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Ethical decision-making, passivity and pharmacy

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ABSTRACT

Background: Increasing interest in empirical ethics has enhanced understanding of healthcare professionals' ethical problems and attendant decision-making. A four-stage decision-making model involving ethical attention, reasoning, intention and action offers further insights into how more than reasoning alone may contribute to decision-making.

Aims: To explore how the four-stage model can increase understanding of decision-making in healthcare and describe the decision-making of an under-researched professional group.

Methods: 23 purposively sampled UK community pharmacists were asked, in semi-structured interviews, to describe ethical problems in their work and how they were resolved. Framework analysis of transcribed interviews utilised the four decision-making stages, together with constant comparative methods and deviant-case analysis.

Results: Pharmacists were often inattentive and constructed problems in legal terms. Ethical reasoning was limited, but examples of appeals to consequences, the golden rule, religious faith and common-sense experience emerged. Ethical intention was compromised by frequent concern about legal prosecution. Ethical inaction was common, typified by pharmacists' failure to report healthcare professionals' bad practices, and ethical passivity emerged to describe these negative examples of the four decision-making stages. Pharmacists occasionally described more ethically active decision-making, but this often involved ethical uncertainty.

Discussion: The four decision-making stages are a useful tool in considering how healthcare professionals try to resolve ethical problems in practice. They reveal processes often ignored in normative theories, and their recognition and the emergence of ethical passivity indicates the complexity of decision-making in practice. Ethical passivity may be deleterious to patients' welfare, and concerns emerge about improving pharmacists' ethical training and promoting ethical awareness and responsibility.

Individuals working within healthcare face ever more ethical problems and although normative ethical theories offer guidance as to how such ethical problems should be resolved, in practice ethical decision-making may be a complex, variable and difficult process. This disjuncture between normative ethical ideals and the reality of healthcare practice has led to concerns regarding the relevance of normative approaches¹ and there has been a burgeoning interest in empirical ethics, which offers increased understanding of the ethical problems encountered by individuals in healthcare and attendant

decision-making.² In contrast to normative theories that champion reasoning alone, empirical insights recognise how difficult ethical decision-making can be in practice, and this is no more evident than in the development of ethical decision-making models that recognise several distinct stages of decision-making in practice. Various decision-making models have been proposed,³ often in a business ethics context and originally serving positivistic aims of explaining and predicting behaviour,⁴ but these have been argued to be relevant to healthcare ethics.⁵ A central feature of many models is a four-stage process of decision-making that was originally proposed by Rest,⁶ involving ethical reasoning and also recognising an ethical problem, intending to act ethically and overcoming self-interest and, finally, acting ethically and implementing what one has decided is the ethically correct decision (figure 1).

Here we present the findings of a study in which these four stages were used to explore how a sample of UK community pharmacists made ethical decisions. Pharmacists were chosen because they have been relatively under-researched in relation to ethics⁷ and also because their ethical reasoning and understanding may be relatively limited⁸ and legalistic⁹ and may be particularly suited to empirical decision-making models that admit of more than reasoning alone. Previous empirical research has framed pharmacists' reasoning in terms of ethical theory such as the four principles of bioethics, but only scant¹⁰ or inferential¹¹ evidence of such normatively informed reasoning emerged. The four-stage model originally developed by Rest was also informed by normative theory—cognitive moral development—but this research follows the approach used by Holm,⁵ in rejecting any definitive normative theory but being informed by the four stages conceptually. The aim was to use the four-stage model to sensitise the question guides for, and the subsequent analysis of, pharmacists' interviews about ethical problems and their resolution, while maintaining an interpretative methodology that valued the possible complexity and variation in actual ethical practice.

It will be argued from the results of the study, however, that pharmacists could more often be described in terms of omissions or deficiencies in the four stages, and the term *ethical passivity* is developed, to describe pharmacists who were ethically inattentive, who displayed limited forms of reasoning, prioritised legalistic self-interest and could not act. Such passivity is argued to be inimical to healthcare practice and may be detrimental both to the welfare of patients and for pharmacy.

Figure 1 Stages of decision-making.

Ethical attention → Ethical reasoning → Ethical intention → Ethical action

METHODS

As part of a larger study concerned with ethical problems, decision-making and the influence of the community pharmacy environment, semi-structured qualitative interviews were used, to allow pharmacists to describe, in their own words, ethical problems and how they tried to resolve them. This method also permitted the researcher to clarify responses and to prompt pharmacists about particular areas of pharmacy practice and encourage them to explore their decision-making. This was underpinned methodologically by an interpretative approach that valued pharmacists' construction of ethical problems and their decision-making, and also the role of the researcher in interpreting and shaping this construction. As such, the use of the four stages represented a loose analytical framework and was not considered definitive.⁵ An interview guide was developed that included questions such as

- ▶ "Could you describe an ethical issue in your work?"
- ▶ "What were the relevant features that made it ethical?"
- ▶ "How did you try to resolve the ethical issue?"

