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CONSCIENTIOUS OBJECTIONS IN PHARMACY PRACTICE IN GREAT BRITAIN

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ABSTRACT

Pharmacists who refuse to provide certain services or treatment for reasons of conscience have been criticised for failing to fulfil their professional obligations. Currently, individual pharmacists in Great Britain can withhold services or treatment for moral or religious reasons, provided they refer the patient to an alternative source. The most high-profile cases have concerned the refusal to supply emergency hormonal contraception, which will serve as an example in this paper.

I propose the pharmacy profession's policy on conscientious objections should be altered slightly. Building on the work of Brock and Wicclair, I argue that conscientious refusals should be acceptable provided the patient is informed of the service, the patient is redirected to an alternative source, the refusal does not cause an unreasonable burden to the patient, and provided the reasons for the refusal are based on the core values of the profession. Finally, I argue that a principled categorical refusal by an individual pharmacist is not morally permissible. I claim that, contrary to current practice, a

pharmacist cannot legitimately claim universal exemption from providing a standard service, even if that service is available elsewhere.

INTRODUCTION

As the new regulatory body for pharmacy, the General Pharmaceutical Council (GPhC) plans to review the conscience clause,[1] which has historically focused on medicines for the control of fertility and conception or termination of pregnancy.[2] In this paper I consider the possible justifications for a conscience clause with a view to suggesting alternative guidelines for practice. Conscience clauses are described in the pharmacy profession's *Standard of Conduct, Ethics and Performance* and *Guidance on the Provision of Pharmacy Services Affected by Religious and Moral Beliefs*[3] (hereafter referred to as 'Ethical Standards' and 'Guidance' respectively). I will illustrate the discussion of conscience clauses

[1] General Pharmaceutical Council (GPhC). 2010. Report on the Responses to the Consultation on the Revised Draft Standards. Available at: http://www.pharmacyregulation.org/pdfs/consultations/gphcstandardsconsultationreportfinal0610.pdf [Accessed 12 July 2010].

[2] J. Wingfield. Should Conscience Come Before Care? *PJ.* 2010; 284: 393.

[3] General Pharmaceutical Council (GPhC) *Guidance on the Provision of Pharmacy Services Affected by Religious and Moral Beliefs.* Available at: *http://www.pharmacyregulation.org/pdfs/other/religiousmoralbeliefguidancev13.pdf* [Accessed at 21 December 2010].

using over the counter supply of emergency hormonal contraception (EHC) as an example.

Emergency hormonal contraception

Some community pharmacists hold conscientious objections to over-the-counter supply of EHC and as such refuse to supply it. Some see this as an appropriate exercise of pharmacists' rights to autonomy and integrity, while others view it as a contradiction of the professional obligations of pharmacists. Pharmacists are urged by the GPhC to ensure that if their "religious or moral beliefs prevent … [them] from providing a service, … [they inform] the relevant people or authorities and refer patients and the public to other providers."[4] In these cases it is accepted by the profession that the individual can make her own decision in a way that to some extent goes against the standard practice of the profession.

The supply of EHC over the counter is one such standard practice, with relevant legislation introduced in 2001,[5] and it has proven

[4] General Pharmaceutical Council (GPhC*) Standard of Conduct, Ethics and Performance* 2010. Available at: *http://www.pharmacyregulation.org/pdfs/other/gphcstandardsofconductethicsandperflo.pdf* [Accessed at 21 December 2010].

[5] Prescription Only Medicines (Human Use) Amendment (No. 3) Order 2000 (S.I. 2000, No. 3231).

controversial.[6] Debate about EHC in academic literature and in the UK media has focused on the morality of its use, the morality of its supply, and whether pharmacists should be able to refuse to supply on moral or religious grounds. The fundamental objection to the supply of EHC is widely taken to be to the prevention of pregnancy and/or the termination of pregnancy,[7] though there can be other complex reasons for refusal. In a study carried out by Cooper *et al*., reasons for refusal included discomfort at being used by the government to reduce rates of teenage pregnancy, and concern that

[6] See for example: G. Barrett & R. Harper. Health Professionals' Attitudes to the Deregulation of Emergency Contraception (or the Problem of Female Sexuality). *Sociology of Health and Illness* 2000; 22; 2: 197-216.; C. Dailard. Beyond the Issue of Pharmacist Refusals: Pharmacies That Won't Sell Emergency Contraception. *The Guttmacher Rep Public Policy* 2005; 8; 3.; A. S. Day. Emergency Contraception – When the Pharmacist Conscience Clause Restricts Access. *Nursing for Women's Health.* 2008;12; 4; 343-346.; D. P. Flynn. Pharmacist Conscience Clauses and Access to Oral Contraceptives. *J Med Ethics* 2008; 34: 517-520.; J. P. Kelleher. Emergency Contraception and Conscientious Objection. *J Appl Pilosl.* 2010; 27, 3: 290-304.; Letters in *PJ.* 2008; 281; 7518: 251-280.; P. Mallia. The Use of Emergency Hormonal Contraception in Cases of Rape - Revisiting the Catholic Position. *Hum Reprod Genet Ethics* 11; 2: 35-39.; L. Purdy. Is Emergency Contraception Murder?. *Reprod Biomed Online* 2009; 18; S1: 37-42.; Stokes, P. 2008. Mother is Denied Pill by Muslim Pharmacist. *Telegraph* 3 October. Available at: http://www.telegraph.co.uk/news/uknews/3129625/Mother-is-denied-pill-by-Muslim-pharmacist.html [Accessed 14/09/10].

