	Quantitative DIT

The overall conclusions were several. The authors claimed that pharmacy ethics was an under-researched area. They commented on the shift occurring in the methodology from quantitative to qualitative approaches with semi-structured interviews (SSI) or focus groups.

The tension between commercial interests and professional ethics was a common theme in the above studies. The community pharmacists interviewed in these studies

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3 D. Hibbert, J.A. Rees and I. Smith, "Ethical awareness of community pharmacists," *International Journal of Pharmacy Practice* 8, no.2 (2000): 82–87.

4 J. Wingfield, T. Theophilou and P. Bissell, "An exploration of the influence of company policy on ethical decision making by community pharmacists," Health Services Research and Pharmacy Practice Conference Presentation, 2004. http://www.hsrpp.org.uk/abstracts/2004_17.shtml (accessed September 30, 2018).

5 R. Cooper, "Are community pharmacists capable of resolving ethical problems in their work? An empirical study," Health Services Research and Pharmacy Practice Conference Presentation, 2005. http://www.hsrpp.org.uk/abstracts/2005_16.shtml (accessed September 30, 2018).

6 Betty Chaar, Jo-Anne Brien and Ines Krass, "Professional Ethics in Pharmacy: The Australian Experience," *International Journal of Pharmacy Practice* 13, no. 3 (2005): 195-204.

7 David Latif, "Ethical cognition, organizational reward systems and patient-focused care," *Journal of Social and Administrative Pharmacy* 15, no.4 (2000): 275-283.

8 David Latif, "Ethical cognition and socialization-selection," *Journal of Business Ethics* 25, no.4 (2000): 255-269.

9 David Latif, "The link between moral reasoning scores, social desirability and patient care performance scores: empirical evidence from the retail pharmacy setting," *Journal of Business Ethics* 25, no. 3 (2000): 255-269.

found difficulty in balancing professional ethics and commercial interests. Wingfield and colleagues commented that these difficulties become more evident if the pharmacists were employed by companies whose culture was focused on maximizing profits. These pharmacists commented that business incentives had a negative effect on their ethical decision making since secondary interests of maximizing profits could take priority over the primary interests of patients' welfare. A gap existed between ideal ethical behaviour and the reality of pharmacy practice business.

The tension between law and patients' best interest was evident in Cooper and colleagues' study. The participants in this study experienced some stress when faced with the ethical dilemma of dispensing an emergency supply of a prescription only medicine (POM) and the patient was not in possession of a prescription. In most of these cases, the pharmacists refused to dispense due to self-interest from fear of losing the warrant even in situations where the patient was in real need of care.

Relationship with the general practitioner was also a central theme. In the study by Hibbert and colleagues many participants reported that they experienced uneasiness when a doctor prescribed a medicine which the pharmacist felt was not indicated for that particular patient. The pharmacists in Chaar and colleagues' study faced similar situations and were aware of professional etiquette and the sensitivity of the situation. Some participants in this study, however, considered patient best interest (PBI) as a priority over the doctor's prescription and refused to dispense.

Confidentiality was another common theme discussed in the Hibbert and Chaar studies. Most cases were of relatives who inquired about the use of the medicine prescribed to their dear ones. Most participants commented that most of these enquires by relatives were done with good intentions. Yet, many participants in these studies lacked ethical confidence to deal with this issue of confidentiality.

Autonomy was also another theme appearing in the above studies. Most participants were aware of the right of the patient to make autonomous informed decisions. Yet, many participants felt that the pharmacist had better pharmacological knowledge and

this led to a paternalistic approach.

Finally, Cooper and colleagues identified another central theme, that of pharmacists' isolation. These authors commented that there were two main factors contributing to this isolation. First reason was the pressure on the pharmacist to sell and secondly the consumers' attitudes of pretending to know best. This resulted in the pharmacist having less and less one-to-one discussions with patients. The pharmacists in this study commented that such a situation gave rise to job dissatisfaction.

1.2.2. Wingfield *et al.*'s Literature Review

J. Wingfield and colleagues provided a critical overview related to pharmacy ethics from 1990-2002.[10] Like Cooper's literature review, they concluded that the area of pharmacy ethics was under researched and there was very little material published on core pharmacy values. Moreover, these authors commented on the lack of a journal on pharmacy ethics. Table 2 gives a summary of the studies identified in this literature review that fit the objectives of this dissertation's research.

Most researchers behind the studies listed in Wingfield's literature review used vignettes. The participants had to explore the various options that these scenarios provided and then to suggest the best solution. Wingfield and colleagues criticized the use of vignettes since they felt that most of these vignettes did not involve ethical issues in a community pharmacy environment. The author of this dissertation, however, does not agree with their criticism, believing that vignettes may provide important insight in examining the pharmacists' EDM.

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[10] J. Wingfield, P. Bissell and C. Anderson, "The Scope of Pharmacy Ethics: An Evaluation of the International Research Literature, 1990-2002," *Social Science & Medicine* 58, no. 12 (2004): 2383-2396.

Table 2: Wingfield's Literature Review Studies

Study	Sample	Methodology
G. Harding *et al*.[11]	UK 362 pharmacists	Postal questionnaire survey
D. Hibbert *et al*.[12]	North East UK consumers and pharmacy staff	94 interviews and 10 focus groups
G. Hughes *et al*.[13]	253 N Ireland pharmacists	Structured questionnaire
E. Kennedy and M. Moody[14]	635 UK pharmacists	Random postal questionnaire
C. Mattheson *et al.*[15]	45 Scottish pharmacists	Telephone interviews
C. Mattheson *et al.*[16]	709 Scottish pharmacists	Cross sectional postal survey
D. Prayle and M. Brazier[17]		Discussion paper
B.K. Redman *et al.*[18]		Discussion paper
L. Rees *et al*.[19]	888 Southern UK pharmacists	Postal survey
D. Resnik *et al.*[20]		Discussion paper

[11] G. Harding *et al.*, "Injecting drug users: pharmacists' attitudes," *Journal of Social and Administrative Pharmacy* 9, no.1 (1992): 35-41.

[12] D. Hibbert *et al.,* "Consumerism and professional work in the pharmacy," *Sociology of Health and Illness* 24, no.1 (2002): 45-46.

[13] G. Hughes *et al.*, "Abuse/misuse of non-prescription drugs," *Pharmacy World and Science* 21, no.6 (1999): 251-255.

[14] E. Kennedy and M. Moody, "An investigation of the factors affecting community pharmacists' selection of over the counter preparations," *Pharmacy World and Science* 22, no.2 (2000): 47-52.

[15] C. Matheson and C.M. Bond, "Motivation for and barriers to community pharmacists' services for drug misuse," *International Journal of Pharmacy Practice* 7, no.1 (1999): 256-263.

[16] C. Matheson *et al.*, "Misuse of over the counter medicine from community pharmacists: A population survey of Scottish pharmacists," *Pharmaceutical Journal* 269, no.5 (2002): 66-68.

[17] D. Prayle and M. Brazier, "Supply of medicine: paternalism, autonomy and realism," *Ethics* 24, no.2 (1998): 93-98.

[18] B.K. Redman, "The ethics of leadership in pharmacy," *American Journal of Health-System Pharmacy"* 52, no.19 (1995): 2099-2104.

[19] L. Rees *et al.*, "Supplying injecting equipment to drug users: A survey of community pharmacists' attitudes, beliefs and practices," *International Journal of Pharmacy Practice* 5, no.1 (1997): 167-175.

[20] D. Resnik *et al*., "The conflict between ethics and business in community pharmacy. What about patient counselling?" *Journal of Business Ethics* 28, no.2 (2000): 179-186.

A.B. Armarsdottir *et al*.[21]	Iceland pharmacists	Focus groups
J.Y. Wick and G.R.Zanni[22]		Discussion paper
Latif[23]	113 US pharmacists	Quantitative/DIT
Latif[24]	113 US pharmacists	Quantitative/DIT
Latif[25]	114 US pharmacists	Quantitative/DIT
A. Cribb and N. Barber[26]		Discussion paper
P. Dressing[27]		Discussion paper
Dingwall and Watson[28]		Discussion paper

A dominant central theme in the studies identified in Wingfield and colleague's literature review was the pressure on the pharmacists to make the business as profitable as possible. L. Rees and colleagues commented that consumer demand determined the community pharmacy service. Many participants in their study were refusing to supply sterile injecting equipment to injecting drug users. These pharmacists were afraid that the presence of these individuals in their pharmacy would make other customers feel

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21 A.B. Almarsdottir and J.M. Morgall, "Technicians or patient' advocates-still a valid question," *Pharmacy World and Science* 2, no.3 (1999): 127-131.

22 J.Y. Wick and G.R. Zanni, "Informed consent. What every pharmacist should know," *Journal of the American Pharmaceutical Association* 41, no.4 (2001): 523-527.

23 David Latif, "Ethical cognition, organizational reward systems and patient-focused care," *Journal of Social and Administrative Pharmacy* 15, no.4 (2000): 275-283.

24 David Latif, "The link between moral reasoning scores, social desirability and patient care performance scores: empirical evidence from the retail pharmacy setting," *Journal of Business Ethics* 25, no. 3 (2000): 255-269.

25 David Latif, "Ethical cognition and socialization-selection," *Journal of Business Ethics* 25, no.4 (2000): 255-269

26 A. Cribb and N. Barber *Developing Pharmacy Values: Stimulating the Debate. A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain, 2000).

27 R.P. Dressing, "Ethics applied to pharmacy practice," *Pharmacy World and Science* 22, no.1 (2000): 10-16.

28 R. Dingwell and E. Watson, "Is pharmacy really an incomplete profession?" *Perspectives on Social Problems* 7, no.2 (1995): 111-128.

uncomfortable. Selling to these injecting drug users was not considered to be economically profitable. Two other studies, one by Harding and colleagues, and the other by Mattheson and Bond, reached the same conclusion that certain patients, like drug misusers, deter other customers from attending the pharmacy and hence could result in loss of business.[29] L. Rees and colleagues also commented that "decisions in the pharmacies owned by companies were taken by few managerial policy makers rather than by individual grass-root pharmacists."[30]

The theme of commercial incentives influencing dispensing practice was also prominent in the E. Kennedy and M. Moody study. These authors concluded that product incentives by sales representatives had greater influence on pharmacy owners who would dispense a more expensive branded product rather than a pharmacological equivalent cheaper generic product.[31]

Two studies by Almarsdottir and Morgall commented on the unwanted outcome of customers who shop around avidly for discounts from the pharmacies.[32] These authors claimed that these pharmacists' behaviour was due to the competitive nature of the business. Moreover, this made the knowledge of the medicines that a patient is taking next to impossible.

The ethical aspects of the deregulation of medicines from POM to OTC was documented

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29 G. Harding, "Injecting drug misusers: pharmacists' attitudes," J*ournal of Social and Administrative Pharmacy* 9, no.1 (1998): 35-41; C. Mattheson and C. M. Bond, "Motivations for and barriers to community pharmacy services for drug misusers," *International Journal for Pharmacy Practice* 7, no.1 (1999): 252-26*3.*

30 L. Rees, G. Harding and K. Taylor, "Supplying injecting equipment to drug users: a survey of community pharmacists' attitudes, beliefs and practices," *International Journal of Pharmacy Practice* 5, no. 1 (1997): 167-175.

31 E. Kennedy and M. Moody, "An investigation of the factors affecting community pharmacists' selection of over the counter preparations," *Pharmacy World and Science* 22, no.2 (2000): 47-52.

32 A.B. Almarsdottir and J.M. Morgall, "Technicians or patient advocates? – still a valid question," *Pharmacy World and Science* 21, No.3 (1999): 127-131; A.B. Almarsdottir and J.M. Morgall, "Professional responsibility for patient welfare. Is it possible to legislate pharmaceutical care?" *Journal of Social and Administrative Pharmacy* 18, no.2 (2001): 45-50.

by Hughes and colleagues.[33] This deregulation enhanced accessibility of medicines for the patient but also increased consumerism with the resultant misuse of drugs. Prayle and Brazier comment that it is difficult to deliver beneficence when the pharmacist simply supplies the product that customers, aided by the manufacturers' advertising, determine they desire.[34]

The theme of the pharmacists' subordination to the physician was prominent in R. Dingwell and P. Watson study.[35] These authors acknowledged the symbolic role of pharmacists to transform a drug from a natural into a social object. Pharmacists could achieve this role due to their knowledge, their informed advice to patients and their knowledge of drug interactions. These authors, however, commented on the marginalization of the pharmacist between care and commerce. The same researchers were aware that sociologists were more interested in work on doctors as this attracted more interest, funding and prestige. The "rapid take-over of pharmaceutical business by large-scale corporate capital had restructured the pharmacy retail and was killing slowly the folk-image of the family run corner-shop pharmacy."[36] In another study, Redman encouraged the pharmacy profession to take leadership to avoid this dominance of the physician. The author suggested that this leadership could start by avoiding mis-advertising of medicines and hence provide genuine patient care.[37]

Haddad in his study emphasized the importance of confidentiality in pharmacy practice. This researcher suggested that confidentiality rested on two pillars: patient's autonomy and the pharmacist's fidelity which was an unspoken promise by the pharmacist to keep

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33 G. Hughes *et al*., "Abuse/Misuse of non-prescription drugs," *Pharmacy World and Science* 21, no. 6 (1999): 251-255.

34 D. Prayle and M. Brazier, "Supply of medicines: Paternalism, autonomy and realism," *Journal of Medical Ethics* 24, no.3 (1998): 93-98.

35 R. Dingwell and P. Watson, "Is pharmacy really an incomplete profession?" *Perspectives in Social Problems* 7 (2002): 111-128.

36 *Ibid.*, 175.

37 B.K. Redman, "The ethics of leadership in pharmacy [practice," *American Journal of Health-System Pharmacy* 52, no.19 (1995): 2099-2104.

silent if the patient wished this.[38]

Wingfield's literature review identified also the theme of the patient's autonomy. J. Y. Wick and G. R. Zanni argued that pharmacists had a professional duty to counsel so that the patients could make an informed decision about their drug therapy.[39] This concept of patient's autonomy contrasted with the view of Hibbert and colleagues' study where the participants preferred a paternalistic relationship with the patients. Another study by P. Dressing considered three basic principles in dispensing practice: autonomy, democracy and solidarity. These principles would help to develop a relationship of trust between the pharmacist and the patient which would guarantee informed consent and concordance in therapy.[40]

An important study included in Wingfield's literature review was that of Latif who studied moral reasoning in community pharmacists and concluded that most belonged to level 3-4 of Kohlberg's six stage morality. Latif concluded that pharmacists with a higher morality level gave a better service and they experienced moral distress if certain circumstances within their working context violated their moral integrity. Latif identified three factors for the low ethical competence in community pharmacy: selection by organizations of pharmacists with low moral competence; pharmacists with high moral competence quitting community practice and a general retrogression of ethical cognition.[41] Cribb and Barber put forward the need for greater "value literacy" in the pharmacy.[42]

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38 A.M. Haddad, "Case Study: keeping confidentiality," *American Pharmacy* NS33, no.12 (1993): 50-52.

39 Y. Wick and G.R. Zanni, "Informed consent? What every pharmacist should know," *Journal of American Pharmaceutical Association* 41, no. 4 (2001): 523-527.

40 P. Dressing, "Ethics applied in Pharmacy Practice," *Pharmacy World and Science* 22, no.1 (2000): 10-16.

41 David Latif, "Ethical cognition, organizational reward systems and patient-focused care," *Journal of Social and Administrative Pharmacy* 15, no.4 (2000): 275-283.

42 A. Cribb and N. Barber, "Developing pharmacy values: Stimulating the debate," *The Pharmaceutical Journal* 264, no.7098 (2000): 804-807; *Developing Pharmacy Values: Stimulating the Debate. A Discussion Paper* (London: Royal Pharmaceutical Society of Great Britain, 2000).

Wingfield and colleagues concluded that pharmacists used mainly common sense to solve ethical issues. These authors recommended a deeper educational basis of ethics for pharmacy students and a constant ethical educative update of practicing pharmacists to enrich their moral competence.[43]

1.2.3. The Researcher's Literature Review

The literature reviews of Cooper and Wingfield stopped at 2005 and no further reviews were published after this date. The present researcher felt the need to fill this lacuna before preceding to answer the research question.

Timmins and McCabe emphasized the importance of using appropriate keywords for an effective search.[44] They suggested that this process should start by identifying the key elements of a Population, Exposure and Outcome (or PEO) framework.[45] The next step involved the identification of synonyms of these keywords for all the component parts of the PEO question, using MeSH (Medical Subjects Heading).[46] These are presented in Table 3.

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43 Wingfield, "The Scope of Pharmacy Ethics," 2383-2396.

44 F. Timmins and C. McCabe, "How to Conduct an Effective Literature Search," *Nursing Standard* 20, no. 11 (2005): 41-47.

45 *Ibid*., 41-47.

46 Medical Subject Headings 2019. https://meshb.nlm.nih.gov/search (accessed September 30, 2019).

Table 3: Index Key Terms

PEO Elements		Index Key Elements
Population	Pharmacist*	Pharmac*
Exposure	Ethical	Moral*
		Problem*
		Dilemma*
Outcome	No moral distress	

After identifying the synonyms, these were combined using the Boolean Operators AND, OR. As shown in Table 4 AND finds results containing all the specified phrases, giving specificity. OR finds results containing either of the specified phrases, giving sensitivity. Bettany-Saltikov explained that this method narrows down the search results by eliminating irrelevant studies, resulting in a more focused search in a shorter time

Table 4: Combining Keywords

	Population	Exposure	Outcome
	AND	AND	AND
OR	1.Pharmacist*	3.Ethical	8.Moral Distress
OR	2.Pharmac*	4.Moral	
OR		5.Issue*	
OR		6.Problem*	
OR		7.Dilemma*	

The inclusion criteria used for this search were: qualitative studies from 2004-2018; written in English; peer-reviewed; and empirical studies on ethical issues in community pharmacies. The exclusion criteria included: abstracts of conferences; letters to editors; newspaper articles; articles on conscientious objection at the beginning and end of life; articles on emergency contraception; studies on pharmacy students; exclusive accounts of pharmacy ethics teaching; dilemmas of the pharmaceutical industry; and interactions

between physicians and medical representatives.

After completion of the search strategy string, an extensive literature search was conducted between 1st August and 30th September 2018. The databases used included: MEDLINE (EBSCO) which covers biomedical literature from 1950 onwards; CINAHL COMPLETE with full text (EBSCO); WEB of SCIENCE; PUBMED, a renowned searching tool for biomedical literature; PROQUEST Social Science database to find articles in the J*ournal of Business Ethics*; and the *Journal Business Ethics Quarterly* was assessed by consulting JSTOR.

Bettany-Salikov describes the process of selecting studies as consisting of two phases.[47] Phase 1 consists of sifting through titles of the articles and deciding which of these needs to be further investigated. The abstracts of these relevant articles were then read. Phase 2 involved the reading of the full text of each of the identified articles that were relevant to the PEO Question. She suggests using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) to document systematic reviews for academic journals. A PRISMA flow diagram is thus produced below.

