Chapter 1

Pharmacy Ethics and the Spirit of Capitalism: A Review of the Literature

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Additional information is available at the end of the chapter

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Abstract

This chapter explores the issue of the conflict (real or potential) between the ethical imperatives that should guide the pharmacist in the typical practicing of the profession (i.e. within a pharmacy) and the economic constraints derived from the business dimension of the pharmacy. Marrying service and business in a single profession, pharmacy is supposed to balance harmoniously its two sides, if not to subject business demands to the higher societal, ethical requirements. However, such a balancing exercise is rather like dancing on a rope, and ethics may be trumped by economics, a phenomenon deplored sometimes by pharmacy academics or hospital pharmacists, and by a part of community pharmacists as well. Economics may prevail over ethics in rough forms such as selling health risk products (as it was in the past for tobacco or alcohol) or in more elusive ones, such as longer work hours and shorter counselling times, promoting or dispensing needless or ineffective products (food supplements, cosmetics, etc.), silently refusing to provide or recommend lower cost generics, etc. Ethical research in the field of pharmacy has generally been scarce, and numerous knowledge gaps remain to be filled by future investigations.

Keywords: pharmacy ethics, capitalism, professional altruism, commercialism, economic constraints, ethical breach

1. Introduction

With rare exceptions, the issue of the conflict (real or potential) between the ethical imperatives that should guide the pharmacist in the typical practicing of the profession (i.e. within a pharmacy) and the economic constraints derived from the economical dimension of the pharmacy has been almost completely ignored in the recent scientific literature, although in the

past, they have been approached to some extent in the Anglo-American literature. The "role tension" or "role ambiguity," as suggestively has been described the conflict between the equally important demands of "professional altruism" and "commercialism" [1], has only faintly been reflected in the scientific publications of the past decades.

When in his seminal paper published in 1957, Ernest Greenwood synthesized and defined the five attributes of a profession, the first characteristic recognized was the authority rooted in an extensive professional education, but he added that "The professional must not use his position of authority to exploit the client for purposes of personal gratification" [2]. Not very different was the view adopted by T. H. Marshall (1963), who viewed the essence of professionalism in a single practitioner with particular abilities and individual responsibility ("which cannot be shifted onto the shoulders of others"), an individual who "is not concerned with self-interest, but with the welfare of the client" [3].

In theory, professions enjoy an extended degree of autonomy and self-regulation, and in exchange they are assumed to place the community needs above their own interests. In fact, there is widespread perception of a disjuncture between theory and factual reality: self-interest is often perceived as being satisfied ahead of the societal needs [4]. Broad studies across professions however, using rigorous methodologies, are lacking and many questions have only been partially answered if at all. Is this situation the same for all professions or are there differences among various occupations? Is this situation the same in different geographic regions and cultures, or are there differences among different countries and traditions? It is known that ethical decisions are influenced by cultural and value differences [5], and despite the levelling tendencies of the globalization, it is doubtful that in the field of pharmacy, ethical expectations and actions are now uniform across borders. The potential ethical conflict between the professional side and business side of pharmacy has been repeatedly asserted in the ethical literature, but its ways of expression, extent and facilitating variables seem to have been rarely investigated in depth. In this chapter, we will explore how this potential conflict between societal needs and economic self-interest is reflected in the ethical literature, based on theoretical considerations or empirical research.

2. Pharmacy: the double face of Janus

The dual character of pharmacy has been perceived and discussed in the scientific and professional literature for more than 100 years, at the beginning of the twentieth century being argued that an absolute divorce between the two sides (commercial and professional) was impossible [6]. Pharmacy has been described as presenting "a unique combination of professional and commercial elements" [7]. In 1943, A. Weinlein in an unpublished MA thesis on the pharmacy as a profession in Wisconsin made similar statements on the dual nature of pharmacy [8].

Pharmacy is a service profession, but it also has a business dimension, especially due to the fact that particular health goods (medicines, cosmetics, medical devices, etc.) are dispensed to patients and money change hands in this process. Business is traditionally seen as apt for those

focused on financial gains, whereas service professions are seen as apt for those valuing altruism and service to others. Moreover, business and service professions are seen as competitive and in a direct conflict [9]. Authorities themselves have looked at pharmacists as professionals in some contexts while "reducing them to a mercantile level" in others [10]. The opposition between the two has been concentrated by E.C. Hughes (1958) in two short Latin phrases: *caveat emptor* (let the buyer—by extension, consumer—beware) and *credat emptor* (let the buyer trust) [9].