[7] This is controversial; some claim emergency hormonal contraception is a contraceptive only, while others claim it is an abortifacient because in some cases it takes effect after fertilisation. In each successful use it works in one of three ways: 1) ovulation is inhibited; 2) mucous of the cervix thickens, blocking sperm; or 3) a fertilised blasotcyst is prevented from attaching to the lining of the uterus.

growing young women would be exposed to large doses of hormones.[8]

The conscience clause of the GPhC's Guidance offers a compromise, which is that the profession provides the services it offers, while also allowing individual professionals to refuse to make the supply themselves. In this paper I examine the key arguments for having a conscience clause and the key arguments against it. I consider current policy in the pharmacy profession in Great Britain. I argue that the Ethical Standards and Guidance should be altered to state explicitly that the refusal should not put unreasonable burden on the patient,[9] and should be changed to prohibit principled blanket refusals. I also argue that conscientious refusals should be based on the core values of the profession, though I accept it may be difficult to translate this into policy.

The first substantive part of the paper is an assessment of the key over-arching values behind conscience clauses, with an examination of moral distress and the relationship between conscience, integrity,

[8] R. Cooper.; P. Bissell. & J. Wingfield. Ethical, Religious and Factual Beliefs About the Supply of Emergency Hormonal Contraception by UK Community Pharmacists *J Fam Plann Reprod Health Care* 2008; 34; 1; 47-50.

[9] Presently the Guidance states, as one of the points for pharmacists to consider before accepting employment, that pharmacists must make the patient their first concern. However, when the pharmacist's moral or religious beliefs are in competition with fulfilling the patient's needs, the pharmacist may appeal to the conscience clause. The implication of this is that the patient's needs are not always the most important aspect to consider.

moral agency and doing the right thing. In the second substantive section I look more closely at integrity within a professional context, with the claim that the only legitimate conscientious objection is one that is based on the core values of the profession.

The third substantive section is a discussion of how these conclusions could be used to inform policy. I will agree with Brock in accepting the incompatibility thesis as applied to individual professionals, but rejecting it as applied to the profession as a whole. I also come to broad agreement with Brock's 'conventional compromise'[10] model of a conscience clause. I and add to this the ideal condition that conscientious refusals are only acceptable if they are based on the core values of the profession. I then argue that categorical conscientious refusals are not acceptable, even if the service could be provided by another pharmacist, since the conditions of the compromise demand that pharmacists make assessments on a case-by-case basis. These conclusions differ slightly from current policy in pharmacy practice in Great Britain. The arguments presented here may be applicable to other professions, but the specific claims I make which apply to policy have been considered in the context of pharmacy practice.

[10] D. W. Brock. Conscientious Refusal by Physicians and Pharmacists: who is Obligated to do what, and why? *Theor Med Bioeth.* 2008; 29: 187-200.

WHY SHOULD WE ALLOW CONSCIENTIOUS REFUSALS?

Broadly speaking, arguments in favour of conscience clauses are about: i) protecting an individual from moral anguish; ii) protecting moral integrity; and/or iii) accommodating a variety of views and beliefs. I will return to the last point in the second substantive section when discussing the core values of the profession. In this section I will pay attention to the first two points: protecting an individual from moral anguish and protecting moral integrity.

Moral anguish

It may be argued that conscientious refusals should be allowed because it would be harmful to force someone into moral distress (caused by acting against one's conscience). One only needs to imagine being asked to do something one strongly disagrees with to appreciate the emotional force of conscience and integrity. As Benn puts it, "[a] person's integrity may be violated if she is made to act against her conscience; the deepest values by which she defines her life are under assault. It is a cause of distress and anger that she should have to do what she thinks is wrong."[11] Pharmacists have

[11] P. Benn. 2007. Conscience and Health Care Ethics. In *Principles of Healthcare Ethics.* R. Ashcroft, A. Dawson, H. Draper & J. McMillan, eds. UK: John Wiley & Sons Ltd.: 345-350: 345.

reported feeling “considerable ethical concern and anxiety” over the decision to deregulate EHC.[12] The level of distress caused by being forced to act against one’s conscience should not be underestimated; after all, ‘discomfort’ can be of enormous magnitude. Cohen describes it as “excruciating moral anguish,”[13] Wicclair as a “significant loss of self-respect”[14] and Smith commented in a letter to the *British Medical Journal* that Savulescu’s arguments against conscientious refusals made him “feel physically sick”.[15]

Benn dismisses such reasons for conscientious refusals as “weak” on the grounds that health care professionals routinely do things that cause distress and make them feel uncomfortable.[16] It may be suggested this is not an entirely fair charge, since Benn is conflating moral distress with distress caused by those things that are agonising in themselves, for example “watching a patient die in pain.”[17] Even so, I would agree with Benn that the ‘moral anguish’ argument is rather weak. While moral anguish may be indicative of the gravity of the values at stake, the anguish is not itself sufficient to justify the existence of a conscience clause. Benn is right that we accept professionals have to experience distress as part of their jobs.