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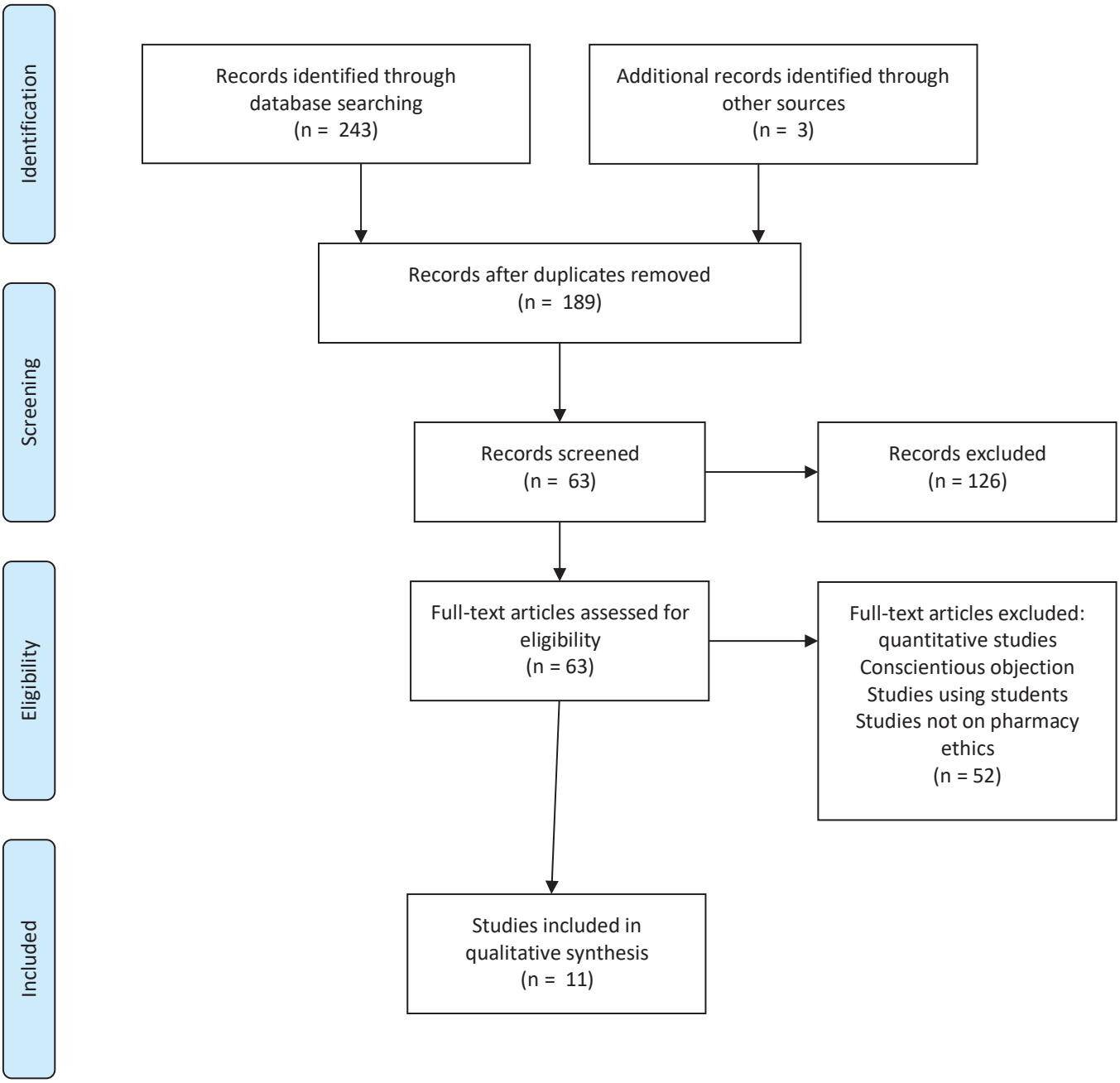
[47] Josette Bettany-Salikov, *How to do a systematic literature review in nursing?* (Berkshire, Open University Press, 2012).

PRISMA 2009 Flow Diagram[48]



[48] From D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, The PRISMA Group, "*P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement," *PLoS Medicine* 6, no.7 (2009): e1000097.

Table 5: The Present Author's Literature Review

STUDY	SAMPLE	METHODOLOGY	DESIGN
A. Benson *et al.*[49]	39 UK pharmacists	Qualitative	SSI
R. Cooper *et al*.[50]	23 UK pharmacists	Qualitative	SSI
R. Cooper *et al*.[51]	23 UK pharmacists	Qualitative	SSI
R. Cooper *et al*.[52]	23 UK pharmacists	Qualitative	SSI
F. Stevenson *et al*.[53]	5 pharmacist and 13 consumers	Qualitative	Observation and interview
M. Krujitboschi[54]	128 Dutch pharmacists	Qualitative	Narrative stories
M. Al-Arifi[55]	682 Saudi pharmacists	Qualitative	Cross section and descriptive
K. Delpasand[56]	28 Iranian pharmacists	Qualitative	SSI
P. S. Sharif *et al.*[57]	505 Iranian pharmacists		Vignettes

[49] Alisa Benson, Alan Cribb and Nick Barber, "Understanding pharmacists' values: A qualitative study of ideals and dilemmas in UK pharmacy practice," *Social Science and Medicine* 68, no.12 (2009): 2223-2230.

[50] R.J. Cooper, P. Bissell and J. Wingfield, "Ethical Decision Making, passivity and pharmacy," *Journal of Medical Ethics* 34, no.6 (2008): 441-445.

[51] R.J. Cooper, P. Bissell and J. Wingfield, "Dilemmas in dispensing, problems in practice? Ethical issues and law in UK community pharmacists," *Clinical ethics* 2, no.2 (2007): 103-108.

[52] R.J. Cooper, P. Bissell and J. Wingfield, "Islands and doctor's tool: the ethical significance of isolation and subordination in UK community pharmacy," *An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 13, no.3 (2009): 297-316.

[53] Fiona Stevenson, Miranda Leontowitsch and Catherine Duggan, "OTC medicines: professional expertise and consumer discourses," *Sociology of Health and Illness* 30, no.6 (2008): 913-928.

[54] Martine Kruijtbosch *et al*., "Moral dilemmas of community pharmacists: a narrative study," *International Journal of Clinical Pharmacy* 40, no.1 (2018): 74-83.

[55] Mohammed N. Al-Arifi, "Community pharmacists perception and attitude toward ethical issues at community pharmacy setting in central Saudi Arabia," *Saudi Pharma Journal* 22, no.4 (2014): 315-325.

[56] Kourash Delpasand *et al*., "Extracting ethical challenges of pharmacy profession in Iran, a qualitative study," *Journal of research in Medical and Dental Sciences* 6, no.1 (2018): 52-58.

[57] Salari Sharif *et al.,* "Pharmacy ethics: evaluation pharmacists' ethical attitude," *Journal of Medical Ethics and History of Medicine,"* 4, no.5 (2011): 1-5.

F. Rapport[58]	39 pharmacists	Qualitative	Focus groups
M. Rubro *et al.*[59]	37 pharmacists	Qualitative	SSI

The tension between commercial interests and ethical dispensing practice was again a central theme in most of the studies identified in this literature review (see Table 5). In fact, in the Arifi study, the accessibility to Over the Counter (OTC) medicine was seen as an opportunity to make more profit while Francis Rapport commented that the community pharmacists in his study were unable to manage the ever-increasing task to match the company's culture of maximizing profit.

Another central theme was the tension between legal responsibilities and PBI. In Cooper and colleagues' study the pharmacists interviewed considered law as synonymous with ethics. Most participants' ethical intention was that of self-interest due to fear of suffering legal problems if they dispensed medication without the corresponding prescription. In Benson and colleagues study the pharmacists experienced moral stress related to pharmaceutical rule breaking and many opted to prioritize law above the emergency medical needs of the patient.

Another theme present in many studies identified in this literature review was that of professional autonomy. In the study by Cooper and colleagues, the pharmacists complained that they felt subordinated to doctors. This caused moral distress in many of the pharmacists. Some pharmacists, however, saw this subordination as a blessing by shifting one's responsibilities onto the general practitioner. Kruijtbosch's study concluded that the main dispensing dilemmas arose in contact with patients and other health professionals who challenged the pharmacist's professional autonomy. Even

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58 Francis Rapport *et al.*, "Eleven themes of patient-centred professionalism in community pharmacy: innovative approaches to consulting," *International Journal of Pharmacy Practice* 18, no.5 (2010): 260-268.

59 Maria Rubio-Valera *et al.*, "Factors affecting collaboration between GPs and community pharmacists: a qualitative study," *BMC Health Service Research* 12, no.1 (2012): 1-10.

Saudi pharmacists felt this subordination to doctors, and they found it difficult to dispense equivalent medication and substitute the physician's prescription. In the Rapport study the participants felt that the public perceived the pharmacist as being less appropriate to support their basic medical needs than the general practitioner. Rubro and colleagues' study commented that the collaboration between the pharmacist and physician was affected by the perception of its usefulness, the professionals' attitude towards each other, economic and organization culture.

The theme of isolation was another common theme in many of the literature review's studies. In R. Cooper and colleague's interviews, the participants commented that they felt isolated from other health professionals, from colleagues and even from the patients/customers. Even Saudi pharmacists, in the Arifi study, experienced isolation from the patient due to overload of work.

Other themes that emerge in this literature review are those of confidentiality and patient's autonomy. In Benson and colleagues' study, the participants reported dilemma in balancing paternalism with patient's self-determination in the choice of treatment. In Stevenson's study, the participants agreed on the asymmetry of knowledge between the pharmacist and the customer. Yet, many consumers did not perceive the need of pharmaceutical knowledge when buying common OTC medication and wanted such transactions to be quick and with no assistance.

Appendix 1 gives a summary of all the themes identified in the three literature reviews.

1.3 Jone's Ethical Decision-Making Model

This chapter continues with the discussion of Thomas M. Jones' EDM Model,[60] a model wildly used in business ethics which was based on five previous approaches by Rest,

[60] Thomas Jones, "Ethical Decision Making by Individuals in Organisations: An Issue-Contingent Model," *Academy of Management Review* 16, no.2 (1991): 366-385.

Trevino, Dubinsky, Ferrell and Hunt.[61]

Ethical attention is the first step of this model. This step involves the recognition of a moral issue, that is, an issue where a person's action, when freely performed, may harm or benefit others. Moral intensity, or the magnitude of the moral issue, is a central component of ethical awareness. Moral intensity is a construct that "captures the extent of issue-related moral imperative in a situation."[62] It is a subjective variable but still sufficiently accurate for a pharmacist to make ethical distinctions.[63] Moral intensity focuses on the moral issue rather than on the moral agent and is directly related to ethical attention. In the pharmacy context, most moral issues are of low to moderate intensity nothing comparable to moral issues in the medical and nursing context. One cannot expect the same ethical attention from a pharmacist as a physician dealing with moral issues at the beginning and end of life.

An important component of moral intensity is the magnitude of consequences of a moral issue.[64] In the many day-to-day situations in the pharmacy, these consequences in the pharmacy context never reach the threshold magnitude of great harm. A patient, who is administered a potent drug, has already been advised and warned about the drug's potential risks by the prescribing physician. The role of the pharmacist is to repeat this advice and convince the patient to be compliant with the doctor's

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61 Richard Cooper, "Ethical Problems and their resolution among UK community pharmacists" (A qualitative Study PhD thesis, University of Nottingham, 2007). See J.R. Rest, *Moral Development, Advances in Research and Theory* (New York, Praeger, 1986); L.K. Trevino, "Ethical decision making in organisations: A person-situation interactionist model," *Academy of Management Review* 11, no.2 (1986): 601-617; A.J. Dubinsky and B. Loken, "Analysing ethical decision making in marketing," *Journal of Business Research* 19. no.2 (1989): 83-107; O.C. Ferrell and L.G. Gresham, "A contingency framework for understanding ethical decision making in marketing," *Journal of Macromarketing* 49, no.3. (1985): 87-96; S.D. Hunt and S. Vitell, "A general theory of marketing ethics," *Journal of Macromarketing* 6, no.1 (1986): 5-16.

62 Thomas Jones, "Ethical decision making," 372. M. G. Velasquez and C. Rostonkowski, *Ethics Theory and Practice* (New York: Prentice-Hall, 1985), 34-36.

63 O.C. Ferrell and L.G. Gresham, "A synthesis of ethical decision models for marketing," *Journal of Macromarketing* 9, no.2 (1989): 55-64.

64 J. Weber, "Managers' moral reasoning: Assessing their responses to moral dilemmas," *Human Relations* 43, no.3 (1990): 687-702.

recommendations.

Another component of moral intensity is the degree of social consensus.[65] A customer expects higher professionalism from a pharmacist than from a retailer. This means that moral issues in a pharmacy are of higher moral intensity than in another retail outlet. Another component of moral intensity is the probability of effect of a moral issue.[66] The pharmacist is many times more worried about the immediate effect of a drug and may put aside the long-term negative effects of a drug.

Proximity or the feeling of nearness is a major component of moral intensity especially in the local pharmacy context. The pharmacist operates in a small area and practically knows many customers/patients by name. Many Maltese rely on the pharmacist's advice to treat minor ailments. This close relationship between the pharmacist and patient results in moral intensity to be more salient and vivid. This proximity to these loyal customers or patients increases the pharmacist's ethical attention to their medical needs. The pharmacist may keep the few remaining boxes of an important medication which is presently out of stock for one's loyal customers only.

Moral intensity has a direct relationship with volition.[67] A pharmacist must be aware that he or she has choice of assuming greater or lower responsibility. A pharmacist, who perceives the consequences of the moral issue faced during dispensing to cause harm in the near or distant future, may feel burdened by the moral issue. This pharmacist becomes more ethically aware and more responsible to deal with this moral issue. A pharmacist who is psychologically or emotionally closer to a patient may be more ethically attentive and more responsible to deal with moral issues during dispensing.[68]

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65 G.R. Laczniak and E.J. Inderrieden, "The influence of stated organizational concern upon ethical decision making," *Journal of Business Ethics* 6, no.4 (1987): 297-307.

66 T.M. Jones, "Ethical decision making," 375.

67 D.J. Fritzsche and H. Becker, "Ethical behaviour of marketing managers," *Journal of Business Ethics* 2, no. 4 (1983): 291-299.

68 J.B. Rotter, "External and internal control," *Psychology Today* 5 (1971): 37-59. Cited in Thomas Jones, "Ethical Decision Making by Individuals in Organisations: An Issue-Contingent Model," *Academy of Management Review* 16, no.2 (1991): 366-385.

Even personality traits can affect the recognition of a moral issue. A pharmacist who is in control of events occurring in the pharmacy and ready to face unpleasant situations, is in a better position to recognize ethical issues during dispensing practices.

The pharmacist, after having recognized a moral issue and assessed its moral intensity, is ready to proceed to Jones' second step of ED, which is the process of moral judgment. Taylor suggested that a moral issue that elicits a high moral intensity may elicit a more sophisticated moral reasoning.[69] In the pharmacy contexts, since moral issues elicit low moral intensity, one expects the pharmacist to economize on the efforts devoted to moral reasoning. In this context, the pharmacist may make use of the 'cognitive miser principle'[70] The pharmacist may adopt cognitive strategies to simplify the moral dispensing issues.

Trevino argued that cognitive moral development strongly influences ethical judgments.[71] Kohlberg's model of moral development,[72] then, may become useful to distinguish four types of community pharmacists according to their moral judgment characteristics.[73] One type is the egoistic pharmacist who is the least morally developed. This pharmacist resolves moral issues based on one's financial self-interest and is ready to break regulations if she or he is certain of not being caught. If challenged for his or her unethical behavior, this pharmacist rationalizes one's action by answering "Everybody does it."

The second type of pharmacist is the legalistic type.[74] This pharmacist is at higher moral level than the egoistic pharmacist. She or he over espouses the law as one's only guide

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69 S.E. Taylor, "On inferring one's own attitudes from one's behaviour," *Journal of Personality and Social Psychology* 31, no.4 (1975): 128-131.

70 T.M. Jones, "Ethical Decision Making," 384.

71 L.K. Trevino, "Ethical decision making in organizations: A person-situation interactionist model," *Academy of Managerial Review* 11, no.3 (1986): 602.

72 L. Kohlberg, "Stages of Moral Development," http://info.psu.edu.sa/psu/maths/Stages%20of%20Moral%20Development%20According%20to%20Kohlberg.pdf (accessed January 2, 2019).

73 P.E. Murphy, G.R. Laczniak and F. Harris, *Ethics in Marketing* (New York: Routledge, 2017), 17-18.

74 *Ibid*.

to ethical reasoning. Such a pharmacist will never dispense a POM without the corresponding prescription. For such pharmacist the law equates ethics.

Moral strivers, the third type, are pharmacists who have progressed in their ethical reasoning and consider multiple stakeholders when adjudicating what makes up moral propriety.[75] They are loyal to the basic duties dictated by the code of pharmacy ethics. Nevertheless, these pharmacists are highly influenced by the company's business culture. They will fall back to lower level of moral development in the absence of good guidance. Theses pharmacists adapt to the standards of their peers in order to please them.

The virtuous pharmacist (type four) has reached the highest level of moral development.[76] His or her behaviour is always ethical even under adverse conditions. This pharmacist wants to build a genuine pharmacist-patient relationship based on trust. To achieve this end, the pharmacist exhibits daily virtues of care, compassion, benevolence and integrity. A pharmacist of integrity combines beliefs, words and deeds and this wholeness persists under all business conditions.[77]This pharmacist succeeds in defeating greed-the greatest foe to integrity. This pharmacist is guided by the virtue of prudence which provides the moral compass to arrive to the good ordering of ethical principles in a given dispensing context.

Once the pharmacist has reached a moral judgment, she or he must decide what to do. This is the moral intent, the third step of Jones' EDM model. A decision about what is morally correct is not the same to act on that reasoning. At this stage the pharmacist balances moral factors with self-interest, usually financial interests.

A pharmacist knows that another pharmacy in a nearby village is giving discounts on sales of medicines. The pharmacist knows that reporting such irresponsible behaviour

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75 *Ibid*.

76 *Ibid*.

77 Geoff Moore, "Humanizing Business: A modern Virtue Ethics Approach," *Business Ethics Quarterly* 15, no.2 (2005): 237-241.

to the authorities is the right thing to do (moral judgement). She or he knows what is 'right' but may decide not to report (moral intent). If another pharmacy in the same locality were giving discounts, however, the moral intent may change. Proximity of this moral issue and the fear that loss of sales may prejudice one's job will result in issues of high moral intensity and moral intent is established more frequently,[78]The pharmacist, in this case, may report this case to the authorities. In this case, moral reasoning and moral intent are congruent.

The fourth step involves acting on the pharmacist's moral intentions. Fishbein and Ajzan argued that the "best predictor of a person's behavior is one's intention to perform the behavior."[79] Yet, in Rest's words "implementing a plan of action … involves working around impediments and unexpected difficulties."[80] Burger links moral intensity with moral behaviour by using the idea of proximity. He suggested that proximity, a component of moral intensity, would positively influence a helping behaviour.[81] Burger's suggestion may play a part in local dispensing practices. A pharmacist may arrive at a moral judgment of not to dispense NSAIDs without the corresponding prescription on the basis of the principle of non-maleficence. This pharmacist's moral intention is always to prioritize this principle for the patient's best interest. Yet, the proximity of this particular patient who is in pain may influence the pharmacist to dispense few sachets of this SAID. This proximity has motivated the pharmacist to help this patient.

1.4. Pharmacists' EDM from the Literature Reviews

The above three literature reviews revealed that many community pharmacists, coming from different countries, adopted very similar EDM processes to deal with dispensing issues. Table 6 shows these common EDM processes in studies extending from 1985 till

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78 T.M. Jones. "Ethical decision making," 387.

79 M. Fishbein and L. Ajzan, *Belief, Attitude, Intention and Behaviour. An Introduction to Theory and Research* (Reading: Addison-Weasley, 1975), 23-30.

80 J.R. Rest, *Moral Development: Advances in Research and Theory* (New York: Prosper, 1986).

81 T.M. Jones, "Ethical Decision Making," 388.

2018.

Table 6: Common EDM Processes in Pharmacy Practice

Study	EDM Process
Hibbert *et al*. Chaar *et al.* Benson *et al*. Cooper's Ph.D. thesis	Participants in these studies do not make COE their own. These participants regarded COE as being developed by few experts without asking for feedback from community pharmacists.
Chaar *et al.* Cooper's Ph.D. thesis Arlifi Delpassand Sharif *et al.*	Participants in these studies show low ethical confidence to deal with ethical issues during dispensing practice. Cooper concluded in his PHD theses that the participants were ethically passive.
Cooper *et al.* Chaar *et al.*	Many pharmacists prioritized legal requirements over patients' best interests.
Hibbert *et al.* Chaar *et al.* Wingfield *et al.* Cooper *et al.* Cooper's Ph.D. thesis	Participants made use of common sense, intuition, experience and consequentialism to arrive at an ethical decision when facing

1.5. Conclusion

The pharmacist's behavior ought to be a moral enterprise grounded in a covenant of trust.[82] The Greek word *diatheke* (covenant), which goes beyond the concept of a contract, might help in this regard as it signifies a special relationship between persons,

[82] Pamela Miller, "Covenant Model for Professional Relationships: An Alternative to the Contract Model," *Social Work* 35, no. 2 (1990): 121-126.

a will or testament.[83] A contract is an agreement between two persons who are mainly interested to safeguard their self-interests. A *diatheke* is a relationship between two unequal parties where the stronger party is committed to look after the welfare of the other party.[84] The pharmacist is always in a position of power due to his/her esoteric knowledge. In its essence a covenant is a beneficent oath of the pharmacist who promises to be the 'companion' and 'teacher' of the patient in times of need.[85] The pharmacist reciprocates the trust which society has bestowed on him or her by going the 'extra mile' to serve the patient's medical needs.