The eclectic nature of pharmacy (as "half business, half profession") has been rejected at least at times by pharmacy academics that have increasingly seen themselves and their graduates as "militant upholders of complete professionalization" [11]. The active lexical transitioning from "retail pharmacy" to "community pharmacy" has been viewed by others as the expression of the profession's own awareness of a strain between the business side and the healthcare side of pharmacy [12].

Dessing and Flameling have argued that universal ethical principles apply to both business persons and professional practitioners (care providers) [13] (and thus the distinction between the two sides would be irrelevant), but their proposition is more "what ought be" rather than "what is," and there are data indicating that a discrepancy between values and facts may in fact exist, despite the fact that a business ethics has been recognized and developed in the past decades [14].

3. Is pharmacy a quasi-profession?

The business dimension of pharmacy has often led to questioning its sociological status as a profession, being sometimes relegated to that of a *quasi-profession*, *incomplete* or a *marginal* one [15]. The profession status has been won based on the social role of the pharmacist in procurement, preparation and assessment of drugs, a role which has gradually vanished with the rise of the modern pharmaceutical industry and the occurrence of the premixed and prepackaged medicines [4, 16, 17]. This change has been described as a loss of the compounding function that relegated the pharmacy to the status of "another link in the chain of distribution" for the new healthcare industry [18].

In the new context, the community pharmacy setting (the "retail pharmacy") has been said to encapsulate "the most non-professional aspects of the profession" (unlike hospital pharmacy, for instance) [15].

As a first argument, the ignoring of the "no advertising" rule has been invoked in the United States where it rarely seems to be applied [15]. This rule, already expressed by Greenwood, refers to the fact that professions discourage advertising [2], because allowing it would undermine the professional authority, entrusting the client with critical abilities in selecting competing professionals, as if the client would be able to judge the quality of a professional service [15]. As a second argument, the subordination of the professional goals to personal ones (noncommitment to altruistic values and goals) was cited by Denzin and Mettlin as a fact

[15], although the contrary vision is usually held by the profession (in line with the ethics codes adopted by it [17]). A third argument advanced for the marginality of pharmacy profession is the acceptance by pharmacists to sell (non-professional items and objects) [15], pursuing a profit rather than perceiving a fee. Additional arguments against a full professional status of pharmacy (community pharmacy in particular) have been derived from the absence of a body of knowledge to be gained by socialization and the absence of a unified organization controlling its members, presumably because of the large heterogeneity of the profession manifested by an increased number of subspecializations [15].

The arguments of Denzin and Mettlin against the incomplete status of the pharmacy profession have been in 1995 refuted by Dingwall and Wilson, who argued that applying them to other professions such as medicine or law (and for some arguments even most other professions), the results would be largely similar [19].

In the United States, in the past, a prevalence of the business spirit over the professional role of pharmacists has been implied from the lack of involvement in purely professional associations [11]. In the majority, if not all European countries, though, this aspect is irrelevant, because according to law, practicing pharmacists have to belong to a professional organization [20].

The "noble profession of medicine," often perceived as one of the most disinterested and altruistic of human occupations, one ignoring mercantile considerations with a quasi-Olympian serenity, has been shown to be in a situation not very different from pharmacy with respect to the conflict between its institutional role and economic pressures, professionalism "giving way to entrepreneurialism" [21]. And a century earlier, Shrady deplored "the growth of commercialism in medicine" [22]. But even in 1922, Fischelis argued that physicians do bookkeeping, although they do not call it "commercial medicine" or lawyers in their practice do have business administration activities, without getting a "commercial" label [23].

There are authors who deny the existence of a sharp distinction between (health) professions and businesses, arguing that there is ethics in modern business on the one hand and that professionals are not wholly altruistic, on the other [24]. Furthermore, it may be argued (as one owner pharmacist from the United Kingdom affirmed) that an ethical decision may often be in the same time a good commercial decision in the long run, even when looked in isolation the pharmacist may seem to lose commercially, because patients will get to know and appreciate the honesty of the pharmacist [20].