Twenty-three UK pharmacists were recruited from two counties in northern England, through a combination of contacts of the researcher, opportunistic approaches and purposive sampling to obtain representation in terms of age, gender, ethnicity and employment status. The sample size was also determined by theoretical saturation being reached when no further themes emerged from interviews. Relevant ethics committee approval was obtained for this study from the University of Nottingham School of Pharmacy. Non-participation was common, and reasons cited for it included not being able to recall an ethical problem or being too busy at work. All but three pharmacists agreed to interviews being recorded, and these were then fully transcribed. In the non-recorded interviews, extensive notes were taken, and interviews averaged 50 min in duration. Framework analysis of transcribed interviews was undertaken using the four stages of decision-making, together with the constant comparative process. All emergent themes were coded and deviant-case analysis was also undertaken to inform further samples. Pseudonyms are used to protect anonymity.

RESULTS

Even before framework analysis of interviews was undertaken, it was apparent that pharmacists seemed to be unused to, and uncomfortable with, talking about ethical problems and decision-making. Analysis of interviews using the four stages revealed that the responses of many pharmacists could be considered negatively, in terms of omissions or inadequacies of the four decision-making stages. Occasional examples did emerge of pharmacists who appeared to be describing a particular stage of decision-making, but this was seldom accompanied by a sustained decision-making process involving all four stages. Each of the four stages is now considered in turn and examples are provided of where pharmacists did not appear to use the stages of decision-making. Counter-examples are indicated, where appropriate, of pharmacists who did appear to use a stage of decision-making.

Ethical attention

Pharmacists described a number of what they perceived to be ethical problems in their work, although these seldom involved rival value conflicts and were frequently procedural or legal conflicts, originating in the routine minutiae of community pharmacy practice; they are reported elsewhere.⁹ It was

apparent that many pharmacists found it very difficult to recall ethical issues in their work, and this combination of a legalistic and procedural construction of problems, coupled with a marked inability to identify and recount ethical problems, led to many interviews being difficult to conduct, because it was difficult to elicit pharmacists' examples and reasoning about ethical problem. This inability to identify ethical issues or ethically relevant aspects of problems led to the emergence of ethical inattention as an appropriate description of many pharmacists and was the first indication of ethical passivity. Paradoxically, such inattention did not prevent some pharmacists claiming to be ethically confident, despite not recognising ethical problems:

Pharmacist: You don't realise that it's an ethical issue that you're dealing with and you just deal with it everyday, yea. So, yea, I think that was it...

Interviewer: Do you think you're doing things correctly, in an ethical way? ...

Pharmacist: Yes, I would say that I was dealing with them ethically.

Interviewer: Even though you might not perhaps be aware of them?

Pharmacist: That's right, yea

In contrast, a minority of pharmacists described ethical problems more readily and in more detail, but such pharmacists also described an attendant ethical doubt and uncertainty. Being able to see what was ethical did not lead to ethical confidence for such pharmacists, and they described not knowing what to do and, like many pharmacists in this study, often referred to the threat of prosecution or disciplinary action.

It was apparent that interviews offered pharmacists an opportunity—and for some the first ever opportunity—to consider and discuss what might be ethical. This post hoc reconstruction of ethical events and details appeared to indicate that little reflection on ethical decision-making and problems had occurred in practice for many, as one pharmacist conceded about ethical issues:

In fact there's probably loads but until you actually sit and think about them.

Ethical reasoning

Pharmacists were asked about their reasoning and justification for decisions, and it was apparent that again, as when trying to describe ethical problems, many found this a very difficult task; it seemed that this was something they had not done before. There was a lack of articulacy about value concepts, but analysis of interviews did reveal several broad areas of reasoning, and examples of appeals to consequences, the golden rule, common-sense experience and religion emerged. Pharmacists were also asked if their training or ethical codes were influential or helpful, but these were summarily dismissed by almost all pharmacists as being of little value in their work.