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[12] Cooper; Bissell & Wingfield. *op cit*. note 8.

[13] C. Cohen. Conscientious Objection. *Ethics* 1968; 78, 4: 269-279: 269.

[14] M. R. Wicclair. Pharmacies, Pharmacists and Conscientious Objection. *Kennedy Inst Ethics J* 2006; 16, 3: 225-250: 244.

[15] V. P. Smith. Letter to editor. *Br Med J* 2006; 332, 7538: 425.; J. Savulescu. Conscientious Objection in Medicine. *Br Med J* 2006; 332, 7536: 294-297.

[16] Benn, op cit. note 11: 348.

[17] Ibid: 348. I would like to thank an anonymous reviewer for this point.

Moral anguish is a *type* of anguish; it differs from other types of anguish in that it is a reaction to the moral wrongs or harms of a situation. In this particular context, it is caused by a (perceived) violation of integrity. What causes us concern about moral anguish is, I suggest, not the anguish itself, but the origin or cause of that anguish.

Further, allowing a conscientious refusal only to avoid extreme moral anguish will frustrate the conscientious objector, who wants her view to be respected for the position it is, rather than be protected from distress. After all, she sincerely believes she is doing the right thing. This is exemplified when professionals are criticised for taking advantage of the availability of the conscience clause to avoid procedures they find merely unpleasant rather than morally objectionable.[18]

In addition, while distress, anguish and other harms are in themselves negative and should be avoided wherever possible and reasonable, the onus rests with the defender of the conscientious refusal to show why moral anguish felt by a professional is enough to override the patient's rights or interests when this is one of the core

[18] M. Millward. Should pregnant doctors work in termination of pregnancy clinics? *BMJ* 2010; 340: 425.

values of the profession.[19] This is particularly important given the asymmetric nature of the professional/ patient relationship.

It is worth recognising the moral anguish that can be caused by acting against one's conscience, and it is also worth minimising this kind of harm to professionals wherever reasonable and possible, but the existence of a conscience clause cannot be justified by this alone. Distress of the professional is not the crucial factor; it is conscience and integrity themselves that are of real concern.

Conscience

For the purposes of this paper I shall assume Curran's definition: conscience is "the judgement about the morality of an act to be done or omitted or already done or omitted by the person".[20] Conscience is usually thought to be closely related to integrity, though tensions between them can exist.[21] For this discussion I take conscience to be the judgement about the morality of the act and, roughly speaking but

[19] Arguably, respecting a professional's conscience may be a core value of the profession given the existence of the conscience clause. I shall not assume it is a core value, since this is the very thing whose justification I have set out to determine.

[20] C. E. Curran. 2004. *Conscience.* New Jersey: Paulist Press.

[21] For further discussion of such tensions see I. Shapiro & R. Adams., eds 1998. *Integrity and Conscience*. New York and London: New York University Press.

explained further below, I take integrity to be a commitment to acting morally.

Personal integrity as a virtue

'Integrity' has multiple definitions and understandings, but there are "clusters of shared intuitions"[22] around the concept. For the purposes of this paper, I take integrity to be a virtue (or set of virtues), namely a commitment to acting morally, which includes a continual critical assessment (and sometimes adjustment) of one's own position, and genuine consideration of other points of view.[23] I use the terms 'integrity' and 'personal integrity' interchangeably, assuming personal integrity to be potentially applicable and important to everyone. There are other types of integrity, for example professional integrity, which I shall come to later.

Understanding integrity as a virtue has the important feature that acts of integrity are linked to the agent having a good grasp of what it is to act morally. It is set apart from Williams' notion of integrity,[24] which is a commitment to a personal, self-contained moral system, a fidelity to those principles and values one holds dear as part of one's own life

[22] D. Cox; M. La Caze & M. P. Levine. 2003. *Integrity and the Fragile Self.* England & USA: Ashgate: 1.

[23] This is informed by Cox; La Caze & Levine. *Ibid.*

[24] B. Williams. 1981. *Moral Luck: Philosophical Papers 1973–1980.* Cambridge: Cambridge University Press: 40-53.

project. On this account an individual would have integrity if her actions were consistent with her values and beliefs, but those beliefs, values and actions need not be right on an objective level. The integrity I refer to also differs from what Ashford calls 'objective integrity',[25] which demands that the agent's set of values and behaviours corresponds so closely with objective morality that it would be impossible for someone to act with integrity and be morally mistaken.

Common use of 'integrity' does imply a relationship with good behaviour, but it does not demand that the agent always gets it right. Because of limitations on how to evaluate what the right moral goals are, if integrity was measured against objective standards of morality we would all have great trouble assessing whether any individual had integrity. As it is, in everyday life we are pretty comfortable identifying numerous individuals with differing moral positions as people with integrity. Common use of the term 'integrity' accommodates a range of interpretations of what is good, including actions that do not in fact bring about a good outcome. This is not to say that acting with integrity is completely divorced from doing the right thing. It would be inappropriate to say a person had integrity just because she steadfastly and stubbornly stuck to her ill-considered principles. If we accept that features of integrity include thoughtfulness, moral reflection and accountability, it follows that a person with these

[25] E. Ashford. Utilitarianism, Integrity and Partiality. *J Phil*. 2000; 97: 421–439.