4. The clash of economics and ethics

The effort of community pharmacists to act with integrity and adhere to the professional standards while acting in a daily business environment has been described as an act of "balancing," but such a balance seems very fragile and often threatened [25]. Reflecting on this balancing exercise between business and ethical requirements, one pharmacist expressed a good knowledge of the ethical theory, as well as of the difficulties to sticking to ethics up to the end: "You're always trying to weigh up the business versus the professional, and obviously

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the professional should take preference…but at the end of the day there's no point being a pauper, is there?" [24]. Vitell et al. [18] reported that 71% of their respondents (US pharmacists) considered that in their industry (pharmacy, pharmaceutical) there are a few unethical practices, whereas 13% judged such practices to be "many," a finding they interpreted that some pharmacists "are becoming more business oriented and less involved with professional activities."

The conflict between economics and ethics has been identified by pharmacy academics who, according to one source, expressed disdain towards the pharmacists from the community setting because they are employed as "graduate grocers" and jeopardize the prestige of the profession by selling cosmetics and a variety of goods that are only distantly related to healthcare if at all [3]. Some hospital pharmacists in the United Kingdom also do not have more respect for the community pharmacists, criticizing their "money grabbing, their lack of concern with professional ethics and the presentation of drugs to patients" [3, 20].

The community pharmacy (owned and operated by one or several pharmacists or large chains of pharmacies) is the setting where the business side of the profession is mostly visible and the inherent conflict between the two sides is manifest, because both pharmacy owners and employees have business-oriented responsibilities (procuring, dispensing/selling a variety of goods, managing staff) and enjoy pecuniary rewards considerably more than in other settings (especially more than in a hospital pharmacy) [9]. This may partially explain why hospital pharmacists seem to be less involved in ethical transgressions than those activating in community settings (in Australia, 1.6% of the pharmacists sanctioned for violations of professional ethics were working in hospitals and 97% in community settings) [26].

Quinney [27] interviewed 80 pharmacists (of whom 20 had been guilty of violating prescription laws or regulations) and found that 94% of the respondents provided positive answers to the following question: "Do you find that the public expects the pharmacist to be both a businessman and a professional man?"

This inner conflict between the professional and business sides of the pharmacy profession may be seen as a form of *sociological ambivalence*, a concept designating a set of norms and counter-norms, or alternating subroles, accompanying specific social positions [28], but redefined along time to describe "contradictory emotions towards the same object" (Weigert, 1991) or "the interface between individual experience and group belonging" [29]. A form of sociological ambivalence is the *ethical ambivalence*, where organizational behaviours, attitudes and norms favoured by the reward system conflict with those in line with the ethical values and judgements of the organizational stakeholders [30].

The existence of a conflict between the ethical imperative and the economic interests or pressures acting on the pharmacist may simply pass unobserved by the pharmacist. It has been reported that many such professionals have difficulties in being able to remember and relate ethical problems, a phenomenon described as "ethical inattention" or "ethical passivity [31]. The level of ethical reasoning of community pharmacists, as measured by the Defining Issues Test P% score, was reported to be lower than that of other health professions (possibly due to a process of selection and socialization), and lower levels of ethical reasoning tend to associate

with lower levels of clinical performance, moral reasoning explaining a significant proportion of the variance associated with the clinical decision-making [4, 32]. However, whether this finding is generalizable to all pharmacists irrespective of place, time, educational background, etc. is doubtful, and more recent data from different countries are necessary to understand if the phenomenon does exist and what may be done in order to increase the level of moral reasoning in practicing pharmacists.

5. When business wins the battle

Contemporary codes of pharmacy ethics promote not only the classical principles of autonomy, non-maleficence, beneficence and justice, but they also tend to acknowledge that allowing business considerations to shape and dominate their demeanour may jeopardize the dignity and wellbeing of the patients [17, 33]. Although ideally ethics should outweigh business, the scarce data available till now indicate that the reverse often does happen, although the regulatory framework, culture, economic environment in which pharmacy is immersed and so on have an important role. Older research into the inherent conflict between the service and business sides of the profession and the service and commercial values reported that pharmacists for whom the business dimension of their occupation was more important than the professional one had a higher likelihood of violating the law regulating the professional activity, a finding related to the probable placing of their own interest ahead of the interests of their patients [9].