The aims of this chapter were several. The literature reviews revealed the lack of empirical studies on pharmacy ethics. The three literature reviews – by Cooper and colleagues, by Wingfield and colleagues and the one by the present researcher – revealed several common themes which describe the pharmacists' encounter with ethical dispensing issues. Finally, the four stages of Jones' ED model were discussed as an analytic guide to EDM. The literature reviews were used again to describe the pharmacists' ways of dealing with ethical issues during dispensing.

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83 *Ibid.*, 121-126.
84 *Ibid.*, 122.
85 *Ibid.*, 123.

Chapter Two: The Research Process

2.1 Introduction

Barry Hoffmaster has rightly claimed that ethical issues arising in health care might be more understood and appreciated by analyzing them in real life situations and by listening to those persons who have experienced them.[1] Today the pharmacist works in a highly complex, competitive and regulated environment. Empirical investigations are central in understanding the contextual nature of these ethical issues emerging during dispensing practices.[2]

This empirical investigation will be the main objective of Chapter Two. This process will have several steps. It will start with the research strategy and the reasons for the author's choice of a qualitative method using semi-structured interviews (SSI). This will be followed by the research design where the author will describe the sampling method and how practical and logistic issues will be solved. The author will then explain in detail how the interviews will be conducted. The last two sections will describe the data collection and data analysis.

2.2. Choosing the Research Strategy

The literature reviews mentioned in the previous chapter reveal that there has been a dramatic shift from a quantitative to a qualitative methodology in empirical ethics research in the last twenty years. In the late 1990s David Latif used questionnaires which provided excellent quality research. This quantitative methodology, however, might have suffered from certain limitations, including the fixed choice nature of the questions which could have hindered the participants' liberty to express their feelings or

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1 B. Hoffmaster, "Can Ethnography Save the Life of Medical Ethics?" *Social Science & Medicine* 35, no. 12 (1992): 1421-1431.

2 Pascal Borry, Paul Schotsmans and Kris Dierickx, "The Birth of the Empirical Turn in Bioethics," *Bioethics* 19, no. 1 (2005): 49-71.

thoughts.[3] The questionnaire method was based on written communications which lacked the richness of other forms of interactions such as body language which could be very revealing.[4] The lack of interpersonal relationship between the interviewer and interviewee could also have hindered the generation of a good rapport.

The researcher's objective in this dissertation is to explore, capture and understand the living experience of the community pharmacist when encountering ethical issues during dispensing practices. The researcher is seeking only meaning and not numbers. Each pharmacist sees reality from one's own perspective and this has a bearing on one's interpretation. The researcher wants to crystallize these pharmacists' experiences and to analyze them in the best possible way in order to generate rich and meaningful data in a hitherto locally unexplored area of health care ethics. The researcher is more after the *"verstehen* rather than the *erklaren,"* that is, more after the why and how rather than the what.[5] A qualitative methodology is well adapted to attain these objectives since it is sensitive to multiple perspectives and wants to understand and not measure the ethical phenomena.[6] Furthermore, this methodology has an epistemological dimension as it examines how the pharmacist interprets the social world.[7] It also has an ontological dimension as it examines the pharmacists' interactions with the community.

2.3. Research Design

Having decided that a qualitative methodology was likely to be the more appropriate approach to answer the research question, the author's next step involved the choice of the research technique. Several methods were considered: investigating pharmacists' documents related to ethical issues; observing the pharmacist at work or even recording

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3 M. Ailsa Benson, "Pharmacy Values and Ethics: A Qualitative mapping of the perceptions and Experiences of UK Pharmacy Practitioners" (Ph.D. thesis, King's College University, 2006), 46-48.

4 *Ibid*.

5 *Ibid.*, 49-51.

6 S.W.F. Holloway, "Values and the practice of pharmacy," *The Pharmaceutical Journal* 265, no. 7111 (2000): 308-312, 310.

7 A. Bryman, *Social Research Methods* (Oxford: Oxford University Press, 2004), 3-7.

the pharmacist during dispensing or interviews.[8] The analysis of pharmacists' documents was considered impossible as pharmacists do not record the ethical issues they encounter. The observation technique was thought to be a potential tool but offered problems of a practical nature, namely the difficulty in obtaining the necessary ethical approval; issues of confidentiality; and the risk of disrupting work activities in the pharmacy. Conversational analysis during dispensing was also considered but problems of confidentiality would make ethical permission unlikely.

The only approach available was that of interviews. This offered the advantage of allowing the pharmacist to express one's meanings and perspectives in one's style and manner.[9] Moreover, the interviewer could clarify and expand on the pharmacist's responses and could delve deeper into the subject's complex reality.[10] The interviewer was also in an ideal position to assess the interviewee' s body language which could be very revealing. Interviews also give time for the interviewee to reflect before giving out one's answers. These reflections would help to discover meaning in these pharmacists' narratives.

Another factor which was considered was whether to conduct the interview with individual pharmacists or with focus groups. At first, the latter process was preferred because it could elicit several perspectives at the same time. It was soon realized, however, that there would be logistic problems. Pharmacists preferred to be interviewed in their working place. The researcher realized that it proved to be an impossible task to get four or five pharmacists together at the same time. Moreover, the researcher realized that focus groups could not delve deep into the subject due to the public nature of the process. It was therefore decided to meet pharmacists individually

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8 Norman K. Denzin and Yvonna S. Lincoln, *The Sage Handbook of Qualitative Research* (London: Sage Publications, 2011), 415-420.

9 N. Bricki and J.Green, "A Guide to Using Qualitative Research Methodology," *Medicines Sans Frontiers,* Feb-2007, http://hdl.handle.net/10144/84230 (accessed November 3, 2018).

10 *Ibid*.

at an appropriate time and place of their choice.

The last step in this research strategy was to determine the best method of interview. Structured interviews were ruled out as these were often used for quantitative research.[11] From the above literature reviews, semi-structured interviews (SSI) were found to be the method of choice. The author opted for this method because it was most suited to answer the research question. Fontana and Frey described in-depth SSI "as the most successful tools for eliciting rich participants' accounts of their experiences and allowed spontaneity, flexibility and responsiveness – all essential components of quality qualitative research."[12] Every pharmacist had to answer the same questions but there was flexibility in the process. Questions that were not considered effective in eliciting the needed information could be dropped and new ones added for the next interview. Furthermore, the interviewer could depart from the planned itinerary to follow the interviewee's interests. In this manner, this SSI would create interactions between the interviewer and interviewee and this would stimulate rapport which would result in a better opportunity to explore attitudes, beliefs, values and motives.[13] The interviewer could be regarded as the tool to shape the interview, keeping the research question always in focus.[14] Unstructured interviews could have been another option but this method did not guarantee control of the interviewer over the interviews and hence there would have been less focus on the research question.[15]

The success and validity of a study based on SSI depends on the truthfulness of the interviewee's account. Denscombe has pointed out, in fact, that persons could respond differently depending on their perception of the interviewer, which is known as the

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11 Bridget Young and Darko Hren, "Introduction to Qualitative research Methods," *MiRoR,* miror-ejd.eu/wp-content/uploads/sites/34/2017/03/Introduction-to-qualitative-research-methods.compressed.pdf (accessed October 31, 2018).

12 A. Fontana and J.H. Frey, "The Interview: From structured questions to negotiated text," in *Handbook of Qualitative Research,* ed. N.K. Denzin and Y.S. Lincoln (New York: Sage, 2000), 645-672.

13 *Ibid*.

14 *Ibid*.

15 *Ibid*.

interviewer effect.[16] Moreover, interviewees could respond by what they thought the situation necessitated. They could also respond in a way to generate a particular professional image.

2.4. Sampling

Qualitative research does not involve random sampling of participants in the statistical sense. This process, however, required a plan as a criterion of selection. Purposive sampling was adopted so that the interviewees reflected the variety of roles and population in the Maltese pharmacist community. The sample size was an important consideration since this would have implications on the validity of the study. Most studies identified in the literature review made use of 23 participants, so the researcher opted initially for this sample size. The final sample size was to be determined, however, by data saturation, that is, when no new information was emerging from the interviews it would end. Another consideration was the gender ratio. This purposive sampling ensured that of the 23 target interviewees, 15 female pharmacists and 8 male pharmacists would be interviewed, a ratio of 2:1 which reflected the actual gender distribution of all registered Maltese pharmacists.[17] Another consideration was to seek good informants where 'good' meant experienced. The author decided to contact those pharmacists with at least more than three years' experience in pharmacy practice. The pharmacists selected had various roles: some were employees while others were pharmacy owners. Of course, this does not mean that this qualitative sample was representative in a statistical sense but the author tried to produce a sample that reflected something of the variety of roles comprising the Maltese pharmacy practice. A summary of the sample of participants appears in Table 7.

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16 M. Denscombe, *The Good Research Guide* (Maidenhead: Open University Press, 2003), 45-48.

17 This data was accessed from the General Pharmaceutical Council (https://www.pharmacyregulation.org/registers.

Table 7: Summary of Sample of the Participants

Participants	N=23
GENDER	
Male	8
Female	15
AGE (years)	
30s	7
40s	6
50s+	10
ETHNICITY	
Caucasian	23
EMPLOYMENT	
Owner proprietor	12
Employee of:	
Small company (1-2 pharmacies)	4
Medium company (3-6 pharmacies)	3
Large company (>6 pharmacies)	4

The researcher considered the method of snowball sampling,[18] but then decided not to use this method since it would not guarantee the representatives sought in the sampling process.

2.5. Gaining Access

The recruitment process followed the following steps. The researcher personally contacted the participants by phone and explained briefly the objectives of the study. All participants contacted agreed to participate except for four pharmacists. There were two reasons for refusal: finding the time and claiming not having experienced any ethical

[18] Snowball sampling is where research participants recruit other participants for a test or study.

issues during dispensing. (This, in itself, could be indicative of a lack of awareness of ethical issues in the work place). The research information sheet (see Appendix II) was emailed to each prospective participant explaining the background of the research. Three days later the pharmacists were contacted again and asked if they had any questions. If they accepted the invitation, the time and place of the interview was determined by the interviewee. Community pharmacists have long hours of work and a busy personal schedule. Many have families with young children. The interviews took place in the pharmacy to accommodate their exigencies.

2.6. Ethical Issues Raised by Participants

All research raises ethical issues. This study was performed in line with the ethical standards held by the University of Malta. Confidentiality and anonymity were key ethical concerns of the participants.[19] The researcher reassured them that the study would not provide information, such as their names, working place, that might enable identification. The author would only make use of pseudonyms when quoting sentences from the interview. Fourteen participants, out of twenty-three, refused to be recorded. All participants were reminded that they had the right to stop the interview at any time. Moreover, all participants requested a copy of the notes taken during the interview to make sure that the transcripts were in line with their thoughts and words.

Informed consent to participate was also an important consideration.[20] Before the start of the interview, the researcher read the information sheet to the participants to make sure that they understood the objectives of the research, even though they had already been emailed to them. They were also informed that the study had no connection with any sponsor such as the Pharmacy Board. No pressure of any sort was exerted on any of the participants at any time. The participants signed the consent form, reproduced in

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19 See P.J. Allmark *et al.,* "Ethical Issues in the use of in-depth interviews: literature review and discussion," *Sheffield Hallam University Research Archive*, November 8, 2009, http://shura.shu.ac.uk/information/html (accessed September 2, 2018).

20 *Ibid*.

Appendix III), but the author used the method of process consent, that is, reaffirming consent throughout the research process.[21]

2.7. Bias

Qualitative research is often criticized for its lack of scientific rigor, lack of transparency in its analysis of data and the influence of the researcher's personal opinions on the findings.[22] This methodology handles non-numerical data and its phenomenological interpretations.[23] This gives rise to subjectivity which fuels a lot of discussion on the quality of such research. The researcher brings in his experience, emotions, prejudices, ideas and personal philosophies. All these human elements can bring about bias. This study would be prone to such bias if the necessary precautions were not taken.

In simple language, bias is a systematic error where a research conclusion deviates from a 'true' finding.[24] Bias is always present in all research and quite difficult to eliminate. It can occur at any stage of the research, in the design, sampling, interview and analysis, and can impact negatively on the validity and reliability of the study.[25] Table 8 identifies the various types of bias which could have happened in this dissertation's qualitative analysis.

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21 *Ibid*.

22 N.K. Denzin and Y.S. Lincoln, *The Sage Handbook of Qualitative Research*, 1-15.

23 *Ibid*.

24 Nigel Norris, "Error, Bias and Validity in Qualitative Analysis," *Educational Action Research 5,* no.1 (1996): 172-175.

25 Helen Noble and Joanne Smith, "Issues of validity and reliability in qualitative research," *BMJ Evidence Based Nursing* 18, no.2 (2015): 34-35.

Table 8: Sources of Bias in the Study

Bias	Source
Design Bias	The author's beliefs, experiences and personal preferences influence the choice of the research question and methodology.
Sample Bias	Participants needed a three-year experience in community pharmacy practice to be enrolled in the study. All participants were selected by the author. These participants were regarded as trustworthy and competent by the author.
Data collection Bias	The author chose SSI and the manner, type and format of the questions could have influenced the participants' responses.
Analysis Bias	When analysing data, the author could have overlooked certain information that did not fit his personal experience or predetermined subconscious hypothesis.

In quantitative research there are instruments, such as, the p-value and confidence interval, that can measure bias. These tools are useless in qualitative research. Concepts of validity and reliability are still, however, applicable in their broadest context in qualitative research. Truth value is the terminology used in qualitative language which corresponds to validity.[26] Truth value is achieved if the researcher presented clearly and accurately the participants' perspectives.[27] The author's experiences and perspectives had to be accounted for and differentiated from participants' accounts.[28]

Reliability is a term used in quantitative language and translated to consistency in qualitative terminology. The methodology had to be trustworthy, that is, the author's

[26] *Ibid*.

[27] G. Rolfe, "Validity, trustworthiness and rigour: quality and the idea of qualitative research," *American Journal of Nursing* 2, no. 53 (2006): 304-310.

[28] *Ibid*.

decisions had to be clear and transparent.[29] An independent researcher should arrive at comparable findings if the author's methodology were to be repeated.

2.7.1. Minimizing Bias

The researcher undertook several strategies to enhance the credibility of the study. He made use of reflexivity to increase the credibility, congruence and confidence in the study. Reflexivity is an "introspective process that limits bias and subjectivity."[30] The researcher's use of reflexivity mitigated the potential adverse effects of his preconceptions on the research and helped him to become aware of his subjectivity. The author reflected on his thoughts, emotions, actions and assumptions. He became aware of their influence on the research process and hence was able to control them. Reflexivity became a "marker of quality; a strategy to meet the criteria of rigour and a tool to promote the quality of qualitative study."[31]

Several interviews were audiotapes and transcribed immediately afterwards. This made possible the repeated revisiting of the data to check emerging themes and remain true to participants' accounts. Participants were invited to check the transcript of their accounts. The researcher made extensive notes of the other interviews that were not audiotapes. All the interviews were conducted by the author and there was no additional angle of vision from other researchers in the generation of themes.

Anther strategy used by the author to minimize bias was data triangulation. The collection of data from different types of people, employees or owners, gave rise to data triangulation which is an important strategy to develop a comprehensive understanding of phenomena.[32] This method is useful in comparing and contrasting participants'

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29 J. Morse, M. Barrett and M. Mayan, "Verification strategies for establishing reliability validity in qualitative research," *International Journal of Qualitative Research* 5*,* no.1 (2002): 1–19.

30 Esha Patnaik, "Reflexivity: Situating the Researcher in Qualitative Research," *Humanities and Social Science Studies* 2*,* no.2 (2013): 98-106.

31 *Ibid.,* 100.

32 M. Paton, *Qualitative Research and Evaluation Methods* (California: Sage, 2003), 98-112.

accounts so that different perspectives are represented.[33]

The researcher made use of the Critical Appraisal Skills Tool (CASP) tool for self-assessing the credibility of the qualitative research.[34] This tool helped the author to self-assess the truthfulness of the research methodology. Answers to the questions set up by this tool are produced in appendix IV.

2.8. Pilot Interviews

The researcher decided to conduct pilot interviews with three pharmacists who had a vast experience in retail pharmacy. These pilot interviews had several objectives. These participants could give their opinion regarding whether the questions were clear and relevant. On reading the vignettes, these three pharmacists found them realistic. Moreover, these pilot interviews served the author to acquire some experience in interviewing. From these pilot interviews, the researcher had a better idea of when to prompt the interviewee, when to listen, when to ask for clarifications.

2.9. The Interview

The researcher used the style of responsive interviewing that emphasizes the importance of trust between the interviewer and interviewee.[35] The interviewee was not under interrogation but participating in a joint activity based on mutual respect.[36] In the interview there was a fair degree of reciprocity and the interviewee was regarded as a partner.[37] Interviewing was done in a supportive, non-confrontational and gentle tone. The interviewee gave his or her time, exposing his or her emotions and creativity

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33 Roberta Heale and Dorothy Forbes, "Understanding triangulation in research," *Evidence Based Nursing* 16, no.4 (2013): 98.

34 "Critical Appraisal Skills Programme," https://casp-uk.net/casp-tools-checklists/ (accessed October 31, 2018).

35 Anna Galletta, *Mastering the Semi-Structured Interview and Beyond* (New York: New York University Press, 2013), 75-118.

36 *Ibid*.

37 *Ibid*.

and was owed confidentiality and personal respect in return.[38] Appendix V details the layout of the interview.

2.9.1. The Opening Segment

The opening segment of the interview had the objective of putting the participant at ease. The interviewer summarized the objective of the research, presented the informed consent form which was signed and then expressed his gratitude to the participant for having accepted the invitation. The researcher then reminded the interviewees of their rights: the right not to answer a question and the right to leave the interview at any time without giving any reason. The interviewer asked their permission to record the interview. Only nine of the twenty-three interviewees accepted to be recorded. The others refused because they were worried about being on record as admitting to some unethical behaviour on their part.

The researcher had spent some time to prepare the questions. This was important because for him it was the first experience of this type. He was determined to be flexible and the order of the questions was dictated by the course of the interview. A balance had to be found between following rules and being totally anarchic. As more interviews were conducted, the researcher realized that the initial format of questions was only a guide not to be used in a rigid manner.

During this opening segment, the researcher tried to create a zone of comfort so that the interviewee felt at ease and was able to give a richer account with deeper generation of meaning. He felt that rapport could be built quickly as all participants had been in a good relationship with the researcher for many years and could therefore feel comfortable to narrate their stories.

In the opening segment of the interview, the researcher sought to give space and time

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[38] *Ibid*.

to the interviewees to narrate a central story that pricked their conscience during their years of dispensing. To the author's surprise, many struggled to find such stories, in spite of the fact that they were informed a week beforehand of the main objective of the research. The researcher had to show patience and this helped the participants to feel more at ease and stories to be presented.

Interviewees could express their experiences and angle of vision regarding this narrative. The interviewer listened carefully, taking down extensive notes and interrupting as little as possible. The interviewer made sure that the narration was focused on the research question. This narrative was a major source of data since it investigated the pharmacists' moral awareness, their moral intent and the way they worked out the ethical decision process.

2.9.2. The Middle Segment

The vignettes were presented in the middle segment of the interview. Vignettes are hypothetical situations designed to elicit moral reasoning. The answers given to questions raised by the vignettes could be looped back and compared to the participants' narrative. These vignettes appear in Appendix VI.

2.9.3. The Final Segment

In the last part of the interview, the participants were asked about their opinion of the pharmacy code of ethics. In this final segment the researcher took the opportunity to explore contradictions that appeared during the interview. Finally, the author asked the participants for any final thoughts and then thanked them for their contribution to the research.

2.10. Data Analysis

Data analysis is a lengthy, reflective, ongoing and iterative process.[39] Data analysis occurs alongside data collection and it goes back frequently to examine again the data to ensure meaning and to improve the quality of the next interview.[40] This continual iterative process helped the researcher to immerse deeper into the pharmacists' dispensing ethical experiences. Two important aspects in data analysis include organization of data and keeping the research question in focus.

Data analysis followed the steps suggested by Anne Galletta and Uwe Flick[41] and the process is described below.

Step 1

The first step consisted in the preparation of a transcript that contained a full, accurate word-for-word rendition of the interview. After each interview, the researcher made notes on the performance of the interview and any reflective ideas. These were inserted into a 'memo' file and any important quote used by the participant was filed into a separate 'quotation' file Each interview was then summarized and this summary included the main points expressed, the pseudonym, the time, date and location of the interview and role of the pharmacist. This information is reproduced in Appendix VI.