virtues is unlikely to be utterly immoral. On this account integrity may be understood as a virtue that keeps in check the balance of other virtues. Thus, having the characteristic of integrity does not guarantee a person will do the right thing, but it is more likely. Cox, La Caze and Lavine put forward this view: “A person of moral integrity cannot be a moral monster … because attributions of integrity, being attributions of an important virtue, presuppose a certain moral success; the qualities that make for a character of integrity only constitute integrity when they succeed in making a person, with some degree of latitude, a good person.”[26]

So integrity is not sufficient for moral action, and in fact it may sometimes lead to wrong action. Neither is integrity *necessary* for a morally desirable outcome (a person can act against her integrity and in doing so happen to bring about a good outcome). In the case of the supply EHC, for example, a pharmacist may act against her integrity and supply EHC because she would like to please her boss, even though she mistakenly believes the act of supplying EHC is wrong. Or a pharmacist may act with integrity when she refuses to supply EHC, but she may be mistaken in thinking that her refusal is morally right.

It is sometimes thought that it would be wrong to pressurise someone to act against her integrity, even in cases in which acting with

[26] Cox; La Caze. & Levine. *op. cit*. note 22, p. 69.

integrity may lead to wrongdoing or an undesirable outcome.[27] If pressurising someone to act against her integrity is wrong, then potentially in this case there are two wrong actions from which to choose the lesser of two evils: pressurising someone to act against her conscience, or letting her do the wrong thing. Using the example of the supply of EHC, there might be a choice between two sets of circumstances. In one version of events, the pharmacist might deny the patient's welfare needs, her right to access certain healthcare, and her right to make an autonomous decision. In another version, the profession might put pressure on the professional to act against her conscience. If integrity is not necessary for moral action, then pressurising someone to act against her integrity to bring about the best outcome could only be wrong if integrity should be valued for some other reason. Such reasons may be that we ought to respect a person's viewpoint and moral reasoning, or that independence of moral deliberation is valuable and should be honoured rather than repressed.

When one of the features of a profession is that it is made up of moral agents, integrity is a valuable quality. All things being equal, it is worth respecting because it is a feature of moral agency and in general should be encouraged because of its instrumental role in doing good. But, as discussed earlier, an agent may be mistaken, therefore she may not always perform good acts, and for that reason

[27] Benn, op cit: note 11: 348.

limitations must be set. It seems to me that it would be very demanding, and ultimately unconvincing, to claim that respecting someone's moral reasoning or giving sanctity to independence could be so valuable that to force someone to commit an act she thought was wrong would *always* be worse than allowing a different morally wrong action to occur. Moreover, individual moral agency is not the only relevant moral consideration. There is something special about acting with integrity in the *professional* setting. In this context, there is a set of professional duties, and the individual is not just a moral agent, but an agent of the profession. There is also a reasonable expectation that the individual upholds and endorses the values of the profession to which she belongs.

INTEGRITY IN A PROFESSIONAL CONTEXT

A profession can adopt a number of positions in relation to conscientious objections. It can i) deny the right to conscientious refusals, calling for all professionals to behave in a prescribed way; ii) allow conscientious refusals of *any* standard practice on the basis of *any* religious or moral grounds; iii) accept conscientious refusals for a selection of practices, and/or on the grounds of certain values. In this section, I propose that the pharmacy profession moves away from its current approach, which is to allow conscientious refusals of any

practice on the basis of any religious or moral grounds. I suggest that instead it should accept conscientious refusals for any practice on the grounds of *certain* values, namely the profession's core values. It may not be possible to translate this into enforceable policy, but there may be other ways for the profession to indicate to its members what counts as appropriate and acceptable bases for using the conscience clause. I shall leave these practical considerations to one side, concentrating instead on what it means to act with integrity in a professional context. I challenge the notion that an individual could make a valid conscientious objection based on values that lie outside the core values of the profession.[28]

Professional integrity

Professional integrity is related to the particular norms and values of the profession in such a way that to act with professional integrity is to be committed to the values of the profession. Cox *et al.* describe professional integrity as "a matter of remaining true to the fundamental role and character of one's profession – to its principles, values, ideals, goals and standards. This requires that a professional

[28] Wicclair makes a similar point when he says conscientious refusals should be based on core values of the profession (M. R. Wicclair. Conscientious Objection in Medicine. *Bioethics*. 2000; 14; 3: 205- 227) and that the refusal should not contradict the recognised goals of the profession (Wicclair. Pharmacies, Pharmacists and Conscientious Objection *Kennedy Inst Ethics J.* 2006; 16; 3: 225-250.).

not merely remain true and publically endorse personal values and principles but that they remain true to the role they are publically entrusted with."[29]

Core professional values

Ordinarily, a professional individual performs her duties competently and acts in accordance with the core values of the profession. [30] In exceptional circumstances, that individual will find that the duties she is expected to perform come up against her personal values, which is when she may feel the only way to preserve her integrity is to use the conscience clause.

As mentioned at the start of the previous section, one of the reasons given for having a conscience clause is to accommodate a variety of views that arise from within a diverse society. The GPhC's policy operates in exactly this way; any personal moral or religious value

[29] Cox; La Caze. & Levine. *op cit*. note 22, p104.