In 1854, when the pharmacy profession was still in its youth in the United States, Edward Parrish was stating that "It is mainly by the sale of quack medicines that many druggists subsist, who yet desire a reform in their business, and would be glad to co-operate in the laudable objects of the association" [34]. This illustrates the fact that well-meaning humans, including healthcare professionals and pharmacists, in particular, may have questionable practices for "subsistence."

In Germany, a complex and detailed legal regulatory framework has been (apparently successfully) adopted with the explicit purpose of ensuring that the professional aspects of pharmacy are not shadowed by commercial concerns [35]. Pioch and Schmidt [35] exploring the German pharmacy system reported that pharmacists in that country felt the strain between the "necessary evil" of the commercial side of the profession and the pharmaceutical side, with the majority of respondents (9 of 13, i.e. 69%) expressing a positive bias towards the professional side (this also means that almost one in every three pharmacists feels the bias in the contrary direction, i.e. towards business). In the words of one of the respondents about selling slimming products, "sure I would make some money if I sold it, but I also have an obligation to use my professional expertise to convince the customers that a product may be no good, even though it has been advertised" [35]. On the other hand, some of the German pharmacists (in this paper now more than 15 years old) were recognizing the increasing economic pressures in a new social and economic context, with "no rosy future" and hopes of resisting for 10–15 additional years until retirement [35].

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In Australia, where the ownership of pharmacies remains the monopoly of registered pharmacists [36], a study based on interviews with community pharmacists identified economic pressures exerted over the professional activity of both employed pharmacists and pharmacist owners from community settings (unlike hospital pharmacists). Many of the employed pharmacists told of incidents where their employer (pharmacist owner) pressured them to "sell" or "move" products, whereas young pharmacist owners stated that their leading concern was not the patient's welfare but their obligation to pay back the financial institutions [17]. Financial considerations had such an impact on these latter pharmacists that the wellbeing of the patient was ignored if they perceived a risk of losing business (e.g. dispensing pseudoephedrine to a hypertensive patient) [17]. Moreover, one of the pharmacists described how the gradual increase in the business-side involvement parallels a gradual decrease in the clinical involvement, to a point where selling a product becomes more important than caring for the patient [17].

A pharmacist typology has been described that may be helpful in understanding when economics trump ethics and the other way round, but it is not clear whether this typology is innately determined, acquired or (as is more likely) determined by a mix of innate and acquired characteristics. Data from a small sample (n = 53) of pharmacists from a US middle-sized urban area including professionals from hospital and independent and chain pharmacies, based on sets of questions assessing the business- and professional-role components, identified four types of pharmacists: "business pharmacists" (in whom the business dimension is prevalent), "professional pharmacists" (the service dimension predominates), "dual pharmacists" (both dimensions have equal importance) and "indifferent pharmacists" (none of the two sides is accentuated). However, when exploring different variables potentially correlated with the different types of pharmacists, they found that both altruistic and financial values were of roughly equal importance to "business pharmacists" and "professional pharmacists," concluding that "The portrait of pharmacists torn between conflicting values is heavily overdrawn. There seems to be little support for the mutually exclusive model of service versus money and prestige values" [9]. This study used a very small sample size (with no statistical power calculations) and instruments whose validity is questionable, and thus its relevance for the understanding of the topic is limited. Quinney found a similar typology (16% professional pharmacists, 20% business pharmacists, 45% dual pharmacists and 19% indifferent pharmacists), but unlike the conclusions of Kronus, he found a disproportionate number of "business pharmacists" among the subgroup violating the regulatory framework of prescription dispensing, no "professional pharmacist" among the same subgroup, whereas those with dual or indifference orientation were represented in a lower proportion [27].