Step 2

The early part of the data analysis, named coding, involved the recognition of concepts and themes from the transcript's texts. Concepts are ideas whilst themes are summary statements expressed by the participants.[42] These concepts and themes were searched and labelled in the transcripts. Further reading of the text gave rise to other emergent

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39 Anna Galletta, *Mastering the Semi-Structured Interview and Beyond* (New York: New York University Press, 2013), 119-124.

40 *Ibid*.

41 Uwe Flick, *Doing Grounded Theory* (London: Sage, 2018), 50-65.

42 Megan Cope, "Coding Qualitative data," https://www.researchgate.net/publication/284143585_Coding_qualitative_data (accessed 13 October, 2018).

concepts and themes. Combining several concepts created new concepts and themes.

Codes were labelled, referenced from where they were derived, and their meaning explored. Codes that overlapped with others or that did not answer the research question were discarded. As data was read further, many codes assumed a fine-tuned characteristic. Eventually some codes emerged as strong, while others died off.

Data analysis moved from within each interview and across other interviews. Within the interview, the author tried to identify the experience, its meaning, how it was expressed in the interview and how it related or contradicted other experiences within the same interview. Furthermore, data in one interview were compared with other data in other interviews to find confirmation or contradictions. In this way, clustering of codes into large codes or categories was accomplished.

Step 3

The codes on a given concept and themes were sorted out and categorized. These themes were weighted in relevance and importance in answering the research question and integrated to create a complete picture. These themes appear in Appendix VII.

2.11. Conclusion

This chapter has discussed in detail the choice of the qualitative method using SSI; the ethical issues raised by the research and how they were resolved; the way the interview was conducted and the objectives behind the questions and the various steps adopted in the data analysis. It has also described in detail the strategies taken to minimize bias and to increase the credibility of the research. The next chapter will now discuss the themes and categories which emerged from the interviews.

CHAPTER 3: Ethical Problems in the Local Community Pharmacy

3.1. Introduction

The methodology discussed in the previous chapter led to the gathering of empirical data on the local community pharmacists' experiences of ethics during their work. This included documenting their main ethical problems which they faced during dispensing. and the gaining of insight into their ethical awareness and decision-making practices to solve these problems. It is now time to discuss the major themes which emerged from these interviews, documenting the participants' main ethical issues during dispensing. This will answer the first part of the research question, that is, *What ethical dispensing practices issues are experienced by Maltese community pharmacists?*

3.2. Central Themes

3.2.1 Fear of losing customers/patients

This research has found out that a central preoccupation of the pharmacist is the fear of losing customers. Indeed, as David Latif points out, "the 'sovereignty' of the customer still has currency."[1]

This concern was examined through Vignette 2 in which the pharmacist was keeping the few remaining boxes of an important drug to one's most loyal customers. The objective of this vignette was to evaluate the importance of this central theme to the participants. Most of them stated that they would behave as the pharmacist in the vignette. Pharmacist 19 commented: "Miss X is a very good, regular customer. I feel I have to

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[1] David Latif, "Ethical Cognition and Selection-Socialization in Retail Pharmacy," *Journal of Business Ethics* 25, no.4 (2000): 343-357.

reciprocate her loyalty by keeping some boxes for her." Only a few participants had a differing opinion. Pharmacist 7 commented: "I treat all patients the same. First come first served. I'll dispense only 1 sheet so more patients can be satisfied."

3.2.1. Subordination to the patient

All participants commented on the negative impact of consumerism on their dispensing practice. The customers themselves often imposed competitive pressures on the pharmacists.

Pharmacist 5 commented: "I am committed to give the best service to customers, they'll come back again and again. Commitment to service gives my pharmacy a competitive edge over nearby pharmacies." The same pharmacist continued:

> Many customers are over demanding. They feel empowered and if I refuse to dispense a medicine either because it requires a prescription or because it is over used and can be harmful, they just simply try another pharmacy. This occurs often with nasal decongestants and more seriously with NSAIDs. But there is a limit to please customers. Some colleagues do not know to draw the line.

An example of being unable to draw the professional line was the acceptance of unused, returned medicine. Pharmacist 18 narrated:

> I opened my pharmacy few years ago. There were several other pharmacies in the area. So I needed to attract customers. I started to accept returned goods. I regret it because now I'm treated as a carpet.

Most participants commented that they did not like to put back a returned item into stock because there was no guarantee that the medicine had been stored at the right temperature. Yet, on the other hand, they sought to please the customer. The fear of losing customers is constantly present in every ethical decision during the dispensing of medicines.

3.2.2. Subordination to the physician

Another important customer for the profitability of the business is the physician practicing in the pharmacy's territory. Vignette 1 described a doctor who was over-

prescribing co-amoxicillin. All the participants were aware that this could increase the incidence of bacterial resistance but all agreed that they would dispense without any hesitation. The pharmacist would not interfere in any way with the medical decision of another professional colleague. They were afraid that if they commented negatively to such unwise prescribing, the physician would refer future prescriptions to another pharmacy. As Pharmacist 3 put it: "My daily bread depends on doctor X's prescriptions. So, I do not dirty the water from which I drink."

All participants commented that the dominance of the medical profession had a long history. Pharmacist 4 commented: "Doctors have a powerful voice. This is understandable as ultimately the patient's responsibility is theirs." Pharmacist 6 explained:

> When I decided to work as a pharmacist, I knew I have entered a practice of relationships. These relationships include other professionals – doctors, nurses, dentists and colleagues. I knew that this required a lot of professional etiquette. All these stakeholders are customers for the pharmacy which pays my income. This co-operative relationship can be of benefit to the patient but it can sometimes create potential for conflict of professional autonomy, which most of the times I try to avoid.

Participants explained that the pharmacists' subordination to the physician was due to the medical profession and patients perceiving dispensing as a simple, routine task rather than a verification procedure for the benefit of all concerned. During this procedure the pharmacist was using all one's knowledge in pharmacology for the patient's best interest. The pharmacist was transferring a piece of paper into a medicine, a symbol of trust.[2]

Pharmacist 7's comment was in line with that of most participants.

> I am sure that this verification procedure can create tensions in my relationship with the doctors if not handled in a professional way. I am filling a gap created by the doctor's failure to provide the patient with clear information about the treatment prescribed.

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[2] David Latif, "Providing Patient-focused Care within a Managed Care and Pharmaceutical Care Environment: a person/interactionist model for community pharmacists," *Journal of Managed Care Pharmacy* 6, no. 3 (2001): 233-239.

This observation by Pharmacist 7 is confirmed by studies which show that most of the information given by doctors is forgotten by the patient.[3] The same pharmacist continued: "The pharmacist is filling this role of clarifying certain doubts and encouraging medication compliance. Some doctors might perceive this service as an intrusion and interference in their field of knowledge."

All participants agreed that "ultimately it is the doctor who has the last say." As Pharmacist 13 pointed out: "The doctor has the patient's medical history which I lack. It is only on the doctor's order that a treatment is initiated or stopped. I have to respect this fact." Participants agreed that if the pharmacist were competent and were to use this knowledge in a professional and visible way, the relationship with the doctor might improve for the benefit of all stakeholders. Pharmacist 6 narrated: "With my GP there is constant communication. There is mutual respect. With politeness and confidence brought by knowledge, things are solved for the patients' best interest. Of course, I have always to keep my place."

Several owners were of the opinion that closer relationships developed when the doctor's clinic was in the pharmacy. The doctor might feel obliged to accommodate the commercial needs of the pharmacist as a way to compensate for the free usage of the clinic. Pharmacist 19 gave a good picture of this relationship: "Our pharmacies have a really excellent relationship with the doctors who have their clinics in our pharmacies. We help each other and they help in pushing our products."

Not all of the participants' stories proved such a collaborative relationship. Pharmacist 22 narrated situations when a busy doctor often prescribed a medication that had no scientific backing. Pharmacist 19 had experienced situations when the doctor was prescribing medications which lacked evidence-based efficacy and commented: "I

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[3] A. Girgis, R. W. Sanson-Fischer and W. H. Mccarthy, "Communicating with patients: surgeons' perceptions of their skills and need for training," *The Australian and New Zealand Journal of Surgery* 67, no.11 (1997): 775-780.

dispense and do not comment. The doctor is our main source of prescriptions and I do not want to cause any tension between us."

Other participants complained about situations when the doctor prescribed only certain products marketed by the same company. Pharmacist 13 narrated a case when a lady came to buy on prescription branded paracetamol tablets with caffeine. She insisted on the brand because the doctor had advised her to stick to that brand and not to let the pharmacist convince her to take another brand. Pharmacist 13 continued:

> It is very frustrating to have a doctor insisting on a particular brand when there are several similar brands on the market. It looks very suspicious and it makes me feel as a pharmacist very little. But one dispenses, we cannot make enemies.

The participants also had relationships with other doctors who did not attend their pharmacy. In this case, the contact was by telephone which could be trickier. Pharmacist 14 gave good advice for handling such encounters, which could cause tension with the physician:

> If it is a minor thing, try to settle it with the patient. If it is an error in dosage or contraindication, then one has to contact the doctor. Respect, politeness and confidence are essential. Just yesterday I had a prescription for Actifed syrup, indicated for children above 2 years. The baby was only 10 months of age. I phoned and explained. He listened but was not convinced. I explained the situation to the mother, showed her the product's leaflet and added that many doctors still use it under 2 years. The mother still decided to follow the doctor's advice. I felt good, I gave her a good advice without harming the reputation of the doctor.

Another participant, pharmacist 7 narrated:

> Many times I phone to inform the doctor if I can change a prescription to another generic because the prescribed medicine is out of stock. I feel very down when I have to phone for such nonsense to get the doctor's permission.

All agreed that this triadic relationship – patient, doctor and pharmacist – was a crucial relationship and that the pharmacist had to handle it with care so that no one was offended. All participants agreed that communication with the doctor had to be done with civility and courtesy. In the words of Pharmacist 20: "I will never say that the doctor is mistaken. I find other words. I regard the pharmacist as the 'go between', give my advice and dispense but never contradict a doctor's prescription."

3.2.3. Bending of rules

All participants confirmed that many times dispensing regulations had to be broken to accommodate the needs of the customer and retain the customers' buying habit. The participants rationalized this behaviour in the name of the patient's best interest. These dispensing rules are established by law and are encoded in the code of ethics (COE).[4] All participants accepted these rules. They were aware that they had the duty to obey them and that breaking the law or the COE carried risks of legal and professional litigations. Yet, participants unanimously identified the concept of the patient's best interest (PBI) as the core ethos underlying the practice of pharmacy and a major determinant for business success.

The participants mentioned many situations when the pharmacist had to prioritize the PBI over the law. Pharmacist 11 explained:

> A patient, who I know well, may come to buy a POM pain killer without a prescription and promises to bring the prescription the morning. Sometimes the doctor phones and asks to dispense a controlled drug without a prescription, promising to deliver it next morning. A mother may come for an antibiotic syrup for her child showing a prescription on the mobile. All these examples are emergency cases and I will not hesitate to dispense.

Participants commented that experience helped in deciding between law and ethics. Pharmacist 12, who has graduated three years ago, commented: "I will stick to the law. I don't want any trouble with authorities." Pharmacist 3, however, who graduated twenty years ago, commented:

> I will consider whether the patient is a person who I know, whether the situation is being repeated several times; whether the patient is a child or elderly; whether not dispensing would affect the quality of life of the patient. Knowledge creates power to decide and I place relationships before rules.

Another pharmacist had another way of solving these issues. Pharmacist 15 said:

> When a patient comes for a controlled drug and starts inventing stories, of how he

[4] Pharmacy Council Malta, "Code of Ethics for the Pharmaceutical Profession," https://deputyprimeminister.gov.mt/en/regcounc/pharmcouncil/Documents/code.pdf (accessed November 26, 2018).

> has lost the pills then I know he is lying. I do not risk my warrant, so I tell him I'm sorry it is out of stock from the pharmacy.

When the interviewer asked Pharmacist 8's opinion on Pharmacist's 15 comment, without revealing the latter's identity, the former participant said:

> "This pharmacist is passing the hot potato to the neighbouring pharmacist. It shows lack of loyalty towards his or her profession and colleagues. Moreover, the pharmacist is avoiding a professional duty and breaking the principle of veracity."

This personalization of rules demonstrated the possibility of partiality. One pharmacist might decide one way while another pharmacist might come to a different decision. Ethical decision making could become habitual and subjective. Such a method of perceiving ethical issues could minimize reflection about each dispensing problem and hinder ethical awareness. A study by O'Neil revealed that many UK pharmacists would not make an emergency supply of drugs on the basis that a prescription could always be obtained with some small effort.[5] Pharmacist 12 commented on this point: "This is very true in Malta where health centres are open and doctors available to write a prescription. A patient can fill a prescription from a doctor at any time."

3.3. Major Theme: Tensions from Commercial Interests

Most participants linked this commitment to retain customers with commercial interests. They argued that a satisfied patient returned again to the pharmacy and this guaranteed more sales, long term profitability and gave higher value to the pharmacy's goodwill. Some participants revealed that there was presently a new business pharmacy plan gaining momentum. Some pharmacies were giving discounts to customers, even on medicinal products, even though it is clearly against article 5.4 of the Maltese Pharmacists' Code of Ethics. Patients were now expecting a good service plus a good discount, otherwise they would switch their buying habit to another pharmacy that offered better financial incentives.

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[5] R. O' Neill, E. Rowley and F. Smith, "The emergency supply of prescription-only medicines: a survey of requests to community pharmacists and their views on the procedures," *International Journal of Pharmacy Practice* 10, no.2 (2011), 77-83.

The study of Chaar and colleagues claimed that the business environment had considerable influence on the pharmacists' ethical decision making and might lead to prioritize profit over professional commitment.[6] Resnick and colleagues commented that commercial interests remained a potential source of conflict in the pharmacy.[7]

During the interviews the participants confirmed this trend in the local community pharmacy environment. All participants were aware of the need to manage the tension between professionalism and excessive search for profit. They know quite well that when greed was great it hindered professionalism. They complained that many times it was the competitive working environment which created this tension. Many participants were aware that retaining customers was more important than a single sale and agreed on the importance to sell combined with good quality advice. Pharmacist 13 summarized this competitive environment and said:

> To stimulate sales and reach targets, the local pharmaceutical dealers offer irresistible profitable deals on medicinal products. With the exponential growth in parallel importation profits for the pharmacy have sky rocketed. All these profits will be lost if the pharmacy does not attract customers.[8]

Pharmacist 16 explained: "It is impossible to refuse offers. Just yesterday a dealer offered me that for every 12 boxes of omeprazole tablets I buy, I get 13 boxes free. That's more than 100% profit." Unfortunately, the patient/consumer was not profiting from this competition, with all profits going into the pharmacy owners' pockets.

Pharmacist 18, who is also an owner, summarized the profit-oriented mentality of most pharmacies well:

> The first question I ask to the salesman is: what is the bonus? With OTC items, there is a little therapeutic difference, if any, between one product and another. We need

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6 Betty Chaar, Jo-Anne Brien and Ines Krass, "Professional Ethics in Pharmacy: The Australian Experience," *International Journal of Pharmacy Practice* 13, no. 3 (2005): 195-204.

7 D.B. Resnik and P.L. Ranelli, "The conflict between ethics and business in community pharmacy: what about patient counselling?" *Journal of Business Ethics* 28, no.2 (2000): 179-186.

8 In the last ten years most sales of cosmetics, baby products, and general body care products have shifted from the pharmacy to the large stores. This has greatly reduced the profitability of the pharmacy. This loss of sales, however, is compensated by the high profit margins of POM and OTC medicines.

> these extra profits to compensate for the losses in sales due to the large stores.

Retaining and winning new customers made economic sense for the participants, especially pharmacy managers and owners. Dingwell and Watson claimed that a pharmacy owner had more pressure to prioritize profits.[9] Tension might arise if organizational values were incompatible with those of the pharmacist.[10] Some pharmacy owners motivated their employees to promote certain OTC products by offering commission on each sale or other incentives for taking ethical short cuts. Pharmacist 4 commented: "My boss wants me to push the bigger pack of painkillers or dispense the brand and not generic to make more profit. Even pharma reps offer me gifts to push their products."

This pharmacist commented that such ethical dissonance could have two outcomes: "The pharmacist has either to quit the job or else accept to lower professional standards."

Other pharmacy owners used the technique of link selling.[11] Pharmacist 11, a pharmacist employed in a chain pharmacy,[12] commented:

> My boss wants me to promote the sales for insect repellent every time a customer comes in and asks for a cream to treat an insect bite. For a patient with sore throat, the boss wants me to sell throat lozenges and antibacterial mouth spray.

Not all participants found these commercial deals to be unethical. Another pharmacy owner, Pharmacist 17, accepted the idea that the pharmacist was a trader and found nothing wrong in prioritizing profit. This pharmacist retorted:

> Even other professionals are traders. Dentists sell toothbrushes and mouthwashes from their clinics. We sell other things besides medicines to compensate for our free medical advice. Competition is tough and we survive because of parallel importation,

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9 R. Dingwall and E. Wilson, "Is pharmacy really an incomplete profession?" *Perspectives on Social Problems* 7, no. 4 (1995): 111-128.

10 D. Hibbert, J.A. Rees and I. Smith, "Ethical awareness of community pharmacists," *International Journal of Pharmacy Practice* 8, no.2 (2000): 82-87.

11 Link selling is the concept that when a customer buys one thing, the seller would try and sell them something else linked to it.

12 As a general definition, a community pharmacy is defined as a "chain community pharmacy" if the organization consists of four or more stores.

> high profits on OTC and remuneration from POYC.[13]

Promotional displays in the dispensing area might also impede the pharmacist's effort to give professional advice. Pharmacist 9 narrated a situation in which a patient decided to interrupt treatment on his own initiative and came to the pharmacy to switch to another treatment**:** "Mr S is on Seroxat, an anti-depressant. One day he came to the pharmacy. He has decided to stop the medicine and start St. John's Wort, acting on the advice from an internet source.*"*

The pharmacist explained that it was difficult to convince Mr S that his action could result in serious harm when on the counter there was a full promotion display of St John's Wort capsules*.*

A new trend in the Maltese pharmaceutical business is the ownership of pharmacies by companies who operate as wholesalers, pharmaceutical marketing agents and parallel importers. These companies have their own agenda and interests. They import their own products. Moreover, they have a strong buying voice and can negotiate advantageous profitable deals with other importers. The participants employed with these companies commented that they had little say in the dispensing process. Pharmacist 8 gave a good picture of this situation:

> The company has its own sales targets and the manager constantly reminds us to promote certain items. Many times, I was thinking of leaving this pharmacy but when I speak to other colleagues working with other companies, they are in the same situation.

The same pharmacist continued to mention a situation in which the owner, who was not a pharmacist, dispensed an OTC medication inappropriately: "The owner recommended an eye drops preparation which was not appropriate for the patient. I did not feel comfortable to undermine the owner's decision."

These participants complained that the pharmacist's professional autonomy was very

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[13] POYC is the Pharmacy of Your Choice system that supplies free medicine every two months to patients who are entitled to benefit from this system.

limited when working with owners who were interested only in profit. One is reminded at this point that Astbury and colleagues report that the pharmacists who did not achieve this balance between ethics and profits demanded by the pharmacy owners suffered moral distress and soon sought out other opportunities of work.[14]

3.4. Ethical Problems in Professional Autonomy

3.4.1. Tensions with colleagues

The objective of retaining and winning customers could be the cause of rising tensions with colleagues working in the same city or village. Some participants commented that certain colleagues tried to be uncooperative in many ways. Some gave discounts to steal the customers of other pharmacies. Pharmacist 10 narrated a bad experience from a colleague working in a nearby pharmacy:

> A lady comes to check her urine for glucose levels. I checked it twice because it showed high levels of glucosuria. I advised her to see the doctor to do a blood test. After 15 minutes she returned in an angry mood. She told me that she did the test in the nearby pharmacy and it was clear. The pharmacist told her that the result was wrong because the pharmacist in the other pharmacy has used expired glucose strips. I took the glucose stick bottle, showed her the expiry date and repeated the test. Again, the test showed alarming levels of glucosuria. Some people do anything to win customers.

Whilst competition might give rise to unethical behaviour among colleagues, lack of competition might put the patient at a disadvantage since commitment to service might be lacking. This is becoming common in Malta as in certain villages one has a number of pharmacies owned by the same company. This situation puts the patient in a situation where the patient has no choice in seeking better pharmaceutical care.