[30] It is not easy to determine what the core values of the profession may be. Empirical research into the values of the pharmacy profession has been conducted by Benson, Cribb and Barber. (A. Benson; A. Cribb & N. Barber. Understanding Pharmacists' Values: A Qualitative Study of Ideals and Dilemmas in UK Pharmacy Practice. *Soc Sci Med* 2009; 68; 12: 2223 -2230.) Key ethical principles (but not 'values') are explicit in the GPhC's *Standards of Conduct, Ethics and Performance*.

can trump the values of the profession, as long as alternative provision is available for the patient. A person's values may be religiously or culturally informed. The GPhC's conscience clause accommodates the kind of variation brought about by diversity of and within society, culture and religion. I suggest this is a mistake because the GPhC is amalgamating and confusing two quite different types of conflict. First, conflict may arise when a professional considers that to provide a certain service or treatment would endanger not only her personal integrity, but also her professional integrity because she is being asked to do something that she sincerely believes the profession is mistaken to support given the fundamental ethos and pursuit of the profession. This type of conflict is important to recognise, and the moral objection should be heard by the profession. Second, conflict may arise when an individual's views that are external to the pursuit of the profession prevent her from providing a service without compromising her integrity. These external values have not been arrived at by the collective body of professionals. They are out of reach of the profession but are given special status and protection by the conscience clause. The GPhC is assigning equal status to moral reasoning that belongs in the profession and moral and religious beliefs that are personally held independently of the profession.

Because the GPhC's conscience clause can be invoked for any moral or religious reason, pharmacists are allowed to deviate from

the core values of the profession whenever they judge that their moral or religious beliefs prevent them from providing a service. In this way an individual's personal values are to some extent given preference over the profession's values. This to me is one of the most puzzling aspects of the way the conscience clause is designed and used. It strikes me it is contradictory for the profession to collectively agree its norms and values and then permit an individual to act in a way that is contrary to those values. It seems straightforward that a profession could not claim to hold core value *V* and simultaneously state that it was acceptable for individuals to directly contradict core value *V*, since the profession would lose that value as part of its identity. If a professional does not want to carry out a certain service, she must surely have to give a good account of her reasons for this, and these reasons must be acceptable to the profession. For a pharmacist to conscientiously refuse to provide a service on the grounds of values that oppose the core values of the profession would be contrary to the profession and as such, for consistency, would require resignation or a move to another area of pharmacy that did not include providing this service.

In preparation for the formation of the GPhC, there was a consultation about ethical standards among the pharmacy profession.[31] There was some opposition to the GPhC's intention to include the conscience clause on the grounds that it contravened the

[31] General Pharmaceutical Council. *op. cit*. note 1.

RPSBG's Code of Ethics principles, "Make the care of patients your first concern" and the guidance, "Consider and act in the best interests of individual patients and the public" and, "Make sure your views about a person's lifestyle, beliefs, race, gender, age, sexuality, disability or other perceived status do not prejudice their treatment or care."[32] Presumably the concern was that personal integrity was being placed above professional obligations and ethical principles, or that the values of an individual professional were being placed above those endorsed by the profession. When an individual claims to make a conscientious refusal, she may a) have non-conscience related objection (e.g. she finds the task unpleasant); b) judge that performing the action would be a violation of a personally held value that is very important to her, but that lies outside the values of the profession; or c) judge that performing the action would be a violation of a personally held value that is very important to her, and that the act she is expected to carry out would not in fact satisfy the core values of the profession in the way the profession claims. Clearly a) is not a conscientious objection at all. I argue that although b) is recognised as a conscientious objection by the pharmacy profession, it should not be accepted. By my reasoning, c) is the only valid use of the conscience clause.

Pharmacy, like other professions, is a live and evolving body. It is made up of individuals who reflect on their practice, which includes

[32] Royal Pharmaceutical Society of Great Britain. 2007. *Code of Ethics for Pharmacists and Technicians.* Pharmaceutical Press, London.

assessing the ethical basis of their work. The profession has a set of values that may reflect, react to, or even influence the changing values of the wider culture and society in which it sits. Changes to accepted practice or attitudes occur relatively slowly. No one individual professional is likely to trigger a cultural shift in a profession, but collectively the continual self reflection will occasionally lead to a change in the consensus. The role of the individual moral agent is essential for the internal critique of the profession.

It may be suggested that since the values of a profession can change over time, it would be unreasonable to expect individuals to leave the profession if the profession's values or policy were to change radically. Radical changes in the profession's values are very unlikely; changes are more commonly gradual refinements, or clarifications of how a value should be interpreted or applied. We can however expect to see more rapid changes to technology and services, and it is not unlikely that new services may come up against some pharmacists previously unchallenged personal values. Before EHC was available over the counter, pharmacists could hold certain values and provide all services. Some may now find that although the profession has not changed its core values, the introduction of the new service conflicts with their own values and beliefs. This conflict could take either of the two forms outlined previously: b) the individual judges that supplying EHC would be to

violate a personal value that is very important to her, but this value lies outside those of the profession; c) the pharmacist judges that to supply EHC would not in fact satisfy the core values of the profession in the way in which the profession claims it does. In the second type of conflict, the pharmacist would be acting professionally if she were to make a conscientious refusal.