Indirect (weak) and mixed evidence regarding the influence of the spirit of capital on the professional ethics may also be obtained from other health professions. It is especially interesting how in countries with low- or middle-income and lax regulations physicians having financial links with pharmacies (such as pharmacies owned by them) tend to prescribe. A study performed in the Philippines found that physicians owning pharmacies did not tend to overprescribe, but persuaded their patients to use their own pharmacies [37]. Instead, in Taiwan, it was reported that clinics lacking on-site pharmacists had less expenditures (with

12–36%) than control sites, indicating that in such contexts physicians tended to prescribe more for financial gains [38]. In Zimbabwe, dispensing doctors (for whom there are pecuniary interests in prescribing) were reported to prescribe more medicines (including antibiotics), inject more patients and spend less time on each patient visit than non-dispensing doctors [39]. Somewhat similar results were seen in the United Kingdom, where it was found that dispensing doctors tended to prescribe more medicines and less generic drugs than the non-dispensing practices [40].

In one study published in 1991, 38% of the respondents considered that ethical standards were lower than one decade ago, whereas only 27% considered ethical standards to be superior. It is interesting to look into the views of the respondents on the most important factors causing standards to be lower or higher. Higher standards were explained by respondents through the progresses in professionalism and education (10%), the improvement of the regulatory framework (8%) and the expanded public awareness and scrutiny (3%); lower standards were explained by most respondents through economic factors: greed and the lust for profit (12%), competition and the general economic context (10%) and pricing (9%) [18]. This indicates that in the opinion of pharmacists, economic pressures are not likely to increase ethical standards, but are in all likelihood to lower them.

6. Ethics in organizational contexts

Independent exercise of the profession and autonomous ethical reasoning by pharmacists may be heavily influenced by the organizational values and objectives, oriented towards ensuring appropriate profits for shareholders [25]. Practicing pharmacy in an organizational setting (as most often does happen in practice) creates an inherent conflict between the two roles played by the pharmacist in this context of "independent professional practitioner and organizational agent" [4].

When a pharmacist is not the owner of the pharmacy in which (s)he practises, the conflict may seem to be between the ethical values of the profession and the requirements of the organization [4]; even in such cases, though, the conflict is most often of an economic nature. The adherence of the pharmacist to the organizational demands is not rooted in the inherent love for the organization but rather in the economic dependence of the pharmacist from it. On the other hand, the organization is most often interested in getting higher profits, which leads to placing drivers on pharmacists to shape their activity in line with this goal. Organizational culture and socialization may also have an impact in shaping the pharmacist behaviour as it has been argued and empirically proven that organizational systems of reward contribute substantially to the behaviours of the organization members, but rewards are often of an economic nature (although not exclusively so) [4]. The business side of pharmacy is connected —like any business—with profits, and it has been shown that reward systems of business organizations are mostly related to profits, and ethical considerations are only of a secondary importance, becoming relevant only when exposing the company to legal consequences [5].

In the past decades, the community pharmacy has evolved considerably in the United States, mostly from small, locally owned and managed, independent pharmacies to large, national pharmacy chains. Besides, new types of pharmacies have occurred, such as mail-order or drive-through pharmacies [33]. In a 2-year time window, it has been reported that about 3000 US independent pharmacies have given up their place to "big drug, grocery and department-store chains" [41]. In Europe, a number of countries (Belgium, Czech Republic, Poland, Romania, Switzerland and the United Kingdom) allow the operation of large retail pharmacy chains, whereas in a large number of European countries, this is not legally possible. However, in these latter countries, the multiplication of "virtual chains," associations of independent pharmacies, has accelerated over the past 10 years [42]. Even the physiognomy of third-party payers (health insurers) has substantially changed: if other times they simply paid for the work or products, they have become now more similar to corporate clients, making efforts to influence the way, form, traits and quality of pharmacy services rendered by pharmacists [3]. These metamorphoses are likely to increase the organizational socializing pressures, as well as economic constraints on pharmacists working in those pharmacies.

Organizational settings can be expected to often exert strong pressures on pharmacists to behave in certain ways (as desired by the management) and adopt particular attitudes despite different requirements of the professional code of ethics and even despite personal values and attitudes, as indicated by an increasingly large volume of empirical evidence [4]. What is more significant, this shaping of individual behaviours by organizations takes place in the absence of a "detailed set of rules, rewards, or obviously coercive structures" [43].