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[14] J.L. Astbury, C.T. Gallagher and R.C. O'Neill, "The issue of moral distress in community pharmacy practice: background and research agenda," *International Journal of Pharmacy Practice* 23, no.5 (2015): 361-368.

3.4.2. Reporting unethical behaviour

Having discussed the issue of tensions arising with colleagues and other medical professionals, the interviewer wanted to push this issue further and enquired how they might deal with unethical behaviour by another professional. Vignette 3 described a case of unethical and illegal behaviour of a locum pharmacist who dispensed Viagra without a prescription to a seventeen-year-old boy. Pharmacist 7's comment summarized the opinion of all participants:

> I will have a good long talk with the pharmacist and make sure that such behaviour is not to be repeated. If this behaviour is repeated, I will terminate his or her service, but I will not report the person to the health authorities.

The interviewer pushed this topic even deeper and wanted to know whether the participants would report a colleague or pharmacy staff who was stealing from the pharmacy. All agreed that such behaviour was to be reported to the manager or owner because this was undermining the profitability of the business and putting their job and reputation at risk.

The interviewer continued to investigate this theme and asked whether they would report a policeman who was on regular treatment with drugs for bipolar disorder. Pharmacist 6 commented: "I think it is not my role to report this person. I think it is the doctor's duty to do this. He has more authority than I have." The other participants had the same opinion as Pharmacist 6.

3.5. Isolation

The participants confirmed that the POYC was a good source of income to the business. Many participants admitted that they were taking more patients than they could handle. These POYC patients or their relatives visited the pharmacy every two months and hence increased the probability of extra sales. Most participants confirmed that these POYC patients or relatives always made some shopping when collecting their bag of medicines.

About 90% of the participants agreed, however, that the load of the POYC was too heavy and the pharmacist felt isolated from the patient. Pharmacist 1 commented: “I feel isolated not only from patients but also from peers or experienced colleagues who can communicate good advices and guidelines.” This statement was the general feeling of all the participants.

Communication was vital in a profession and this contributed to an open ethical debate creating a situation compatible with discourse ethics where the pharmacist could appreciate others’ suggestions towards a better ethical decision making. This isolation deprived the pharmacist from ethical guidance. Formal structures, such as the COE, offered little assistance as emerged in the interviews.

The participants felt that they were also isolated from the medical profession. The professional contact with the physician working in the pharmacy area was sporadic and often did not involve any serious professional dialogue. Pharmacist 21 explained well the pharmacist’s isolation from the medical profession: “The only contact I had with doctors in my 20 years of community pharmacy is to inform him of a product that is out of stock.”

3.6. Refusing Treatment to Certain Patients

Paradoxically, refusing treatment to certain patients can also be linked to the central theme of retaining customers. Pharmacist 2 commented that a few patients, due to their behaviour, were better not retained for commercial reasons. This pharmacist narrated two episodes where he refused to treat POYC patients. One of these patients had been caught shop lifting several times. The pharmacist admitted, “It was a hard decision but it was my company policy. The patient was told to apply for the POYC medicine at another pharmacy.”

The same pharmacist also remembered another case: “We had a POYC patient who was very aggressive, a lot of swearing and we had to refuse his application.”

These were extreme cases and these patients were causing financial losses to the

pharmacy due to stealing and the aggressive behaviour which might cause problems to other customers.

3.7. Confidentiality

The pharmacist is not exposed to high drama ethical issues and dilemmas as experienced by physicians and nursing professionals.[15] Certain common ethical problems, however, do arise. Only two participants cited confidentiality as an ethical problem in their work. Pharmacist 14 commented:

> I am always insisting with my staff to never discuss patients' information and drug therapy to outsiders and between themselves. I insist that patients who need private conversation with me are given the time and space to do so.

This pharmacist suggested that all pharmacies needed to have a demarcation line on the floor at a certain distance from the dispensing practice. Patients should wait after that line for their turn.

Pharmacist 1 mentioned the case when a lady came to enquire about the use of a medicine prescribed to her husband:

> Mr S had received a drug for treatment for benign prostate hypertrophy. The following morning his wife wanted to know the indication of the drug her husband has been prescribed. His wife was asking this question not out of curiosity but to plan the way to take care of her dear one. We went to the back room and together we read the patient's leaflet and explained it carefully to her. All this information is public information, so I did not feel I had broken any confidentiality.

Pharmacist 12 had a rather different opinion of confidentiality situations and commented that a pharmacist could not disclose information to others without the patient's permission. "It is not in the pharmacist's discretion to decide." Confidentiality was a non-negotiable principle and the value-neutrality of the pharmacist was an essential component.[16.] Pharmacist 12 continued:

> The relationship between patient and enquirer does not eliminate the duty to keep

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15 Frances Rapport *et al.*, "Eleven Themes of Patient Centred Professionalism in Community Pharmacy: innovative approaches to consulting," *International Journal of Pharmacy Practice* 18 (2010): 260-268.

16 D.E. Zoutman, Douglas Ford and A.R. Bassili, "The confidentiality of patient and physician information in pharmacy prescription records," *Canadian Medical Association Journal* 170, no. 5 (2004): 815-6.

> the patient's history private. If somebody asks me what drug a certain relative is receiving, I cannot reveal this information unless it is a police case or there is danger of harm to third parties. I came across such a case when I suspected that a patient was abusing of dopamine agonists.[17] This patient was living with a family where there were young girls. These drugs are reported to increase sexual libido and can lead to sexual rapes of underaged persons. I had to inform the family hosting this patient of this risk.

3.8. Conclusion

This chapter has documented the main ethical problems encountered by the participants and identified the main themes emerging from these narrations. Several themes were identified and most of them were linked to the central theme: the fear of losing customers.

The pharmacists admitted to bending rules by dispensing POM without prescriptions; dispensed OTC products without the appropriate warnings; encouraged the selling of large boxes of OTC products instead of smaller versions; displayed OTC stands, such as Panadol, on the main dispensing counter. All these actions had the aim of increasing sales. Even the pharmacist's subordination to physicians was related to the central theme. For the participants, the physician was an important customer who was not to be antagonized in any way. When dealing with colleagues, however, their competitive nature emerged as they tried by all means to switch customers to their pharmacy, even by giving discounts. For the same reason, all participants admitted to accepting more patients in the POYC system than they could handle, knowing that this additional overload would result in isolation from their patients and routinization of work which brought professional distress leading to less responsible pharmaceutical care.

[17] Dopamine agonists are used to treat Parkinson's disease and can cause increased orgasmic intensity.

Chapter 4: Ethical Decision Making in Local Community Pharmacies

4.1. Introduction

The previous chapter has identified the main themes emerging from the participants' interviews. This chapter will address the second part of the dissertation question, that is, how pharmacists dealt with the ethical problems they faced during their dispensing practice. In particular, the researcher will focus his attention upon the several theoretical stages in the decision-making process, following the widely used ethical decision-making model by Jones discussed in Chapter one.

This process will start with the evaluation of the participants' ethical awareness or attention. The next stage in Jones' model is that of ethical reasoning and the present chapter will attempt to identify the main ways of the participants' ethical reasoning. The third stage is that of ethical intent and the research attempted to discover the participants' central ethical intention. Finally, the chapter will conclude by describing the participants' ethical resolution of the case they have described.

4.1. Ethical Attention

For an ethical decision process to begin, the pharmacist needs to be able to recognize the moral issue at hand.[1] Ethical attention ought to be an active process but it can be associated with ethical doubt and passivity.[2] The interviews revealed that the participants possessed varying degrees of ethical awareness. Some pharmacists refused to take part in the study and declared that they have never encountered any ethical

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1 T.M. Jones, "Ethical decision making by individuals in organisations: an issue contingent model." *The Academy of Management Review* 16, no. 2 (1991): 366-395.

2 S. Holm, *Ethical Problems in clinical practice: The Ethical Reasoning of Health Care Professionals* (Manchester: Manchester University Press, 1997), 45-64.

problem during their dispensing work. These non-participants would occupy the lower spectrum of the ethical attention scale. They could not even recognize a moral issue.

The interviewer wanted to investigate the participants' opinions regarding the level of moral intensity of moral issues encountered during the dispensing practices. There were various opinions. For Pharmacist 17 these moral dispensing encounters were of low intensity except for: "The only thing I can think of is the dispensing of emergency contraceptive. But surely I encounter other issues, but I solve them even if I do not perceive them as ethical."

Pharmacist 5's opinion, however, represented the general comment of most participants:

> Many customers come every day to buy a few sachets of Catafast. I know that this is a powerful medicine and has many adverse reactions. The doctor has definitely warned them to use the drug with caution. I repeat these advices. I know, by experience, that these situations are small issues and easily dealt with.

Pharmacist 12 continued to say that one has to be ethically aware of situations which can have serious consequences. This pharmacist narrated:

> When I receive a prescription for isotretinoin,[3] I make sure that the young lady understands that the drug is teratogenic. I explain carefully and in simple language the EU protocol that demands that a young lady starts the contraceptive pill four weeks before starting the acne drug and to continue the pill for another four weeks after the end of treatment.

Pharmacist 21 reinforced the argument of Pharmacist 12. This pharmacist argued that in many situations the moral issues during dispensing were of low moral intensity and that pharmacists tried to simplify matters. This pharmacist, however, was certain that the pharmacist was always on the alert to recognize serious moral issues and to deal with them adequately. Pharmacist 21 narrated:

> The psychiatrist attending the pharmacy prescribes 90 25mg amitriptyline and 90 diazepam 5mg. I knew the lad; he was not to be trusted with so many tablets. So I dispensed only 6 tablets of each. He protested but I told him to come in two days-time. Next morning his father came to the pharmacy and accused me of being irresponsible. The lad had swallowed them all and slept all day. I told him that his

[3] Isotretinion is a drug used for severe acne.

son was still living because I was thoughtful and didn't dispense all tablets.

The interviewer was also curious to investigate the participants' ethical awareness of an action that could produce long term harm to future generations. The interviewer used Vignette 1 (the over prescribing of antibiotics by GP) to investigate this concept. All participants agreed that such a situation was common. The comment of Pharmacist 8 summarized well the position of other participants on this issue: "I know that this can cause bacterial resistance. I cannot, however, judge the case because I have not examined the patient." Most of the participants were aware of the possibility of the temporal immediacy of harm of the over-usage of antibiotics. The pharmacists, however, did not link this over-prescribing of antibiotics with the possibility that future generations would not be able to benefit from the drug's therapeutic efficacy. All the participants were not aware of the principle of stewardship.

Next, the researcher asked the participants whether they were cooperating in evil by not reporting the misconduct of another health professional. Most participants were of the opinion that such phrases as 'cooperation in evil' were too big for pharmacy work. Pharmacist 9 commented: "This phrase, 'cooperating with evil', is too big for our work. We dispense medicines recommended by other professionals and no evil is never intended."

From the above brief comments, it was evident that most participants adjusted their ethical attention depending on the magnitude of the moral issue faced during dispensing. In most situations, these were of low moral intensity, requiring a low level of ethical attention. In other situations, however, when the magnitude of harmful consequences was above a certain threshold of safety for the patient, the pharmacist would assume a stand of maximum ethical attention.

Merleau-Ponty[4] compared ethical inattention to a searchlight, picking out objects

[4] Maurice Jean Jacques Merleau-Ponty was a French phenomenological philosopher, strongly influenced by Edmund Husserl and Martin Heidegger. The constitution of meaning in human experience was his main interest and he wrote on perception, art, and politics.

without further discernment.[5] When the moral issue was of low intensity, the pharmacist was like this searchlight. When the dispensing situation was of high moral intensity, the pharmacist's ethical attention could be compared to a strong beam of light which was able to examine in detail the implications of the moral issue being faced. Blum believed that such ethical attention would set the right atmosphere for subsequent good moral action.[6]

The researcher could not avoid mentioning that few participants, mainly pharmacy owners, were ethically blind. Pharmacist 23 commented:

> I have invested quite a big sum of money in pharmacies. I give employment to several families. I try to give a decent service but try to maximize my profits. I tell my employees to push those OTC items that have more profit, to sell branded products and not generics because the former are more expensive and to advice the use of products that have a close expiry date. What is wrong with that?

To conclude, most participants were neither Scylla, neglecting all problems, nor Charybdis, taking problems too seriously, but somewhere in between these two extremes.[7] Most participants were behaving in line with the 'cognitive miser principle'.[8] They possessed moderate ethical awareness but adopted cognitive strategies to simplify moral dispensing issues. Pressure coming from the competitive pharmaceutical environment and company culture of maximizing profits, however, was pushing hard the pharmacist to move towards Scylla.

4.2. Ethical Reasoning

The second step in Jones' ethical framework is ethical reasoning. Most of the participants were ethically aware that moral issues of low to moderate intensity existed during dispensing practices and the pharmacist needed to take a moral judgment. Issues

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5 M. Merleau-Ponty, *Phenomenology of Perception* (London: Routledge, 2002), 43-50.

6 L. Blum, "Moral Perception and Particularity," *Ethics* 1, no.4 (1991): 701-725.

7 In Greek mythology Scylla was a monster that lived on one side of a narrow channel of water, opposite her counterpart Charybdis. The two sides of the strait were within an arrow's range of each other: so close that sailors attempting to avoid Charybdis would pass dangerously close to Scylla and vice versa.

8 J. Weber, "Managers' Moral Reasoning: Assessing their responses to three moral dilemmas," *Human Relations* 43, no.3 (1990): 687-702.

of low moral intensity requires less sophisticated moral reasoning. Since ethical judgement takes time and energy to arrive at accurate judgments it is likely that a pharmacist may economize efforts devoted to deep reflective moral reasoning. The pharmacist will adopt cognitive strategies that are simple and give rapid adequate solutions. This explains why some participants confirmed that they made use of common sense and experience to reach moral judgments. These methods of moral reasoning were identified in previous empirical pharmacy research by Hibbert e*t al.*, Chaar *et al.* and Cooper's Ph.D. thesis. Pharmacist 18 was one of the many participants who used these appeals:

> On a daily basis we meet many small problems. Some customers need few sachets of an NSAIDs, others want 2 tablets of Ativan for the next 2 days before getting a prescription, others want a box of Augmentin because they are going abroad. One knows these persons from a life time. Experience and some common sense is needed and all are happy.

Besides the moral intensity factor, Trevino claimed that the person's cognitive moral development was an important factor in determining one's moral reasoning. As explained in Chapter Two, Kohlberg's stages of CMD may explain the pharmacists' way of moral reasoning. Some participants, mainly pharmacy owners, belonged to Kohlberg's stage 1-2. These pharmacists were motivated by self-interest and consequentialism was a common form of ethical reasoning used for their ethical justification. These pharmacists considered the maximization of profit as intuitive to business. For reaching this objective, these pharmacists tried to attract more customers in all possible ways. They felt safe to bend laws and they promoted OTC medicines that had higher profit margins. Pharmacist 19 commented:

> If a patient comes in pain and needs some anti-inflammatory or a person comes for few tablets of Ativan until he contacts his doctor for a physician I dispense to help out. All these cases are emergencies and I'm helping a vulnerable person."

After comments such as the one above, the researcher questioned himself: Was this breaking of the law to satisfy the medical demands of the patient an act of altruism or was it fear of losing a customer and hence business? Was ethics an ace card to be used in difficult situations when the illegal dispensing of drugs could be questioned by the

authorities? This reminded the author of Kant's example of the witty shopkeeper who did not cheat the customers not because it was a wrong action but because he wanted them to return again to his shop.[9] These pharmacists might be doing as the shopkeeper, doing the right action when putting as a priority the patient's service, but for the wrong moral reason.

Some participants belonged to Kohlberg' stage 3 and adapted to the standards of their peers to please them. These pharmacists' moral reasoning was highly influenced by the company's culture. Pharmacist 13 commented: "My boss pays me well. I'm happy working in this pharmacy and follow the company's guidance and business strategies."

Two of the 23 participants belonged to Kohlberg's stage 4 and gave priority to legal procedures in their EDM. One of these, pharmacist 10 commented:

> A patient can always obtain a prescription from a physician. Health centres are open all day. I never accept excuses. I explain gently my position and many respect me because they know they are dealing with a professional. I will never accept prescriptions written an SMS on a mobile nor a telephone call from a doctor dispense a controlled drug.

Few participants belonging to Kohlberg's stage 5-6 made use of the Golden Rule as a form of ethical justification. The use of the Golden Rule is unique as it has been rarely identified in empirical pharmacy ethics research. The golden rule is a simple form of ethical reasoning which does not require the considerations of outcomes, agents and utility[10]. Pharmacist 11 said: "When I see a customer I see my mother. I give her the best service I can."

Besides practical reasoning there are other external sources that the participants could have used to help in. This included the COE but all participants commented that they have never read it and could remember just one phrase: 'in the patient's best interest'. Guidance could have come from colleagues working in other pharmacies or government

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9 I. Kant, *Groundwork of the Metaphysics of Morals* (Cambridge: Cambridge University Press, 1998), 56-58.

10 Randolph Ellis, "The Golden Rule," *Rural Theology* 15, no.1 (2017): 52-54.

pharmacy service. Most of the pharmacists did not make use of these external sources, the theme of isolation appearing again. An exception is Pharmacist 22 who when in doubt found help from the POYC unit:

> I had a prescription for methotrexate for a child, an off- label indication, I contacted the POYC who advised me to get a signed letter from the physician so that he assumes all responsibility of the off-label use.

4.3. Ethical Intention

The third step in Jones' ethical framework is ethical intent, a process that might be in resonance or out of phase with ethical reasoning. Once the pharmacist has reached a moral judgment, she or he, then, have to decide what to do. A decision of what is correct to do (moral judgment) may not be the same as a decision to act on that judgment (moral intent). The pharmacist, a moral agent, balances the moral factors against other factors, usually self-interest. The researcher investigated the participants' congruence between moral judgment and moral intent from their answers to the vignettes.

In Vignette 1 all participants agreed that the over-prescribing of the same antibiotic by the GP was not correct (moral judgment). Yet most of the participants would dispense without any hesitation. They had no intention of interfering with the doctor's professional autonomy. They would never want to create unnecessary tension with the doctor (moral intent).

In Vignette 2, all agreed that one ought to dispense L-Thyroxine tablets on a first come first served basis, when this product is in limited stocks (moral judgment). Yet, many commented that they would reserve the few remaining boxes of the medicine to their loyal customers (moral intent).

In Vignette 3, all agreed that they would reprehend the locum pharmacist for dispensing Viagra without a prescription to a 17-year-old youth (moral judgment). Yet all intended to do nothing about it and would not report the locum pharmacist to the health authorities (moral intent).

The answers to the above vignettes indicated that the participants considered proximity

to the patient as an important determinant of moral intent. For the participants proximity was understood as the fear to lose customers. The pharmacists knew that they would inform a patient, who was not their customer and was asking for a low stocked medicine, that it was out of stock when in fact they were storing the few remaining boxes for a loyal patient.

It was evident that proximity to the patient elicited stimuli that were vivid and salient. These emotive stimuli intensified the pharmacists' cognitive and behavioural responses to the extent of prioritizing the PBI over legal duties. The below comments made by two participants confirmed the relevance of the element of proximity on moral intent.

Pharmacist 10 commented:

> I practice in an area where I receive patients from all over the island especially after 7pm and on Sundays. I can say that I have no loyal customers. I dispense only on prescriptions because I do not want to risk my warrant.

In R. Cooper's doctoral thesis, the UK pharmacists feared legal repercussions and gave priority to self-interest, that is, an absolutist approach to respect the law with no exceptions. This meant that if a patient was in pain and had no prescription, UK pharmacist would not help.

Pharmacist 5, an owner of a small village pharmacy, commented:

> Many patients come for NSAIDs without a prescription. I repeat hundred times that these are dangerous drugs *bla, bla, bla.* But people in pain do not understand this language. So I give them 3-4 sachets and repeat again the same advices. It's not for the money, what do I earn from 3 sachets, may be, 30 cents. It is more for my commitment to the patient who has been my customer for ages.

Reputation was another factor which could intensify the cognitive and behavioural responses of the pharmacy to the extent of creating dissonance between moral judgment and moral intent. Pharmacist 4 summarized this concept well:

> The good pharmacist is one who is competent, gives good advice to solve minor ailments for the patient and builds trust between him and the patient. This builds up reputation and the patient knows that the pharmacist is always there to give a helping hand without risking any harm. Reputation brings more customers to my pharmacy and makes me feel good.