Usually, when an individual becomes a professional pharmacist she agrees to the principles of the standards of conduct and ethics.[33] Being a sincere pharmacy professional is more demanding than simply providing services. It requires one to make moral judgements. Pharmacy practice has evolved into a values-based profession[34] and ethics is a key feature of this.[35] Even so, there may be cases in which

[33] The exceptions to this are the pharmacists whose beliefs would prevent them from providing certain services. In such cases they would have to notify the profession of this. To avoid circularity, I shall leave this to one side.

[34] A. Cribb. & N. Barber. 2000. Developing Pharmacy Values: Stimulating the Debate - A Discussion Paper. London: Royal Pharmaceutical Society of Great Britain.

[35] The definition of 'profession' is not settled; a hard and fast definition is difficult to pin down with a traits approach sometimes favoured. It is fairly typical for one of these traits to be the existence of a code of ethics, and a survey by Trauslen and Bissell established a list of characteristics most associated with professionalism, which included having a code of ethics. (J.M. Trauslen & P. Bissell. Theories of Professions and the Pharmacist *Int J Pharm Pract* 2004; 12: 107-114.) On the assumption that one of the essential characteristics of a professional is the capacity to make professional judgements, (R. O'Neill. 2001. Professional Judgement and Ethical Dilemmas. In *Pharmacy Practice*. K. Taylor & G. Harding, eds. London: Taylor and Francis: 203-226: 213.) including values-based judgements (A. Cribb & N. Barber. 2000. Developing Pharmacy Values: Stimulating the Debate - A Discussion Paper. London: Royal Pharmaceutical Society of Great Britain), decisions with a moral dimension must be led by the pharmacist's values.

a pharmacist fulfils her duties and never raises a conscientious objection, but is motivated to fulfil her duties not through a shared sense of the profession's core values, but because of external values. Take for example Christopher, a pharmacist whose values are based on Christianity. When interviewed about his ethical decision-making, Christopher said, "Every kind of moral or ethic that I'm faced with, ultimately, come back to my Christian experience and I'd measure it against my Christian value – whatever that was."[36] While I claim that acting on the core values of the profession is necessary for making a conscientious refusal, I do not extend that to claim it is necessary for fulfilling standard duties and services. The difference lies in the need for sound justification for wandering from the standard. It would be pointless to criticise the basis on which Christopher makes his decisions if he always fulfils his duties fully and competently. Notice that if Christopher were to make a conscientious refusal on the basis of his religious beliefs, the GPhC would accept this, even though Christopher's fundamental reasoning would be detached from the non-religious values that underpin the pharmacy profession.

See also: J. Edmunds. & M. W. Calnan. The Reprofessionalisation of Community Pharmacy? An Exploration of Attitudes to Extended Roles for Community Pharmacists Among Pharmacists and General Practitioners in the United Kingdom' *Soc Sci Med*. 2001; 53: 943-955.; E. Freidson, 1994. *Professionalism Reborn: Theory, Prophecy, and Policy*. Chicago: Chicago University Press.; T. Parsons 1954. *Essays in Sociological Theory*. New York: Free Press.

[36] From R. J. Cooper; P. Bissell & J. Wingfield. Ethical Decision-making, Passivity and Pharmacy. *J Med Ethics.* 2008; 34: 441-445 (443).

It is possible that a pharmacist could believe she was acting within the core values of the profession, but interpret those values differently to others. This may be the case in some instances of refusal to supply EHC. Suppose for example one pharmacist, George, believes the soul is created when life begins, which, he believes, is when egg and sperm unite to become the two-celled zygote. George understands that EHC is not an abortifacient, and he is correct in his belief that the use of EHC could destroy a zygote. George believes all humans that are presented to him at his pharmacy are his patients. Subsequently, George believes both the woman and the zygote are his patients. George shares the core values of the profession. Let us suppose one of the core values of the profession is that the patient's interests are of great importance. Suppose another pharmacist, Luke, also believes that souls exist, but believes that the soul does not come into existence until after birth when a human develops the faculties of autonomy and sentience. Luke also understands that EHC is not an abortifacient. Luke shares the core values of the profession, and believes he is only presented with one patient when a pregnant woman enters his pharmacy, and that she, as his patient, is his main concern.

Leaving to one side arguments about the woman's right to choose, and the interests of the pregnant woman, George has a conscientious objection to supplying EHC. Luke has no such objection. The only differences in their positions are their beliefs

about the moral and ontological status of the united egg and sperm cells. George and Luke have arrived at two different decisions about what should be done, and both claim to be able to justify their decisions on the grounds of the core values of the profession. The origins of some positions will be met with more understanding than others, and I suspect the more familiar belief systems (recognised religions, for example) would be met with greater understanding than the less well-known, some of which may be classed as eccentric, or mistaken. Imagine George is asked to justify his position to his peers. I suggest a sensible assessment of whether this was an acceptable use of the conscience clause would consider what George understood the core values to be, how he came to decide that supplying EHC would contravene those values, and whether his position was held sincerely. George's peers may conclude his position is valid, they may even re-consider the profession's stance on supplying EHC. Alternatively, they may decide that George's fundamental beliefs are so out of kilter with the scientific basis upon which pharmacy rests that he is mistaken and that this has led to a misapplication of the core values.