Appeals to the consequences of an action were the most frequently identified reasoning, but such justification was often limited; pharmacists did not, for example, include a comprehensive assessment of consequences for other possible individuals and it was frequently only the patient who was considered. It was also apparent that the value of utility referred to in relation to consequences was often the "best interests" of the patient—a legal term that pharmacists could not explain further. The golden rule was also used as a form of

ethical reasoning by several pharmacists and involved them reflecting upon their decisions in terms of how they or their relatives would feel if they were the recipient of the decision. This was typified by one pharmacist, when explaining why he helped a patient who was being prevented from speaking to her doctor by the surgery:

... how would you feel if that was your mother, father, being treated like that? And that's the way I try and think of it, what service would you want? ... How would you feel and how would you want to be treated ... I'm not saying I'd break the law or bend rules, you know what I mean, but always try to take their [point of view ...]

This quote also indicates the tension between legal and ethical considerations and that, for almost all the pharmacists, a legal consideration was usually important, too.

The role of experience and common sense appeared to be significant for many pharmacists in explaining how ethical decisions were made. This was valued above undergraduate ethics training or the code of ethics but, unfortunately, there was a marked difficulty in further explaining or exploring this experiential approach, as Sharon noted:

It's difficult because with ethics, I feel it's something that you learn in your job—you don't really learn it at university. You can be given all these things, all these scenarios, but really you need to put them into actual practice and then you sort of use your gut instinct.

Religion also appeared to be important in the reasoning and justification of a minority of pharmacists, although others argued that religious faith was not relevant to pharmacy work. What was striking in the case of those who used religious justification was the unconditional nature of such reasoning, to the exclusion of other factors, and as Christopher explained:

Every kind of moral or ethic that I'm faced with, ultimately, comes back to my Christian experience and I'd measure it against my Christian value—whatever it was.

The sale of emergency hormonal contraception (EHC) was especially problematic for such pharmacists, and it was religion that underpinned their decisions not to sell such medicines and led to their belief that it was a form of abortion. However, as will be seen in discussion of the fourth stage, ethical passivity due to a sense of subordination led such pharmacists to continue dispensing EHC, because a doctor was considered superior and ultimately responsible.

Other forms of reasoning did emerge, although these were infrequent and included implicit appeals to autonomy, although pharmacists never used the actual word. Pharmacy customers were often cited, and several pharmacists argued that they should not be prevented from purchasing medicines and pharmacists were resigned to merely giving advice or warnings. However, when appeals to autonomy were made, they did not appear to involve any balancing with rival values or principles.

Three pharmacists referred to the broader social background of patients, and their reasoning involved relatively detailed narratives of patients and customers; but among the sample in this study, such sensitivity and attention to the wider context of ethical decision-making were rare.

Ethical intention

The third stage of empirical decision-making involves intending to act, and overcoming concerns such as self-interest. However,

what was striking among almost all the pharmacists interviewed was concern about legal prosecution or disciplinary action in relation to how an ethical problem should be dealt with, as Sharon illustrated:

I do try and look after the patient's best interests but I won't put my certificate on the line. I won't do anything that the law says that I shouldn't be doing, you know what I mean? ... More covering myself, yea, rather than looking after the patient. That's terrible. It's not terrible but it's looking after myself.

In this stage, it was apparent that pharmacists had identified an ethical problem or a value therein but had prioritised their own interests and, in particular, the threat of legal prosecution or disciplinary action. While this was a common concern for pharmacists, occasional examples of ethics trumping law were mentioned, and in one example a pharmacist argued that a doctor's genuine mistake in prescription writing should not mean denying patients necessary medicines.

Ethical action

The final, empirical decision-making stage involves acting upon what one has decided, and it emerged that many pharmacists were unable at times to do what they believed they should do and that when this happened they simply did nothing or allowed supervening acts or the intervention of others to resolve the situation. An example of this was pharmacists' observations of what they believed to be unacceptable standards or practices of other healthcare professionals—doctors, nurses and pharmacists. When prompted, the pharmacists admitted that they should have done something but did nothing and, furthermore, often recognised that their inaction might have perpetuated the problem and even could have resulted in harm. Specific examples included not challenging a local doctor's repeated prescribing of medicines that could interact dangerously, not fully reporting suspected sexual harassment, not reporting a nurse who was suspected of being under the influence of alcohol while working and, in the following example, not offering assistance to a police enquiry that involved an appeal for information about a criminal suspect who was known to the pharmacist as a patient:

I think eventually they caught him anyway so I didn't actually have to do that [identify the patient]. It was very convenient in the end, yes, but I did sweat on it for a week or two. So in a way I suppose that was shirking my responsibilities. Was that ethical? I don't know.