4.4. Ethical Enactment

The final attention of the researcher turns to the enactment of the ethical choice. Rest argued that implementing an action was never straightforward as one had to work around barriers of unexpected difficulty.[11] Participants working in chain pharmacies were aware of these barriers, which usually consisted of financial incentives. Pharmacist 20 commented:

> I believe that the pharmacist ought to encourage the consumer to use medications with care. Customers are coming to the pharmacy to buy OTC non-steroidals. My boss insists to sell large packs of these medicines. I feel it is not correct to promote large packs because it gives the consumer the wrong impression that these drugs are safe.

Burger claimed that proximity to a patient could influence the pharmacist's ethical enactment and could generate a helping behaviour. Pharmacist 8 confirmed Burger's hypothesis:

> A patient came on Saturday evening asking for an emergency supply of an antidepressant. He was a regular user but his doctor was abroad. I knew that legally this was not Ok, and I always insist for a prescription. But I knew this person who was passing from a very bad moment. He had lost his wife few days ago. So I dispensed for four days and made him promise to come with a prescription as soon as possible.

Some participants who were ethically attentive, made correct moral reasoning and had the right moral intent but still had doubts and uncertainties of how to deal with dispensing issues. They could recognize an ethical issue but lacked ethical confidence. They appeared not to be 'fully-pledged ethical agents'.[12] Pharmacist 22's story proved this:

> A lady came to ask for a fat blocker to reduce body weight. The assistant gave her a good selling presentation. But I still was not convinced. I knew the lady, she had three children and spending more than 30 euro every fortnight was surely a burden. Moreover, I was aware that all this fat blockers have no real scientific back up. The lady needed a good professional advice from a nutritionist. Yet, I was a bit hesitant because I did not want to butt into the assistant's good work.

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11 J.R. Rest, *Moral Development: Advances in Research and Theory* (New York: Prosper, 1986).

12 Richard Cooper, "Ethical Problems and their resolution among UK community pharmacists: A Qualitative Study" (PhD thesis, University of Nottingham, 2007), 187.

This pharmacist was fully aware of the clinical and financial issues but also of ethical issues such as concern for the lady's best health advice, the assistant's distress if the pharmacist interfered in her story and the ethics of selling a product that might not be of benefit to the customer. Nevertheless, the pharmacist was still uncertain of how to proceed.

4.5. Conclusion

From the interviews, it appeared that most pharmacists' ethical attention was directly proportional to the moral intensity of the dispensing issue. Since most dispensing problems were of low moral intensity, the participants used common sense, intuition and experience. Other participants, mainly owners, used financial utility as their focus of action. They considered the retaining of customers and the maximization of profit as their main outcomes in their daily dispensing work. Few other participants considered the law as their guideline and were not ready to bend the rules to please the patient. Still few other participants applied the principle of the Golden Rule in their ethical judgment and never treated customers as mere means to a profitable end.

A prominent pharmacist's figure emerges from this study's analysis. The pharmacist is committed to help the customer even to the extent of sometimes bending the law. The pharmacist needs to retain the customer to make one's business fruitful. The pharmacist gives competent advice to customers on many common ailments. The pharmacist, however, lives in a highly competitive market and pharmaceutical companies offer high incentives to sell their products. This can give rise to conflict of interest with the pharmacist giving the right advice but dispensing the product that gives the highest profits. In the next chapter, the ethics of incentives will be discussed to demonstrate how it gives rise to conflict of interest in pharmaceutical care.

Chapter 5: Findings and Implications

5.1. Introduction

The aims of the present research were to discover the ethical problems which pharmacists come across in their work and how they deal with them. The findings and conclusions of the study will now be summarized, compared and contrasted with findings from other pharmacy ethics research presented in the literature reviews in Chapter One. The researcher will then consider the several implications arising from the dissertation's conclusions and their management. The dissertation will conclude by identifying the limitations of the study, suggesting areas of further investigation and the author's final reflexive insights.

5.2 Mapping the Findings and Implications of the Study

All participants agreed that commercial interests would always create a potential conflict in dispensing practice. They attributed this tension to the fact that the pharmaceutical business is a highly competitive one due to the many pharmacies in a small area and the fact that sales of non-prescription items have migrated to the large supermarkets and internet buying. Pharmacist 23 explained it in the following way:

> With a 20% gross profit no pharmacy can make ends meet. The pharmacists give useful advice free of charge. Many items such as shampoos, baby products and many others are being bought at supermarkets. We need to promote OTC products of good value and high profit making.

This participant added: "This need to promote high profit products does not mean that the pharmacist feels less responsible and accountable for the welfare of the patient."

This tension between commercial interests and professional ethics was even more pronounced in the many local pharmacies owned by pharmaceutical dealers and parallel importers. These companies were run by managers, usually not members of the pharmaceutical profession. Their main objective is to maximize profits. Pharmacist 8, an employee in a chain pharmacy, commented: "I have to fit in this profit-seeking culture.

I have no say which products are stocked. This makes me feel professionally dissatisfied."

The identification of subordination was another important theme in this study which reflected concerns about status and power. All participants believed that the medical profession dominated the medical arena. This subordination left little scope for the pharmacists' professional autonomy and restricted the areas of expertise which could be undertaken. This limitation, in having little if any relevant medical say, resulted in the pharmacist feeling professionally dissatisfied. Some participants, however, used this subordination as an easy way out when confronted with hard decisions and would advise the patient to seek the physician's opinion. Many other participants accepted this subordination as being part and parcel of the financial survival of a pharmacy. The physician was an essential 'customer' of the pharmacy due to his or her daily prescriptions. Hence, the pharmacists never dared to challenge a prescription due to the fear of upsetting the physician, creating tensions and losing prescriptions.

This theme of subordination was apparent also in the pharmacist-patient relationship. The participants claimed that the patients demanded emergency supplies of POM without having a prescription. Moreover, the participants added that there was a new upcoming habit for patients/customers shopping around pharmacies looking for better discounts. The competitive business environment plus the pressure from pharmacy owners coerced many of the participants to yield to these patients' demands. Some pharmacist bent rules by supplying emergency supplies of POM medicines without the possession of a valid prescription in order to retain customers. Commercial interests seemed to override PBI.

Another important finding which emerged from the interviews was that of isolation of the pharmacist from the patient/customer. The POYC is an important source of income for the pharmacy; without its income many pharmacies would not be commercially viable. All participants complained that the daily routine work of the POYC resulted in less proximity to patient/customer. This isolation could be ethically problematic in

several ways.

This isolation disrupted the healthy dialogue between the pharmacist and patient and gave rise to lower care from the pharmacist. It prevented the pharmacist from developing a professional relationship with the patient/customer. The pharmacist was no longer near the patient to understand the latter's narrative history which is vital for building of trust. Isolation prevented the pharmacist from having a deep, reflective face-to-face encounter with the patient and could explain the low ethical awareness evident in some participants. Pharmacist 21 explained:

> I have over 1000 patients enrolled in the POYC system. I have to prepare their prescription every two months. It takes a lot of time and I have much less contact with patients. This I feel is bad for my professional development.

Another finding which surprised the researcher was the poor ethical literacy of many participants. This ethical literacy could explain the low ability of the participants to deliberate with confidence about ethical issues during the day-to-day dispensing activities. Most participants had little familiarity with bioethical principles. Other bioethical principles such as beneficence, non-maleficence and justice were never mentioned. Confidentiality was mentioned only by a participants. In a small country like Malta, where everybody knows everybody, confidentiality should have been a main ethical concern. The Principles of Stewardship, the Common Good and Human Dignity were never mentioned. Only one participant had a basic knowledge of consequentialism and deontology but no idea of virtue ethics. It could be concluded that participants lacked basic ethical undergraduate education. It has to be said also that more than 65% of the participants were over 50 years of age. These participants admitted that they did not receive any lessons on ethics during their graduate years at University.

Autonomy of the patient was rarely mentioned as all participants believed that harm/benefit balance considerations belonged only to the judgement of the pharmacist. Pharmacist 1 commented: "I am the pharmacist, I have studied pharmacology, so I know best."

Another finding, related to ethical literacy, was that about 70% of participants found it difficult to recall ethical problems during dispensing throughout their working career. Moreover, some pharmacists refused to participate in the study because they declared that ethical issues in pharmaceutical care were non-existent. One may conclude that some participants were ethically inattentive. The commercial and competitive business environment could have contributed to this ethical inertia. Another determining factor was the fact that most dispensing issues which they faced were of low moral intensity.

Another surprising finding was that all participants had never read the COE since they believed that it offered no assistance in their dispensing practice. It seems that pharmacists are losing good professional guidance by this lack of interest in their COE. This could have also contributed to the participants' poor ethical literacy.

Regarding ethical judgement, some participants, mainly pharmacy owners and managers, made use of a consequentialistic approach. The participants restricted the meaning of utility to those for whom they felt special responsibilities and relationships. The participants considered the patient's needs and the business as the most proximate factors which could decide EDM. These participants made a cost/benefit analysis of the repercussions of their decisions on these special relationships. Their main objectives was to please their customers by offering a competent medical advice and to make the business financially viable. Furthermore, other participants claimed to use common sense, intuition and experience to solve ethical problems of low moral intensity. Common sense, intuition, experience and habits might, however, obscure the complexities of ethical sensitive situations and render the pharmacist ethically inattentive and unable to reflect deeply on one's decisions.

A few other participants made use of deontology as their guiding ethical compass. For these pharmacists, legal procedures were a priority over PBI and regulations had to be obeyed by the book. A few other participants regarded virtue ethics as their guidance to ethical behaviour. One considered the Golden Rule as an excellent principle to help customers. Care, compassion and benevolence were the leading virtues which guided

all their dispensing work. Pharmacist 14 commented:

> Patients come and ask me for non-steroidal pain killers without having a prescription. I start to investigate the patient's need. Is he really in pain? Why is he asking for such a drug? Are there any contraindications? I explain to him that the easy way was to give him a box but my main concern is the patient's welfare. I even phone his doctor to get his opinion. Patient's appreciate this care and putting financial gains as secondary.

Conflict of loyalties was another important finding from the interviews. All participants claimed to find it difficult to report to the health authorities a colleague who was behaving in an unprofessional way. In this way, they would be cooperating with evil and contradicting earlier claims of always acting in the PBI. Conflicts of loyalties were also evident when the pharmacist has to decide the harm/benefit balance between respecting the physician's prescription and the patient's present or future harm by the prescription. All participants admitted that they would not confront a physician who was overprescribing an antibiotic or writing expensive medicines to please a pharmaceutical dealer.

Finally, the central theme that linked all the above findings was that of the fear of losing customers. The participants gave priority to patients'/customers' best interest over legal or procedural duties. The participants admitted that the decision to prioritize PBI over law was taken to retain customers and attract new ones, thereby ensuring profitability for their business. Every business needs customers to survive and the pharmaceutical business is no exception.

5.3. Comparing the Dissertation's Conclusion with Literature Review Studies

Most of the conclusions reached by this research were similar to those obtained by the studies identified in the literature reviews mentioned in Chapter One. The similarities and differences between this study and other past studies is produced in Appendix VI. Important themes such as commercial interests, subordination to patients and physicians, bending of rules and isolation are common in several studies. A major difference occurs in the pharmacist's ethical dilemma to choose between legal

obligations and PBI. In Richard Cooper's doctoral thesis, the pharmacist prioritized legal obligation over PBI in a UK context because of his or her fear of having problems with the health authorities.[1] In this dissertation, most participants prioritized PBI in order to please the customer and retain one's buying habits. Some participants, mostly pharmacy owners, behaved in this way from their own free will; others, employees, were coerced by company managers to bend rules not to lose customers and sales.

The competitive community pharmacy environment can be regarded as the source of all these themes which emerged during the interviews. Incentives become relevant in this discussion.

5.4. The Ethics of Incentives

There has been an exponential growth in incentives offered to the pharmacist from pharmaceutical dealers and parallel importers. An incentive is an extrinsic prompt, usually financial, designed to elicit a desired response that shifts behaviour from its usual path.[2] An incentive can be seen as a form of power.[3] These incentives target pharmacists directly by motivating them to promote the product. In the pharma business these incentives can be several and include: 1) high bonusing on OTC and generic products; 2) personal gifts such as free meals; 3) competition with prizes such as prizes for those who sell the highest quantity of cough syrups; and 4) marketing lectures followed with expensive dinners.

The researcher concluded that the participants assumed one of two attitudes: the ethical attitude focused on the virtuous character of the agent who did the right action for the right reason or the other view which had no consideration for moral quality but only sought personal benefits. Those who took this latter view did not want to sacrifice

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1 *Ibid.*, 130-137.
2 Ruth W. Grant, "Rethinking the ethics of incentives," *Journal of Economic Methodology* 22, no.3 (2015): 354-372.
3 *Ibid.,* 358-361.

personal gains for a utopian dream of moral perfection. In the local pharmaceutical environment, the researcher was of the opinion that the latter view seemed to be dominating.

The pharmaceutical wholesalers and parallel importers are aware of the pharmacist's strategic position to market their products. They therefore try to incentivize pharmacy owners with the best business deals. Both the pharmaceutical representatives and pharmacists enter this deal voluntarily. Such deals, however, could affect the pharmacists' character as greed might become a priority. Moreover, the customer would receive no financial benefit as prices would be high to accommodate such heavy bonusing.

Participants who were pharmacy owners admitted that they would do their utmost to get a good bargain during the buying procedure. In chain pharmacies, the situation was more demanding. The manager might put undue pressure in various ways. The manager might use one's position of power and 'force' pharmacist employees to promote these products against their will. The owner might use bargaining methods to influence behavior, such as giving extra remuneration on sales. More often, pharmacists accepted this situation and adjusted their dispensing practices to the financial needs of the owner. Such methods of bargaining cannot be said to be voluntary on the pharmacists' part. One participant, Pharmacist 8, who was an employee, commented: "Every day I have a reminder from my boss which products to recommend. Usually, these are products which the boss imports, or short dated products or products with sky-high profits."

5.5. Implication of Incentives: Conflict of Interest

Participants in this research admitted that incentives give rise to conflict of interests (COI). Pharmacist 4 commented:

> Which product will I dispense, the branded or the generic which is much cheaper? Which expectorant will I advise to the patient, that product that costs more than 8 euro but has 100% profit or that expectorant which has the same active agent as the former but costs only 4 euro but has only 20% profit? These financial ties with the industry do exert a significant negative influence on my professional judgement

> involving the primary interests of medicine.

A COI is a set of circumstances that create a risk for a professional judgement and action regarding a primary interest to be unduly influenced by secondary interests.[4] These primary interests are the rights of the patient to expect a pharmacist to promote his or her welfare. Secondary interests are usually financial gains but can also be professional advancements, personal recognition and favours to friends. These secondary interests become questionable when they have a greater weight than the primary interests in professional decision making. All participants agreed that COI could threaten the quality of care of the patient and diminished the public trust in the pharmacy profession. The patient has to be certain that professional judgements are not compromised in any way by commercial interests. This certainty creates patients' trust in the pharmacist.

Apart from COI, pharmacists also face conflicts of obligations. In the interviews, most participants mentioned the conflict between the law and PBI. Both are important values but only one action can be taken. Pharmacist 2 disclosed:

> "A patient on an antidepressant comes on Saturday evening desperate because he has no supply for the weekend. I have either to refuse to dispense these medicines since the patient has no prescription or else decide to break the law and supply emergency quantities. That's a hard decision for me."

This situation did not involve a COI because both claims were primary interests; but it does involve an ethical dilemma, a difficult choice to make.

5.6. Managing these Implications

The present study has provided the researcher with some certainties but many surprises. The pharmacists' search to increase the profits of the business was something expected. The researcher was surprised, however, to observe an ethical illiteracy in most of the participants and even a somewhat low level of professional practice.

The researcher believes that the pharmacist's ethical illiteracy can be managed with

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[4] Institute of Medicine, C*onflict of Interest in Medical Research, Education and Practice* (Washington: National Academies Press, 2009), 44-61.

some new efforts. There appears to be the need of more intensive basic undergraduate ethical education in the pharmacy curriculum. Pharmacy students need to gain deeper understandings of ethical principles and acquire more confidence in EDM. Moreover, the COE has an important role in ethical augmentation and more emphasis on its importance ought to be given both to future and practicing pharmacists. Another initiative could be the encouragement of pharmacy graduates to embark on a postgraduate masters' degree in business ethics. Furthermore, the Maltese Regulatory Council should launch educational programmes on ethics for practicing pharmacists. One needs to stress, however, the argument that this ethical passivity demonstrated by some participants was not only the consequence of a lack in ethical education. This ethical inertia is also the result of broader social trends including the rise of consumerism, financial incentives to reach sales targets and ambitious company cultures. All these factors erode ethical behaviour.

The subordination of the pharmacist to the physician has also to be managed for the benefit of the patient and the two professions. There is the need of introducing the concept of professional socialization.[5] This means bringing the two professions closer together so that, by sincere dialogue, they start cooperating for the PBI. This professional socialization ought to start at undergraduate level. Students from both faculties can attend lessons on ethics together. It can be a good initiative for pharmacists and physicians to meet for professional programmes on ethics on a regular basis. In these meetings both sides can suggest ways to coordinate better patients' care.

Isolation of the pharmacist from the patient is an urgent problem to be tackled. The cause of this isolation is the burden of the POYC. During the regular visits to pharmacies, the researcher has experienced various deficiencies which were confirmed by many participants. Many pharmacies are too small to accommodate the working space

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[5] B.K. Redman, "The ethics of leadership in pharmacy [practice," *American Journal of Health-System Pharmacy* 52, no.19 (1995): 2099-2104.

needed for an efficient output. The pharmacist or a staff member prepares the medicines in a bag and hands it to the patient. There is no real communication about medication compliance, any enquiry of side effects and other useful advice. A model to be followed is that used by a participant whose pharmacy has two rooms allocated for the POYC which have a separate entry from the pharmacy. The first room is a waiting area, air conditioned, where patients can sit comfortably while waiting for their turn. Then they enter the other room where they find the pharmacist. Together they prepare the medicines, discuss compliance, the mode of taking suited for the patient and any drug reaction or adverse reaction are reported to the POYC system. This is the way forward to improve the pharmacist's image with the public.

This image may be further enhanced by improving certain professional practices. Displays of sweet counters on the dispensing counter give a retail image to the pharmacy. Even OTC products, such as Panadol, should not occupy the dispensing counter because this may reinforce the customers' perception that OTC products are ordinary, safe retail products. Pharmacists who are caught giving discounts and who dispense POM products without a proper prescription have to answer for such behaviour. During the interviews, the author noted that all participants were writing the dosage regimen on the medicine box. This habit should be discouraged as it shows poor professionalism. Pharmacists ought to have an 'advice writing pad' where they write the name of the drug, dosage and other useful information.

Staff members should receive regular documented training by the pharmacist on nutritional supplements. They ought to be in possession of a recognized certificate which recognizes their qualification to give advice on such products. Even staff members who sell cosmetic skin preparations ought to be in possession of the relevant certifications so that customers are confident that they are receiving an informed advice.

The authorities should also play their part in this re-professionalization of the local pharmacist. The authorities need to reinforce their control methods to wipe out any

attempts by pharmacists to bend rules or to sell products with discounts. The authorities should also educate the public about the availability of generics and their bioequivalence to the original products. The Maltese authorities ought to imitate other EU countries which allow the registration of a generic drug only if it is 50% or more cheaper than the original product.[6]

5.7 Limitations of the Study

One of the major limitations of this study was that the researcher was the person who selected the participants, did the interviews, collected and analysed the data, generated the main themes and arrived at certain conclusions. The author has knowledge on business management and ethics but it was his first experience in the technique of interviewing, data collection, data analysis and identification of themes. This lack of experience had undoubtedly caused some bias in the study.

Time was another limited resource which could have created some limitations in the study. Interviewing 23 pharmacists took the researcher more than two months. Most of these interviews were done in pharmacies and were continuously interrupted since the pharmacist had to attend to customers. All these interruptions increased the researcher's difficulties in interviewing.

The participants were recruited by the researcher himself. These participants knew the author for many years. They knew that the researcher was well knowledgeable on the pharmaceutical market environment and also that he has a postgraduate education in ethics. All this could have caused the 'interviewer effect'; that respondents might have said what the interviewer wanted to hear. The validity and reliability of the interview data therefore might be questionable. Some participants might have also wanted to

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[6] Panos Kanavos and Olivier Wouters, "Pharmaceutical Policies in Cyprus: A Review of the Current System and Future Options," *The London School of Economics and Politics*, August 2014, https://www.moh.gov.cy/moh/moh.nsf/All/73AB0132AA5867CDC2257D3A0046AFC8/$file/18.8.2014.Cyprus_WHO_Report.pdf?OpenElement (accessed January 10, 2019.)

impress the researcher and exaggerated their true dispensing experiences.