Now suppose that, in a slight variation, George does not believe the zygote is his patient, but he does believe that destroying a soul is a mortal sin, and that for that reason he thinks it is not in the woman's best interests to take EHC, and so he refuses to make the supply. In such a case I would doubt whether this interpretation of 'best

interests' would match the profession's understanding of the concept, or what are regarded as relevant considerations in assessing best interests. As such, George would not be acting in accordance with the core values of the profession, and so his conscientious refusal should be invalid.

Suppose George does not think the zygote is his patient, and neither does he think the woman should herself be prevented from taking EHC, but he does not want to supply EHC to her because he does not want to participate in the destruction of a soul. Let us also assume it would be in the patient's best interests to take EHC. This is perhaps the most realistic version of this scenario. In such a case, George would not be acting in accordance with the core values of the profession in refusing to make the supply. Instead, George would be placing his personal values above those of the profession. He could not claim with any sincerity that he was assessing what the core values of the profession really meant and how they should be applied in these circumstances. So by my argument George could not justifiably use the conscience clause in this case.

Allowing conscientious refusals for *any* moral or religious reason is, I have argued, a mistake. Professional integrity is important in a self-reflective, values-based profession. Allowing a pharmacist to deviate from the standard that has been agreed by the profession is only justifiable when the non-compliance is the result of honest

disagreement of how the profession's values should be applied. In contrast, it should not be acceptable to deviate from standard practice by appeal to external, potentially unsubstantiated moral or religious beliefs that are not endorsed by the profession.

THE CONSCIENCE CLAUSE

So far, the discussion has centred on the importance of integrity and how a profession's core values should be compatible with a professional's actions. One of the key objections to conscientious refusals is that a patient may be denied a treatment or service that she would normally be entitled to receive. In order to overcome this problem, the pharmacy profession adopts a compromise model of the conscience clause. In theory, this allows a pharmacist to preserve her integrity while the profession fulfils its role as a service provider. In the first part of this section I outline Brock's defence of the compromise position against the charge that professionals are not fulfilling their duties when they refuse to provide treatments or services.[37] In the second part I argue that, since one of the key factors in the compromise model I have argued for is dependent on particular circumstances, blanket refusals are not acceptable.

[37] D. W. Brock. *op cit.* note 10.

The conventional compromise

The conscience clause of the GPhC's Guidance and Ethical Standards offers a compromise, which is that the profession provides the services it is obliged to provide while also allowing individual professionals to refuse to make the supply themselves. A similar model of a compromise has been proposed by Brock, and is termed the 'conventional compromise.' It has three components: 1) the professional informs the patient about the relevant service or treatment; 2) the professional refers the patient to someone who can provide that service or treatment; 3) the referral does not put unreasonable burden on the patient.[38] The term 'unreasonable burden' is vague but its assessment might include consideration of financial or psychological burdens and inconveniences. The availability of a service or treatment is relative to the patient and her circumstances, so that someone who was, for example, without transport or in distress and vulnerable, may be considered unable to easily access the treatment from an alternative source. Such considerations and qualifications require further exploration elsewhere.

Incompatibility thesis

[38] *Ibid*.

Critics of conscientious refusals sometimes claim the incompatibility thesis, which is that to refuse to supply a treatment or service promised by the professional body is to fail to meet one's professional obligations.[39] The incompatibility thesis can be broken down into the obligations of the professional body and the obligations of the individual professional. The incompatibility thesis applies to the profession as a whole since it carries an obligation to supply EHC, and it would be failing as a profession if EHC was not actually available to patients. The incompatibility thesis does not apply to individuals, since in refusing to supply EHC and directing the patient elsewhere, that individual pharmacist has not prevented the profession from fulfilling the obligation to supply EHC.[40] Under the conditions of the conventional compromise, the pharmacist would have to redirect the patient to a compliant pharmacist who was reasonably accessible to that patient.

Moral responsibility

Conscience clauses may be criticised for failing in their primary aim, which is to allow the professional to have a clear conscience.[41] One of the ways in which a conscience clause is usually thought to

[39] Savulescu., *op. cit*. note 15.

[40] Brock, op. cit. note 10, 193.

[41] Wicclair. *op cit.* note 14.

preserve integrity is in allowing the individual to distance herself from wrongdoing and have a clear conscience that, whatever supposedly immoral action eventually occurs, she is not responsible for it. However, under current guidelines, the objecting pharmacist cannot evade participation entirely, given that the profession adopts a policy that conscientiously objecting pharmacists are obliged to direct the patient to another source of EHC. Re-directing a patient to another pharmacist who is prepared to supply EHC is to be complicit to some extent in making the supply. If acting with integrity requires not participating in wrongdoing (at the least as perceived by the individual pharmacist), then it looks like the GPhC guidelines fall short of protecting integrity.