Pharmacists' ethical passivity was also apparent in allowing others to resolve ethical situations: in the above example of a nurse suspected of consuming alcohol at work the pharmacist admitted that her inability to act meant that the nurse continued to work and posed a possible threat to patients' safety, and that it was only the intervention of another nurse that brought the situation to light. As noted earlier, the example of EHC and pharmacists' apparent subordination to doctors also indicated ethical passivity, as pharmacists admitted avoiding the need to confront an ethical problem—dispensing EHC—by shifting ethical responsibility to the prescribing doctor, as when Christopher claimed:

I'm just a tool of the doctor really. I'm not happy with it, I'm passing the buck and not accepting the responsibility that I should be taking.

DISCUSSION

Considering community pharmacists' ethical decision-making in terms of four distinct stages was intended to reveal how variable and complex decision-making approaches may be in healthcare. However, the emergence of predominantly negative examples of decision-making and the emergence of ethical passivity gives a rather bleak account of the pharmacists sampled. Before considering the implications of such passivity for pharmacists and healthcare, several possible concerns must be addressed. First, it may be argued that instead of describing pharmacists' attempts at decision-making as being merely sensitised by the four stages, the research invited direct comparison. This appears to have elevated the four stages to more than a loose analytical framework and to represent another example of pharmacists' ethical experiences being compared with theory. Addressing this concern, it is argued that the four stages are relatively uncontested as regards their significance and that, furthermore, the research was sensitive to other possible strategies but that little emerged from the interviews. However, it was also in comparing the occasional examples of some pharmacists' more active ethical approach with the predominantly negative examples that our awareness of passivity emerged, since, although such instances were rare and inconsistent, some pharmacists were at times ethically attentive, overcame a fear of prosecution and acted decisively. Hence, our emerging awareness of the ethical passivity among pharmacists was at least in part a result of comparing pharmacists' responses, rather than of appealing to an objective standard.

It is argued, however, that the four stages are relevant and may be of value in considering how healthcare professionals try to resolve ethical problems in practice. Despite being either ignored or implied in the normative literature, ethical attention, for example, has been argued to be significant as a step towards ethical reasoning and also to be intrinsically valuable.¹² For Murdoch,¹³ ethical attention was not an isolated act, but rather an attribute that allowed individuals to avoid difficult instantiations of ethical choice. She distinguished between attention and merely looking (echoing Merleau-Ponty's use of the term *bemerken* or simply noticing indiscriminately),¹⁴ and this typified many pharmacists, who could recall situations that were undoubtedly difficult but framed such problems, not in terms of ethics or values, but of practical, legal or procedural details. However, pharmacists who were more ethically attentive could not avoid difficulty and uncertainty in their decision-making, in contrast to Murdoch's claim; this may be because the interview process revealed only isolated instantiations of attention and also because even attentive pharmacists were still influenced by legal concerns and lacked sustained and consistent reasoning. Furthermore, remaining open to the type of reasoning also revealed insights that have been seldom explored in the normative literature, and this was no more apparent than in the case of the golden rule. Although often considered a basic form of reasoning, its simplicity appeared to be a strength and it was employed by several pharmacists. Ethical intention has also been argued to be a relevant concern; Maitland,¹⁵ for example, considers self-interest to be of relevance in practice, but the manifestation of intention as self-interested concern about *legal prosecution* is especially relevant. The jurisprudential literature has often concentrated upon the influence of ethics upon law, and philosophers usually acknowledge the primacy of ethics; but, in practice, laws affect all healthcare professionals and can lead to ethical and legal conflicts for them.¹⁶ Including an ethical intention stage

highlights this conflict and offers further insights into the practical difficulty of decision-making.

Ethical passivity does more than offer a bleak account of pharmacists' limited attempts to try to resolve ethical problems in their work: it may also be detrimental to patients. In particular, the fourth stage of ethical inaction revealed that pharmacists' inaction, by their own admission, could possibly lead to harm. In the aftermath of incidents such as the Shipman affair (in which suspicions about a general practitioner who killed many of his patients were ignored or not followed up) in the UK and increased awareness of the need to report concerns,¹⁷ it is clear that the inability of healthcare professionals to act upon what they know to be professionally and ethically wrong because of ethical passivity could lead to harm to patients. Furthermore, pharmacists' lack of ethical awareness could result in their neither appreciating the ethical significance of healthcare situations nor recognising even the needs of patients in terms of values. Ethical passivity also appeared to allow pharmacists to avoid ethical responsibility, and although there may be occasions when someone more appropriate should deal with a problem, many problems of healthcare ethics must be resolved by individual practitioners. Gilligan¹⁸ used the image of passivity to illustrate abdication of ethical responsibility but argued that such passivity and inactivity might delay and also worsen eventual "confrontations with choice". It is argued that ethical passivity applied to healthcare could make problems in practice even worse, to the potential detriment of patients, if unethical or unprofessional practices continued or if patients' ethical values were not recognised and respected.