Another limitation could be that the number of participants in the study was small. Data saturation was used which might have lessened this limitation. The conclusions of the study might not necessarily reflect the views of all local community pharmacists. Sex, age and employment status definitely had a bearing on the amount of information the participants were ready to divulge. Some of the findings in this study therefore could be artefacts of the research.

5.8. Further Research

There is great scope of further research in this area to enrich these findings and new ones through uncovering more details. An interesting future experience could be investigating the pharmacists' personal experience of the POYC system. Another future research could be the investigation of the ethical impact of the pharmacist working as an employee in chain organizations. A study similar to this research could investigate how ethical issues are handled by GP's. The best way to educate undergraduates in the medical professions could be another important future research. Finally, a useful future research could be the investigation of how values and ethics could be transmitted as norms within the community pharmacists.

5.9 Final Reflection

Do the findings identified in the study project a 'grey picture' of the Maltese pharmacy profession? A rather bleak account of the participants' ethical literacy has emerged. The objective of this research was not to rate the pharmacists' ability to tackle ethical issues but to identify key issues to be seen as challenges in a positive way and to address them. It appears from this study that the principle of 'sovereignty of the customer' has still important currency in the local pharmaceutical business scene. This has its positive side as the local pharmacist will do one's best to give the best medical advice to the patient. The findings of this research, however, have highlighted the negative impact of financial pressures on EDM. Local pharmacists have to regain their public prestige. This can only

be achieved by pharmacists claiming a more prominent role in health care and taking control of the greedy appetite of consumerism which can challenge the accomplishing of medicinal surveillance and professional work in the community pharmacy.

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Appendix I: Themes in the Three Literature Reviews

	Cooper *et al*.'s	Wingfield *et al.'s*	Researcher's
Commercial pressures	Negative effect on EDM	Pressure to make business as profitable as possible	Accessibility to OTC seen as an opportunity to increase sales
Organization's Culture	Manager takes buying decisions.	More pressure if organization's culture is greedy	More pressure if organization's culture is greedy
Professional Autonomy	Subordination to GP	Subordination to GP	Subordination to GP
Confidentiality	Important but no confidence of how to solve.		Confidentiality issues present
Patient's Autonomy	Paternalistic view	Patients need information to make an informed decision.	Consumers want sales in OTC to be quick as in retail shops.
Isolation	Isolation from peers and patients.	Isolation from peers and patients.	Isolation from peers and patients.
Refusing Treatment	Patients who are problematic can cause loss of sales.		
Law vs PBI	Law prioritized over PBI.	Law prioritized over PBI.	Law prioritized over PBI.

Appendix II: Participants' Information Sheet

Dispensing Practice Among Maltese Pharmacies: Ethical Issues

Study Participants' Information Sheet

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. If you decide to take part you may keep this leaflet. Thank you for reading this.

Background of the study

The aim of this study is to investigate what ethical problems arise for pharmacists in their community pharmacy work and to gain an understanding of how pharmacists attempt to deal with such ethical problems.

What does the study involve?

The study involves conducting what are known as semi-structured interviews. These will involve the investigator asking you a number of open questions that allow you to talk about issues for as long as you want and to express yourself fully. A suitable location will be required for the interview. This might often be your place of work if there is a quiet period such as during a lunch break, for example. If this is not possible, an alternative venue can be mutually arranged and agreed upon. The interview is not formal and you may ask for clarification about anything during the interview and at the end you will be given the opportunity to ask any question you might have. The interview will be recorded unless you request otherwise. The recorded interview will then be anonymously transcribed into written form to allow the researcher to understand the interview better. A form of qualitative data analysis will then be used to explore the issues raised in the interview.

Why have you been chosen?

You have been selected to help in this study because you are a community pharmacist working in Malta. You are one of several pharmacists asked to help in this study to provide a representative sample of Maltese community pharmacists.

Do you have to take part?

It is up to you to decide whether or not to take part or not. If you do decide to participate in this research, you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason for doing so.

What do I have to do?

As a participant in this study, you will be required to take part in what is known as a semi-structured, in-depth interview. This will usually last between 30-50 minutes and it will involve the investigator asking you several questions about your work and, in particular, ethical issues. Such interviews are quite informal and are not tests. Prior to the interview, it would be helpful to think about a couple of what you consider to be ethical problems that you have encountered in your pharmacy work and to be prepared to discuss such ethical problems at the interview. The investigator may ask you why you thought the problem was an ethical dilemma and ask how you dealt with the problem. It is important, however, that you respect the confidentiality and anonymity of any patients/customers/employees/employers/health care professionals such as doctors or nurses and not allow any such individuals to be identifiable during any interview.

What are the possible disadvantages and risks of taking part?

No disadvantages or risks in assisting in this research are envisioned. If, however, you feel that you have been affected by the interview or any of the issues raised, you are welcome to discuss these with the researcher or another appropriate person. The study follows the ethical guidelines of University of Malta issued by the university research ethics committee.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. Any information about you which leaves the research unit will have your name, address and all identifiable data removed so that you cannot be recognized from it. Upon completion of the interview, you may request a copy of your interview transcript if you would like to.

What will happen to the results of the research study?

The results of this study will be used primarily for a dissertation leading to a Master of Arts in Business Ethics which is expected to be completed in 2019. Results from this study may be subsequently published or presented at conferences. However, all results from this study will be anonymized and participants will not be identifiable in any way.

Who is organizing and funding the research?

The study is being undertaken by Mr Anthony Gatt as partial fulfilment of the requirements for the Master of Arts in Business Ethics at the University of Malta. No funding has been made available for the researcher and the researcher has no conflict of interests.

Contact for further information

Should you require any further information or want to discuss any aspect of this study, please contact the researcher, Mr Anthony Gatt, or his supervisor, Rev. Dr Raymond Zammit.

Mr Anthony Gatt

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Thank you once again for offering to help in this study.

Appendix III: Consent Form

Dispensing Practice Among Maltese Pharmacists: Ethical Issues

Name of Investigator: Anthony Raphael Gatt

Study Participants' Consent Form

Please read this form and sign it once you have been made fully aware of the aim of the study and that any queries related to this research have been addressed to our satisfaction by the researcher Anthony Gatt

- I voluntarily agree to take part in this study.
- I confirm that I have been given a full explanation about this study and that I have read and understood the information sheet given to me and kept in my possession.
- I have been given the opportunity to ask questions and discuss the study with the investigator or his supervisor on all aspects of the study and have understood the advice and information given as a result.
- I authorize the investigator to disclose the results of my participation in the study but not my name or any other identifiable material.
- I understand that information about me recorded during the study will be kept in a secure database/
- I understand that I can ask for further instructions or explanations at any time.
- I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing.

NAME	
Address	
Telephone Number	
Signature	
Date	

Appendix IV: CASP TOOL

Was there a clear statement of the aims of the study*?*

Yes, the research questions were clear. The answers could throw some light on the present state of the Maltese pharmacy profession. These answers could suggest changes for the benefit of both the local pharmacy profession and the patient.

Is the qualitative method appropriate*?*

Yes, the qualitative method was appropriate. The researcher was not testing a hypothesis, was not after numbers but only interested in the living experiences of the pharmacist's dispensing practice.

Was the research design appropriate to address the aim of the study?

The researcher chose the SSI method because it allows spontaneity, flexibility and responsiveness. Moreover, most studies on this topic in the last 20 years worked with this method.

Was the sampling appropriate?

To reduce design sampling bias, the author used purposive sampling so that the interviewees reflected the variety of roles and population in the Maltese pharmacist community. The gender ratio for male to female was 1:2, and the ratio employee to owner was 1:1. The author selected the participants because he wanted to make sure that they had the necessary experience and competence.

Was the data collected in a way that addressed the research issues?

The author utilized responsive interviewing, a method that emphasized the importance of trust between the interviewer and interviewee. Interviews were conducted in non-confrontational, friendly manner where the interviewee was considered as a partner. The interviews stopped when the author felt that there was saturation of data.

How was the relationship between the interviewer and interviewee?

The fact that the author is a fellow pharmacist can be a positive factor to the outcome

of the interview. The interviewee could give an 'insider account' rather than a 'public account'. Moreover, the knowledge of moral philosophy gave better guidance in putting questions.

Have ethical issues taken in consideration*?*

The author reassured the participants that the study would not provide information, such as their names, working place, that might enable identification. Moreover, the study has been done in accordance to the ethical standards held by the University of Malta.

Was the whole process transparent?

The research process was transparent from beginning till the end. The researcher described himself as a pharmacist with long years of experience in the field, as holding a Master in Business Management and another in Bioethics as well as being in the process of reading for a Master's in Business Ethics. He gave the participants full details of the method of sampling, full details of the interview and a full account of what was said to avoid convenient summaries by the researcher.

Appendix V: The Semi-structured Interview Plan

The research information sheet is emailed two or three days before the interview to the interviewee. This gives ample time to the interviewee to read it slowly and ask any questions by phone or email.

The interview starts at a place and time that have been chosen by the interviewee. The planned time of interview is 35-45 minutes.

The interviewer repeats the aims of the interview to the participant. The interviewer reminds the participant of the right not to answer any question and even to stop the interview at any time. The interviewee then signs the informed consent form and is thanked for his/her participation. The author uses a model of continuous consent, where the researcher reaffirms consent throughout the interview.

The interviewer asks the interviewee's permission to record the interview.

Opening segment

Question**:** Can you recall and narrate a specific ethical problem that you were forced to resolve in your daily dispensing practice? (The interviewee is advised not to include any episode of conscientious objection involving the contraceptive pill and morning after pill).

As the story is told, the interviewer listens, takes notes and interrupts as little as possible.

Probing questions and clarifications of the story.

What made the story ethical?

What were the values/duties/principles involved?

How did you resolve it?

Do you find this solution as satisfactory?

Were there any pressures?

Middle segment

Vignettes (see Appendix VI).

The Vignettes are read and the pharmacists would discuss how they would deal with the issue.

Final Segment

Do you ever consult the Maltese Pharmacy Codes of Ethics or any person of trust?

Appendix VI: The Vignettes

Vignette 1

A busy general practitioner, who is a major source of sales for the pharmacy, continuously prescribes all the time a particular expensive brand of amoxiclav. The pharmacist is convinced that there is an irrational prescribing of a powerful, useful antibiotic, besides some connection between the physician and the distributor of the medicine. Many times, the pharmacist has asked the patients what was their medical complaint. Many have described the symptoms of a common cold. The owner, sensing the frustration of the pharmacist, reminds him/her, “Do your duty, dispense.”

Questions

1. What makes the story ethical?

2. How would you deal with the physician? Why?

3. How would you resolve this case?

4. How do you feel about financial concerns regarding the dispensing of a higher priced product?

Vignette 2

Presently, L-thyroxine tablets are out of stock. This particular pharmacy has few stocks left of this item. A customer enters the pharmacy. The pharmacist immediately knows that this person is coming from outside the village and is not a customer. The person asks whether the pharmacy has any stocks left of this medication. The pharmacist answers, “Sorry, it is out of stock.” The pharmacist wants to keep the stocks for the loyal customers.

Questions

1. What makes this story ethical?

2. What ethical principle or value is in question?

3. Do loyal customers deserve more care?

Vignette 3

Mr Gauci is a loyal customer and a personal friend of John, the pharmacist. John is surprised to see Mr Gauci entering the pharmacy in a fighting mood. “John, I always thought you were a reliable pharmacist. Look what I found in my 17-year-old trousers’ pocket.” Mr Gauci took out a blue hexagonal shaped tablet. John immediately recognized the tablet as Viagra. John was puzzled. Miss Agius, the sales assistant, whispered to John and told him that it was the locum pharmacist who had dispensed the tablet without any prescription. She added that the locum pharmacist dispenses all medicines, irrespective of whether the prescription is presented or not.

Questions

1. What is the ethical issue in this case?
2. What ethical principles are violated?
3. Would you report this locum to the authorities?

Appendix VII: Quotations file

Pharmacist 1

Female, in her 30s, owner and interviewed on 12/09/2018.

Main quotations

- "Mr S had received a drug for treatment for benign prostate hypertrophy. The following morning his wife wanted to know the indication of the drug her husband has been prescribed. His wife was asking this question not out of curiosity but to plan the way to take care of her dear one. We went to the back room and together we read the patient's leaflet and explained it carefully to her. All this information is public information, so I did not feel I had broken any confidentiality."
- "I am the pharmacist, I have studied pharmacology so I know best."
- "I feel isolated not only from the patients but also from my peers or experienced colleagues who can communicate good advices and guidelines."

Main Themes

1. Confidentiality
2. Autonomy-paternalistic attitudes.
3. Isolation.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP's behaviour not correct	Never report another professional	Dispense
Vignette 2	All patients treated equally	Loyal customers preferred	Keep aside
Vignette 3	Loum pharmacist's behaviour not correct	Never report	Warn

Pharmacist 2

Male, in his 30s, employed with a chain pharmacies company interviewed on 12/09/2018.

Main quotations

- "We had a POYC patient who was very aggressive, a lot of swearing and we had to refuse his application."
- "It was a hard decision, but it was my company policy. The patient was told to apply for the POYC medicine to another pharmacy."
- "A patient on an antidepressant comes on Saturday evening desperate because he has no supply for the weekend. I have either to refuse to dispense these medicines since patient has no prescription or else decide to break the law and supply emergency quantities. Very hard decision for me but I dispensed."

Main Themes

1. Refusing treatment theme linked to possible loss of business.

2. Ethical dilemma between two important values (law and PBI) is evident.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP behaviour not correct	Wanted to Talk this over to doctor	Barrier by owner who wants no tension
Vignette 2	All patients the same.	Fairness	First come, first served
Vignette 3	Locum pharmacist's behaviour not correct	Report to authorities	Not courage to report

Pharmacist 3

Female, in her 30s, owner, interviewed on 07/09/2018.

Main quotations

- "My daily bread depends on doctor X prescriptions. So, I do not dirty the water from which I drink."
- "I will consider whether the patient is a person who I know, whether the situation is being repeated several times; whether the patient is a child or elderly; whether not dispensing would affect the quality of life of the patient. Knowledge creates power to decide and I place relationships before rules."

Main Themes

Relationships with the GP and customer/patients are prime considerations for good business.

Vignettes

	Moral Reasoning	**Moral Intent**	**Moral Enactment**
Vignette1	GP behaviour not recommended	Relationships before rules	Dispense-no tension with GP
Vignette 2	Loyal customers deserve best treatment	Respect loyal customers	Keep few boxes for loyal customers
Vignette 3	Locum behaviour bad for business	Customer service prime consideration	Tell locum pharmacist to find other job but no reporting.

Pharmacist 4

Female,in her 30s, employee interviewed on 23/09/2018.

Main quotation

- "Doctors have a powerful voice. This is understandable as ultimately the patient's responsibility is theirs."
- "My boss wants me to push the bigger pack of pain killers or dispense the brand and not the generic to make more profit. Even pharma reps give me gifts to push their products."
- "The pharmacist has either to quit the job or accept to retrogress in ethical cognition."
- "Which product will I dispense, the branded or the generic which is much cheaper? Which expectorant will I advise to the patient, that product that costs more than 8 euro but has 100% profit or that expectorant which has the same active agent as the former but costs only 4 euro but has only 20% profit? These financial ties with the industry do exert a significant negative influence on my professional judgement involving the primary interests of medicine."
- "The good pharmacist is one who is competent, gives good advice to solve minor ailments for the patient and builds trust between him and the patient. This builds up reputation and the patient knows that the pharmacist is always there to give a helping hand without risking any harm. Reputation brings more customers to my pharmacy and makes me feel good."

Main Themes

1. The pharmacist accepts subordination to the GP.
2. The pharmacist accepts the competitive nature of one's job. The pharmacist is a moral striver; aware of certain values but retrogresses to lower level of cognitive moral development to please the owner.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Aware of unprofessional GP behaviour	GP knows best-subordination	Dispense
Vignette 2	All patients treated the same.	Fairness	Follows the recommendations of the owner

Vignette 3	Locum pharmacist may put the managing pharmacist into trouble	Report is the first intent.	Not enough courage to do so.

Pharmacist 5

Male, in his 30s, owner interviewed on 05/09/2018.

Main quotation

- "I am committed to give the best service to customers, they'll come back again and again. Commitment to service gives my pharmacy a competitive edge over nearby pharmacies."
- "Many customers are over demanding. They feel empowered and if I refuse to dispense a medicine either because it requires a prescription or because it is over used and can be harmful, they just simply try another pharmacy. This occurs often with nasal decongestants and more seriously with NSAIDs. But there is a limit to please customers. Some colleagues do not know to draw the line."
- "Many patients come for NSAIDs without a prescription. I repeat hundred times that these are dangerous drugs, bla, bla, bla. But people in pain do not understand this language. So I give them 3-4 sachets and repeat again the same advices. It's not for the money. What do I earn from 3 sachets? May be, 30 cents. It is more for my commitment to the patient who has been my customer for ages."

Main Themes

1. This pharmacist is highly committed to give the best service to the patients in order to retain and gain new customers.
2. The pharmacist mentions also the issue of consumerism. Customers demand POM without a prescription and shop around to have them. This put pressure on the pharmacist to dispense in order not to lose customers and sales.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Doctor's responsibility	Doctor is an important 'customer' for pharmacy.	Dispense
Vignette 2	My customers deserve deserve more care.	Loyalty to near ones	Keep boxes for my customers
Vignette 3	Locum pharmacisr's behaviour bad.	Maximize service to customers.	Do not report f

Pharmacist 6

Female, in her 30s, employee interviewed on 27/10/2018.

Main quotations

- "With my GP there is constant communication. There is mutual respect. with politeness and confidence brought by knowledge, things are solved for the patient's best interest. Of course, I have always to keep my place."
- "When I decided to work as a pharmacist, I knew I have entered a practice of relationships. These relationships include other professionals; doctors, nurses, dentists and colleagues. I knew that this required a lot of professional etiquette. All these stakeholders are customers for the pharmacy which pays my income. This co-operative relationship can be of benefit to the patient but it can sometimes create potential for conflict of professional autonomy, which most of the times I try to avoid."
- "I think it is not my role to report this person. I think it is the doctor's duty to do this. He has more authority than mine."

Main Themes

1. Relationships are important and one needs to avoid any sort of tension with other professionals.
2. These relationships are important to maintain the profitability of the pharmacy.
3. Another theme is that of subordination as the pharmacist keeps out of certain issues which he or she considers to be the doctor's responsibility.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Over-prescribing of antibiotics causes harm.	Relationship with GP must be excellent at all times.	Dispense not to create tensions with GP.
Vignette 2	All patients are to be treated the same	Fairness	Inform loyal customers whether they want to keep in store the medicine for them.
Vignette 3	Behaviour is bad.	Professional behaviour	Advice

Pharmacist 7

Female, in her 30s, employee, interviewed on 03/10/2018.

Main Quotations

- "Many times I phone to inform the doctor if I can change a prescription to another generic. I feel very down when I have to phone for such nonsense to get the doctor's permission."
- "The pharmacist is filling this role of clarifying certain doubts and encouraging medication compliance. Some doctors might perceive this service as an intrusion and interference in their field of knowledge."
- "I will have a good long talk with the pharmacist and make sure that such behaviour is not to be repeated. If this behaviour is repeated, I will terminate his/her service but I will not report the person to the health authorities."
- "I treat all patients the same. First come first served. I'll dispense only 1 sheet so more patients can be satisfied."

Main Theme

The pharmacist feels irritated when one's professional autonomy is put into doubt. The pharmacist's role of advising the patient may be perceived as an intrusion into the doctor's work.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP' over-prescribing is to be condemned.	Give best advice possible to my knowledge	Advice patient to wait for 2 days before starting antibiotic. If fever persists, then come to buy it.
Vignette2	All patients have to be treated with respect.	Fairness	Give a sheet to all those who demand the drug.
Vignette 3	Locum pharmacist's behaviour to be condemned.	Treat medicine with respect.	Long good talk.

Pharmacist 8

Female, in her 40s, owner, interviewed on 12/10/2018.

Main quotations

- "The company has its own sales targets and the manager constantly reminds us to promote certain items. Many times I was thinking of leaving this pharmacy but when I speak to other colleagues working with other companies, they are in the same situation."
- "The owner recommended an eye drops preparation which was not appropriate for the patient. I did not feel comfortable to undermine the owner's decision."
- "I know that this can cause bacterial resistance. I cannot, however, judge the case because I have not examined the patient."
- "I have to fit in this profit-seeking culture. I have no say which products are stocked. This makes me feel professionally dissatisfied."
- "Every day I have a reminder from my boss which products to recommend. Usually, these are products which the boss imports, or short dated products or products with sky-high profits."