Take for example Sarah, a pharmacist who refuses supply of EHC but directs the patient to another pharmacist who makes the supply. Sarah's actions are not sufficient for the patient to take EHC (i.e. re-directing does not guarantee that EHC will eventually be taken, and other agents are necessarily involved), but her involvement was necessary in this particular series of events for the patient to take EHC. As such, Sarah cannot evade responsibility entirely. However, this is not as problematic as it initially appears. First, it may be that doing what is instructed or requested of you, but not what you have singularly decided upon, or that re-directing the patient elsewhere, is

to have 'diluted' responsibility for the action.[42] Dilution of responsibility may reduce culpability sufficiently that the pharmacist correctly perceives that she has not committed any wrong-doing, even by her own standards.[43]

The second reason for thinking a pharmacist can preserve her integrity when she re-directs the patient is that the conscience clause policy is by its very nature a compromise, which for the pharmacist means a *moral* compromise. It has been suggested that moral compromise can be compatible with moral integrity because it can be a fulfilment of a deeper level of responsibility, which is to meet commitments to others.[44] Although Sarah believes that to supply EHC is to misapply one of the core values of the profession, she acknowledges that her view is not an established one among her peers. She may think, for example, that supplying EHC is not in the patient's best interests when the principle 'make patients your first concern' is properly understood. She may think it is time for the profession to re-assess its understanding of best interests, and indeed she may voice those views to her peers. However, she

[42] For further discussion of this see G. Mellema. Shared Responsibility and Ethical Dilutionism. *Australas J Philos* 1985; 63, 2: 177-187.

[43] Empirical evidence shows that in some cases pharmacists who refuse to supply EHC over the counter will supply EHC if it has been prescribed by a doctor because they feel less responsible. Cooper; Bissell & Wingfield., *op cit.* note 8.

[44] See B. J. Winslow & G. R. Winslow. Integrity and Compromise in Nursing Ethics. *J Med Philos.* 1991; 16 (3) 307- 323. and J. D. Goodstein. Moral compromise and personal integrity: exploring the ethical issues of deciding together in organizations. *Bus Ethics Q.* 2000; 10; 4: 805-819.

recognises that her opinion is in the minority, and she holds a higher value, which is to not stand in the way of patients accessing services the profession has agreed to provide.

Thus for many pharmacists, it is quite possible that re-direction would be a compromise they would and should be content with, since they would have diluted their responsibility without depriving the patient of the service they have a duty to help provide to some extent. It is also worth noting that in the report of the GPhC's consultation, the issue of responsibility did not arise. The only objection to the inclusion of a conscience clause was its incompatibility with the principles of the RPSGB's code of ethics (which are now in the GPhC's Ethical Standards).

In light of the discussion so far I suggest that the current compromise model is sound. I suggest that ideally there would be an additional condition, which is that refusals must be based on the core values of the profession. However, I accept the substantial practical and epistemic problems in identifying, defining and describing these values. In the final subsection I will show that it follows that pharmacists cannot legitimately claim a blanket refusal to provide a service, even if that service is easily available elsewhere.

Against categorical refusals

Discussions surrounding whether and how a conscientious objection should feature in the ethical standards of the GPhC has included the suggestion that pharmacists should display a notice in their pharmacies.[45] I am working on the presumption that the suggestion is that this notice would inform patients of the pharmacist's objection to supply EHC. The implication of this would be that a pharmacist could make a categorical refusal. Indeed, there is nothing stated in the current policy to suggest that a pharmacist cannot make a blanket refusal, as long as the pharmacist refers the patient to an alternative source that is accessible within the timeframe required for EHC to be effective. The point I make here is very straightforward but important given the GPhC's deliberations over policy on this issue. My claim is simply that the set of justifiable conditions for a conscientious refusal are circumstantial and, as such, pharmacists should not be permitted to refuse a service or treatment without proper consideration of the circumstances of each case.

Pharmacists who refuse to supply EHC over the counter fall into three categories: those who always supply (provided the standard clinical conditions are met); those who sometimes supply, depending on the situation; and those who never supply.[46] By my argument, categorical refusal is not justified. It is possible that for every case presented to a certain pharmacist, the pharmacist meets each

[45] General Pharmaceutical Council., *op. cit.* note 1.

[46] Cooper; Bissell & Wingfield., *op. cit*. note 8.

condition of the conventional compromise. By that I mean it is possible that in all cases the pharmacist has an objection, this objection does not contradict the core values of the profession, and the patient can be re-directed to an alternative source without taking on an unreasonable burden. However, it is not *necessarily* the case that all these conditions will be met. For example, it is not necessarily the case that the patient will be able to find an alternative source of the service without undergoing significant inconvenience or distress. Given this, it is unjustifiable for a pharmacist to hold a categorical refusal with no capacity to accommodate situations in which a patient would be unreasonably burdened by the refusal, or would for some reason be unable to easily access the service elsewhere.

CONCLUSIONS

Pharmacy as a profession holds a set of obligations towards its patients. The professional body must ensure that the individuals making up the profession fulfil those obligations wherever possible, and that the profession as a whole fulfils its obligations. In a values-based profession, moral integrity is of great importance; it can be instrumental in bringing about good action and it is precious to the moral agent. For these reasons, integrity should be protected by a conscience clause where reasonable. Current policy for pharmacy

practice in Great Britain accepts refusals for *any* moral or religious reason. I have made the case that conscientious objections are only valid if they are based on values that do not contradict the core values of the profession. I accept the difficulties in determining what these values are, how they should be interpreted and how such a policy would be enforced.

The GPhC's policy states the patient must be the pharmacist's first concern, but it is not clear what this means. I would suggest that when the policy is reviewed by the profession the GPhC considers stating explicitly that patients should not be put under unreasonable burden by a conscientious refusal. I have also made the case that categorical refusals by pharmacists are not acceptable. There may well be circumstances in which a refusal would cause unreasonable burden on the patient, so each request for EHC should be assessed on a case-by-case basis.

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