Before we conclude, two study limitations must be addressed. First, despite purposive sampling, these findings cannot necessarily be generalised to other pharmacists or healthcare professionals, although the empirical ethics literature does contain descriptions of healthcare professionals—and especially nurses—who appear to exhibit a similarly passive approach. Deans¹⁹ described a sample of UK pharmacists as "not facing up to problems or acting primarily from fear of disciplinary procedures". In the nursing literature, Wurzbach²⁰ noted that nurses avoided ethical confrontation, and Omery (in a study reported by Holm⁵) identified "accommodating" nurses who could be characterised by avoidance and legalism. It may be no coincidence that the emergence of such passive approaches to ethical problems occurs in healthcare professions that have been regarded as being subordinate,²¹ but further research may be needed to explore this in relation to ethical responsibility. Second, it is recognised that ethical passivity emerged in relation to the problems that pharmacists described and it remains a possibility that pharmacists might have used different decision-making if given more dramatic hypothetical vignettes. Hence, while it is argued that how healthcare professionals try to resolve the problems they actually encounter is important in understanding what occurs in practice, further research using the four stages of decision-making and hypothetical scenarios may yield further insights.

CONCLUSIONS

The use of an empirical model of decision-making offers the possibility of exploring and describing more contextually how healthcare professionals try to make ethical decisions in practice, while being sensitive to the difficulty of such decision-making. The emergence of ethical passivity presents a formidable challenge for pharmacists and the pharmacy profession, raising questions about how ethics and values can be effectively taught, communicated and applied in pharmacy

practice, to avoid ethical passivity. Further research may be necessary in other professions to explore the four stages and consider whether ethical passivity occurs.

Competing interests: None.

REFERENCES

1. **Hoffmaster B.** Can ethnography save the life of medical ethics? *Soc Sci Med* 1992;**35**:1421–31.
2. **Hurst SA**, Hull SC, DuVal G, *et al.* How physicians face ethical difficulties: a qualitative analysis. *J Med Ethics* 2005;**31**:7–14.
3. **Jones TM.** Ethical decision making by individuals in organisations: an issue-contingent model. *Acad Manage Rev* 1991;**16**:366–95.
4. **Loe TW**, Ferrell L, Mansfield P. A review of empirical studies assessing ethical decision making in business. *J Bus Ethics* 2000;**25**:185–204.
5. **Holm S.** *Ethical problems in clinical practice: the ethical reasoning of health care professionals.* Manchester: Manchester University Press, 1997.
6. **Rest J.** *Moral development: advances in research and theory.* New York: Praeger Publishers, 1986.
7. **Cooper RJ**, Bissell P, Wingfield J. A new prescription for empirical pharmacy ethics: a critical review of the literature. *J Med Ethics* 2007;**33**:82–6.
8. **Latif D.** Ethical cognition and selection-socialization. *J Bus Ethics* 2000;**25**:343–57.
9. **Cooper RJ**, Bissell P, Wingfield J. Dilemmas in dispensing, problems in practice? Ethical issues and law in UK community pharmacy. *Clin Ethics* 2007;**2**:103–8.
10. **Chaar B**, Brien J, Krass I. Professional ethics in pharmacy: the Australian experience. *International Journal of Pharmacy Practice* 2005;**13**:195–204.
11. **Hibbert D**, Rees JA, Smith I. Ethical awareness of community pharmacists. *International Journal of Pharmacy Practice* 2000;**8**:82–7.
12. **Blum L.** Moral perception and particularity. *Ethics* 1991;**1**:701–25.
13. **Murdoch I.** *The sovereignty of good.* London: Routledge, 1970.
14. **Merleau-Ponty M.** *Phenomenology of perception.* London: Routledge, 2002.
15. **Maitland I.** The human face of self-interest. *J Bus Ethics* 2002;**38**:3–17.
16. **Kalvemark S**, Hoglund AT, Hansson MG, *et al.* Living with conflicts—ethical dilemmas and moral distress in the health care system. *Soc Sci Med* 2004;**58**:1075–84.
17. **Department of Health.** *Safeguarding patients: the Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam inquiries.* London: Stationery Office, 2007.
18. **Gilligan C.** *In a different voice.* Cambridge, Massachusetts: Harvard University Press, 1993:143.
19. **Deans Z.** Ethical issues in pharmacy practice as discussed by pharmacists. *International Journal of Pharmacy Practice* 2005;**13**:R95.
20. **Wurzbach ME.** Long-term care nurses' moral convictions. *J Adv Nurs* 1995;**21**:1059–64.
21. **Turner B.** *Medical power and social knowledge.* London: Sage, 1995.

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