Main Theme

Subordination to the company's culture to maximize profits.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Respect for the professional autonomy of the GP.	Follow guidelines of company	Dispense no judging of others' decision.
Vignette 2	Respect each patient	Fairness	First come first derved basis, company's policy
Vignette 3	Locum pharmacist went outside professional responsibilities	Follow company's guidelines	Talk to locum to hear his or her reasons for acting this way. But never report.

Pharmacist 9

Female, in her 40s, employee, interviewed on 12/10/2018.

Main Quotations

- "Mr S is on Seroxat, an anti-depressant. One day he came to the pharmacy. He has decided to stop the medicine and start St. John's Wort, acting on the advice from an internet source."
- "I knew that the nearby neighbour was giving discounts to customers on medicines. I had decided many times to report this behaviour but I did not want to create friction with my colleague working in that pharmacy."
- **"**Which product will I dispense, the branded or the generic which is much cheaper? Which expectorant will I advise to the patient, that product that costs more than 8 euro but has 100% profit or that expectorant which has the same active agent as the former but costs only 4 euro but has only 20% profit? These financial ties with the industry do exert a significant negative influence on my professional judgement involving the primary interests of medicine."

Main Theme

Many times commercial interests are not good bedfellows with EDM. Competitive pharmaceutical environment does not help professional ethical judgment.

Vignettes

	Moral Reasoning	**Moral intent**	**Moral reasoning**
Vignette 1	GP's over-prescribing increases bacterial resistance.	Antibiotics must be used judiciously.	Dilemma but finally dispense.
Vignette 2	All patients are treated equally.	Fairness	Dispense a sheet on first come first served basis.
Vignette 3	Locum's behaviour not professional.	Professional considerations in all dispensing practices.	Will not report.

Pharmacist 10

Female, in her 40s, employee, interviewed on 30/10/2018.

Main Quotations

- "A lady comes to check her urine for glucose levels. I checked it twice because it showed high levels of glucosuria. I advised her to see the doctor to do a blood test. After 15 minutes she returned in an angry mood. She told me that she did the test in the nearby pharmacy and it was clear. The pharmacist told her that the result was wrong because the pharmacist in the other pharmacy has used expired glucose strips. I took the glucose stick bottle, showed her the expiry date and repeated the test. Again, the test showed alarming levels of glucosuria. Some people do anything to win customers."
- "A patient can always obtain a prescription from a physician. Health centres are open all day. I never accept excuses. I explain gently my position and many respect me because they know they are dealing with a professional. I will never accept prescriptions written an SMS on a mobile nor a telephone call from a doctor to dispense a controlled drug."
- "I practice in an area where I receive patients from all over the island especially after 7pm and on Sundays. I can say that I have no loyal customers. I dispense only on prescriptions because I do not want to risk my warrant."

Main Theme

1. A legalistic young pharmacist who espouses the law above PBI.
2. The competitive nature of the pharmaceutical business may give rise to unethical behaviour by colleagues.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Doctor is in a better position since she or he examines the patient.	Obey the instructions of the prescription	Dispense
Vignette 2	All patients have to be treated without any type of discrimination.	Give service to each patient irrespective of age, race, a customer or not.	First come first served basis but dispensing one sheet only.
Vignette 3	Locum's behaviour to be condemned.	POM need always a corresponding prescription.	Will terminate locum's job but no reporting.

Pharmacist 11

Male, in his 40s, employee in a chain pharmacy, interviewed on 17/09/18.

Main Quotations

- "My boss wants me to promote the sales for insect repellent every time a customer comes in and asks for a cream to treat an insect bite. For a patient with sore throat, the boss wants me to sell throat lozenges and antibacterial mouth spray."
- "A patient, who I know well, may come to buy a POM pain killer without a prescription and promises to bring the prescription next morning. Sometimes the doctor phones and asks to dispense a controlled drug, promising to deliver it next morning. A mother may come for an antibiotic syrup for her child showing a prescription on the mobile. All these examples are emergency cases and I will not hesitate to dispense."
- "When I see a customer I see my mother. I give her the best service I can."

Main Theme

1. Commercial conflict of interests
2. Subordination to company's culture are evident themes.
3. The pharmacist prioritizes PBI over legal duties.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Aware of unprofessional behaviour of GP.	Follow company's guidelines.	Dispense as company wants no tension with GP.
Vignette 2	Aware that patients are to be cared equaly.	Follow company's guidelines.	Dispense on first come, first served basis.
Vignette 3	Locum,s behaviour not professional	Follow company's guidelines	Terminate locum's job. No reporting.

Pharmacist 12

Male, in his 40s, employee, interviewed on 25/09/2018.

Main Quotations

- "I will stick to the law. I don't want any trouble with authorities."
- "The relationship between patient and enquirer does not eliminate the duty to keep patient's history private. If somebody asks me what drug a certain relative is receiving, I cannot reveal this information unless it is a police case or there is danger of harm to third parties. I came across such a case when I suspected that a patient was a abusing of dopamine agonists. This patient was living with a family where there were young girls. These drugs are reported to increase sexual libido and can lead to sexual rapes of underaged persons. I had to inform the family hosting this patient of this risk.."
- "This is very true in Malta where health centres are open and doctors available to write a prescription. A patient can fill a prescription from a doctor at any time."
- "When I receive a prescription for isotretinoin, a drug used for severe acne, I make sure that the young lady understands that the drug is teratogenic. I explain to her carefully and in simple language the EU protocol that demands that a young lady starts the contraceptive pill four weeks before starting the acne drug and to continue the pill for another four weeks after the end of treatment."

Main Theme

1. A legalistic pharmacist who goes by the book and prioritizes legal duties.
2. Confidentiality is important and must be maintained at all times except when there may be harm to a third person.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Over-prescribing of antibiotics is harmful to population	Respect the prescription of a doctor.	Dispense.
Vignette 2	Treat all patients with respect.	Respect the needs of the patients.	Dispense with no preferences to loyal patients.
Vignette 3	Locum's behaviour irresponsible.	Legal obligations must be observed.	Terminate the locum's job.

Pharmacist 13

Male, in his 40s, employee, interviewed on 04/09/2018.

Main Quotations

- "It is very frustrating to have a doctor insisting on a particular brand when there are several similar brands on the market. It looks very suspicious and it makes me feel as a pharmacist very little. But one dispenses, we cannot make enemies."
- "To stimulate sales and reach targets, the local pharmaceutical dealers offer irresistible profitable deals on medicinal products. With the exponential growth in parallel importation profits for the pharmacy have skyrocketed. All these profits will be lost if the pharmacy does not attract customers."
- "My boss pays me well. I'm happy working in this pharmacy and follow the company's guidance and business strategies."

Main Theme

1. The theme of subordination to the doctor and even to the consumer is evident. The pharmacist feels a certain moral distress that on such small issues one has no say.
2. The pharmacist refers to the competitive nature of the business which involves also the medical profession.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP's behaviour not to be recommended	Respect the legal duties of pharmacist	Dispense , no tension with GP
Vignette 2	All patients treated fairly.	Fairness	Dispense to all, first come first served basis.
Vignette 3	Locum's behaviour not to be recommended	Respect the legal duties	Warn the locum but no reporting.

Pharmacist 14

Female, in her 50s, owner, interviewed on 04/09/2018.

Main Quotations

- "If it is a minor thing, try to settle it with the patient. If it is an error in dosage or contraindication then one has to contact the doctor. Respect, politeness and confidence are essential. Just yesterday I had a prescription for a cough medicine indicated for children above 2 years. The baby was only 10 months of age. I phoned and explained. He listened but was not convinced. I explained the situation to the mother, showed her the product's leaflet and added that many doctors still use it under 2 years. The mother still decided to follow the doctor's advice. I felt good, I gave her a good advice without harming the reputation of the doctor."
- "I am always insisting with my staff to never discuss patients' information and drug therapy to outsiders and between themselves. I insist that patients who need private conversation with me are given the time and space to do so."
- Patients come and ask me for non-steroidal pain killers without having a prescription. I start to investigate the patient's need. Is he really in pain? Why is he asking for such a drug? Are there any contraindications? I explain to him that the easy way was to give him a box but my main concern is the patient's welfare. I even phone his doctor to get his opinion. Patient's appreciate this care and putting financial gains as secondary.
-

Main Themes

1. A pharmacist belonging to Kohlberg's level5-6 who tries to build a pharmacist-patient relationship based on trust, care and compassion.
2. Another theme is that of confidentiality.
3. This pharmacist uses the Golden Rule as the compass for EDM.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP's behaviour not recommended	PBI comes before any other obligation	Advice the patient to get another GP's opinion.
Vjgnette 2	All patients are important.	Every person has an innate human dignity to be respected.	I dispense a sheet to all without any distinction.

Vignette 3	Locum's behaviour is unethical.	Do the correct action.	Warn the locum and convince to improve professional behaviour.

Pharmacist 15

Female, in her 50s, employee, interviewed on 23/09/2018.

Main Quotations

- "When a patient comes for a CD and starts inventing stories, of how he has lost the pills then I know he is lying. I do not risk my warrant, so I tell him I'm sorry it is out of stock from the pharmacy."

Main Theme

1. The pharmacist is passing the dispensing responsibility to one's colleagues.
2. The pharmacist wants to obey the legal duties.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP's decision is to be respected	Dispense all legal prescriptions.	Dispense
Vignette 2	All patients treated the same.	Fairness	Dispense no distinction
Vignette 3	Locum causing trouble to reputation of the pharmacyand managing pharmacist.	Reputation of the pharmacist is a prime consideration.	Dismiss but no reporting.

Pharmacist 16

Male, in his 50s, owner, interviewed on 01/10/2010/

Main quotations

- "It is impossible to refuse offers. Just yesterday a dealer offered me for 12 boxes I buy I get 13 boxes free. That's more than 100% profit"
- "In 20 years- experience as a community pharmacist, I have never refused to dispense a prescription except once when I received an illegal prescription for a controlled drug (CD). In fact, the customer has stolen some green forms and was self- prescribing a CD with a fake doctor's signature."

Main Themes

1. The competitive nature of pharma business gives rise to conflict of interests where secondary interests for profit outweigh the pharmacist's primary interests for patient's welfare.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP is responsible for one's action.	Legal obligations to dispense	Dispense
Vignette 2	All patients have to be treated equally.	Legal duty to dispense.	Dispense with no distinction between loyal or non-loyal customer
Vjgnette 3	Locum legally liable	Dispense only if prescription is valid.	Dismiss but no reporting.

Pharmacist 17

Male, in his 50s, owner, interviewed on 10/10/2018.

Main Quotations

- "Even other professionals are traders. Dentists sell toothbrushes and mouthwashes from their clinics. We sell other things besides medicines to compensate for our free medical advice. Competition is tough and we survive because of parallel importation, high profits on OTC and remuneration from POYC."
- "The only thing I can think of is the dispensing of emergency contraceptive. But surely I encounter other issues but I solve them even if I do not perceive them as ethical."

Main Themes

1. Commercial interests again dominate the discourse of this pharmacist who has seen a sharp decline in sales of non-prescription products. These products are bought now from the large stores.
2. This pharmacist shows low moral awareness.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP 's behaviour not to be recommended	Respect professional judgement of other health carers.	Dispense no questions asked.
Vignette 2	All patients have to be treated equally.	Respect to all.	Dispense without any favoritism.
Vignette 3	Locum's behaviour not professional	Professional behaviour present at all times	Warn seriously but do not report.

Pharmacist 18

Female, in her 50s, owner, interviewed on 08/10/2019.

Main Quotations

- "The first question I ask to the salesman is what is the bonus. With OTC items, there is a little therapeutic difference, if any, between one product and another. We need these extra profits to compensate for the losses in sales due to the large stores."
- "I opened my pharmacy few years ago. There were several other pharmacies in the area. So I needed to attract customers. I started to accept returned goods. I regret it because now I'm treated as a carpet."
- "On daily basis we meet many small problems. Some customers need few sachets of an NSAIDs, others want 2 tablets of Ativan for the next 2 days before getting a prescription, others want a box of Augmentin because they are going abroad. One knows these persons from a life time. Experience and some common sense is needed and all are happy."

Main Themes

1. Commercial interests dominate dispensing practice.
2. Subordination to customers in order to retain and win customers.
3. Experience, common sense and consequentialistic ways of EDM.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Respect decisions of GP	Respect for GP professional autonomy	Dispense, no tension with GP.
Vignette 2	Respect the medical needs of all customers	Provide an excellent service to loyal customers	Keep several boxes for loyal customers.
Vignette 3	Locum's behaviour deplorable	Professional behaviour present at all times.	Terminate the locum's job.

Pharmacist 19

Male, in his 50s, owner, interviewed on 03/09/2018.

Main Quotations

- "Our pharmacies have real excellent relationship with the doctors who have their clinics in our pharmacies. We help each other and they help in pushing our products."
- "I dispense and do not comment. The doctor is our main source of prescriptions and I do not want to cause any tension between us."
- "If a patient comes in pain and needs some anti-inflammatory or a person comes for few tablets of Ativan until he contacts his doctor for a physician I dispense to help out. All these cases are emergencies and I'm helping a vulnerable person."
- "Mrs X is a very good, regular customer. I feel I have to reciprocate her loyalty by keeping some boxes for her."

Main Themes

1. Subordination to doctor regarding medical opinion.
2. Commercial conflict of interests due to close business relationship between GP and pharmacist.
3. Fear of losing patients and thus priority to PBI over legal duties.

Vignettes

	Moral reasoning	**Moral Intent**	**Moral enactment**
Vignette 1	Respect professional autonomy of GP	Respect GP 's professional decision	Dispense. No tension with GP
Vignette 2	Satisfy the medical needs of customer.	Fear to lose loyal customers.	Keep boxes for my loyal customers.
Vignette 3	Locum's behaviour not professional	Professional behaviour to keep customers happy.	Dismiss the locum pharmacist, but no reporting.

Pharmacist 20

Female, in her 50s, owner, interviewed on 08/10/2018.

Main quotations

- "I will never say that the doctor is mistaken, I find other words. I regard the pharmacist as the 'go between', give my advice and dispense but never contradict a doctor's prescription."
- "A patient came on Saturday evening asking for an emergency supply of an antidepressant. He was a regular user but his doctor was abroad. I knew that legally this was not Ok, but I always prioritize PBI over law. So I dispensed for four days and made him promise to come with a prescription as soon as possible."

Main Themes

1. Subordination to GP.
2. PBI given priority

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Respect GP's professional autonomy	Respect GP's professional autonomy	Dispense no tension with GP.
Vignette 2	Allm patients treated equally.	Patient's medical needs are main concern.	Dispense one sheet to all patients.
Vignette 3	Locum's behaviour not professional	Respect for the profession's standards	Warn but no reporting.

Pharmacist 21

Female, in her 50s, employee, interviewed on 26/10/2018.

Main Quotations

- "The only contact I had with doctors in my 20 years of community pharmacy is to inform him of a product that is out of stock. Very depressing."
- "The psychiatrist attending the pharmacy prescribes 90 25mg amitriptyline and 90 diazepam 5mg. I knew the lad, he was not to be trusted with so many tablets. So, I dispensed only 6 tablets of each. He protested but I told him to come in two days-time. Next morning his father came to the pharmacy and accused me of being irresponsible. The lad had swallowed them all and slept all day. I told him that his son was still living because I was thoughtful and didn't dispense all tablets."
- "I have over 1000 patients enrolled in the POYC system. I have to prepare their prescription every two months, It takes a lot of time and I have much less contact with patients. This I feel is bad for my professional development."

Main Themes

1. Complains of lack of professional socialization between doctor and pharmacist.
2. A virtuous pharmacist who dispenses with care, compassion and intelligence.
3. Isolation.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	GP's behaviour not recommended	Give the best advice to the patient.	Advice the patient to wait for 2 days before starting the treatment.
Vignette 2	All patients have equal human dignity.	Give the same excellent service to all.	Give a sheet to each patient.
Vignette 3	Locum's behaviour unethical and unprofessional.	Respect for the profession's standards	Warn the locum and give advice for better behaviour.

Pharmacist 22

Female, in her 50s, owner, interviewed on 26/10/2018.

Main Quotations

- "I dispense and do not comment. The doctor is our main source of prescriptions and I do not want to cause any tension between us."
- "A lady came to ask for a fat blocker to reduce body weight. The assistant gave her a good selling presentation. But I still was not convinced. I knew the lady, she had three children and spending more than 30 euro every fortnight was surely a burden. Moreover, I was aware that all this fat blockers have no real scientific back up. The lady needed a good professional advice from a nutritionist. Yet, I was a bit hesitant because I did not want to butt into the assistant's good work."
- "I had a prescription for methotrexate for a child, an off- label indication, I contacted the POYC who advised me to get a signed letter from the physician so that he assumes all responsibility of the off-label use."
-

Main Themes

1. Respect others' professional autonomy not to cause tensions.
2. Not confident in taking an ethical decision.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Gp 's behaviour ought to be better	Respect other's professional autonomy	Dispense.
Vignette 2	All patients ought to be treated the same.	Respect all patients.	Difficult to decide as loyal customers may deserve more care.
Vignette 3	Locums behavior bad and inconsiderate	Respect for the profession's standard	Talk to locum to explain the situaion but no reporting.

Pharmacist 23

Female, in her 50s, owner, interviewed on 01/10/2018.

Main Quotations

- "I use my intuition and common sense to solve these situations."
- "I have invested quite a big sum of money in the pharmacy. I give employment to three other families. So I try to do a decent job, give a good advice but try to maximize my profits. What is wrong with that?"
- **"**With a 20% profit no pharmacy can make ends meet. We give useful advice free of charge. Many items such as shampoos, baby products and many others are being bought at supermarkets. We need to promote OTC products of good value and high profit making. This need to promote high profit products does not mean that the pharmacist eels less responsible and accountable for the welfare of the patient."

Main Themes

1. Commercial conflict of interests with EDM.
2. Common sense and intuition as ways to make EDM.

Vignettes

	Moral reasoning	**Moral intent**	**Moral enactment**
Vignette 1	Respect GP's decision	Respect others' professional autonomy.	Dispension, no tension with GP.
Vignette 2	All patients treated the same.	Loyal patients deserve more attention.	Keep last boxes foe the loyal patients.
Vignette 3	Locum's behaviour can irritate patients	Professional service to patients of prime importance	Dismiss the locum but no reporting.

Appendix VI: Main Themes emerging from Interviews

Central Theme: Ethical problems arising from fear of losing customers.

- Subordination to patients
- Subordination to general practitioner
- Ethical problems in breaking rules

Major Themes:

- Ethical problems related to medicinal sales
- Ethical problems in professional autonomy
    - Relationships with colleagues
    - Reporting Unethical Behavior
- Isolation

Minor Themes:

- Confidentiality
- Refusing treatment to certain patients

Appendix VII: Comparing dissertation's conclusions with studies from literature reviews

Dissertation's Conclusions	Similar conclusions in literature reviews: examples	Different conclusions in literature reviews
Commercial interests dominate	Common to most studies. Examples include: Hibbert *et al.*; Cooper (2005); Chaar *et al.*; R. Dingwall and P. Watson (2002); E. Kennedy and M. Moody (2000**).**	
Subordination to organizational culture	This theme was common to most studies of the three literature reviews.	
Bending Rules: PBI prioritized over law		Chaar *et al.*; Cooper *et al*. doctoral thesis; Alisa Benson, Alan Cribb and Nick Barber (2000); all give priority to law due to fear of consequences.
Subordination to physicians	This theme was common in most studies of the literature reviews.	
Isolation	R. J. Cooper, P. Bissell and J. Wingfield**,** (2009); Mohammed N. Al-Arifi (2014); P. Salari Sharif *et al.* (2011)	
Limited ethical education	Chaar *et al.* (2005); Hibbert *et al.* (2000); R. J. Cooper, P. Bissell and J. Wingfield, (2009).	
Ethical attention depending on moral intensity of dispensing issues.		R. Cooper doctoral thesis: participants described as ethical

		passive
No reference to the Code of ethics	In most studies COE is not considered of any help in EDM.	
Common sense, intuition, experience and consequentialism. as a tool for EDM	Chaar *et al.*; R. J. Cooper doctoral thesis. P. Bissell and J. Wingfield, (2009).	
Golden Rule	Some participants in R. Cooper's doctoral thesis used also the Golden Rule in EDM.	