The approval or disapproval (normative beliefs) of employers, managers and patients was reported by Latif [44] in one study to explain only 7.6% of the variance related to clinical decision-making, but the limitations of that study suggest that organizational pressures may have a higher influence than the one measured there.

Extrapolating from other professions, Latif [51] argued that three factors may favour a selection and socialization process where those working in pharmacy may be more liable to breaching ethical standards in certain organizational settings such as the community pharmacy (this model is based on a number of empirical studies in contexts not involving pharmacists, but it is to a good extent speculative):

(a) Pharmacists with less developed ethical skills might tend to select themselves in the community pharmacy practice (positive selection).

(b) Pharmacists with more developed ethical skills might tend to leave out settings perceived as unethical (negative selection).

(c) An acculturation and assimilation of new members may lead to (various degrees of) suppression of their ethical abilities (socialization) [4].

7. Motivational outlook for choosing pharmacy

One would expect that the clash between economics and ethics is influenced by how altruistic or less so is the professional. Therefore, there is a certain interest in knowing the motivational outlook of people entering the pharmacy profession. Older studies claimed that pharmacy students entered the profession mainly because pharmacy offered the prospects of economic security or matched certain aptitudes of the candidates, whereas only a small proportion were motivated by altruistic reasons [15, 45]. More specifically, a number of first-year pharmacy students were asked about the motivations for which they selected pharmacy school and found half of them choose pharmacy because of a certain aptitude, 40% for financial security reasons and only 14% mentioned a desire to contribute the good of others [45]. This would indicate that pharmacists adopted this profession not because of altruistic reasons but for more prosaic motivations and purposes. Because these data are about five decades old, their relevance for today is difficult to establish and new investigations have to be examined. Moreover, the methodology used only provided indirect insight into the role strain, as it did not measure directly various behaviours of pharmacists.

A study on Australian pharmacy students in 2006 reported that the most important factor when choosing entry into the pharmacy school was represented by future employment prospects (somewhat confirming the older studies) and the second was "the desire to make a contribution to healthcare" (indicating a more important role to the altruistic dimension, although the question may not necessarily be interpreted in an altruistic sense) [46]. Somewhat similar results were reported in a study from 1989 in the United States [47], whereas in New Zealand, the desire in helping people was listed by students as the first reason for choosing pharmacy, while the prospect of earning a high salary was indicated by considerably less students [48]. In a recent study in United Arab Emirates, the desire to help and serve others and interest in science were found to be the most important determinants of pharmacy choice [49], whereas in Nigeria, advancement opportunities and salary were the two most important factors identified by students as reasons for entering the pharmacy schools [50]. These data (which are not exhaustive) are illustrative enough of the fact that altruistic motivations may or may not be the most important determinants of choosing pharmacy.

8. The curious relationship between age, experience and moral reasoning

Although the theory of cognitive moral development would predict that older and more experienced pharmacists have a higher level of ethical reasoning, survey-based data generated by Latif reported that first-year pharmacy students had better ethical cognition than more experienced pharmacists and moreover, the more experienced the pharmacists were, the lower their ethical cognition level was [4]. Another study carried out by the same author reported that among a group of community pharmacists, the subgroup with the lowest level of moral reasoning had a mean tenure of 22.7 years in that setting, those with a medium level had a mean tenure of 17.2 years and those with the highest level of moral reasoning had the shortest mean tenure—15.7 [51]. Because of the cross-sectional nature of the study and its limitations

[51], it is not clear whether this is a chance finding or a general truth and further investigation is necessary in this direction. Even if the findings are valid, their explanation (as proposed by Latif, who also suggested alternative explanations) may reside in the differences in educational backgrounds of the more and less experienced pharmacists, including the changes in ethics teaching along time. An older study published by Lowenthal [52] investigated in a comparative manner the answers of two groups of students (first professional year and third professional year, respectively) and one group of experienced pharmacists to certain ethical dilemmas. Unlike the findings of Latif, in this study, it was reported that both groups expressed a high priority for the welfare of the patient in the majority of situations. With respect to certain dilemmas, there were certain differences reflecting the degree of experience between the two groups, but there was no conclusion of an ethical reasoning retrogression in the more experienced pharmacists as compared with the students [52].

9. How economics may trump ethics in daily pharmacy life

The notion that (community) pharmacy is not "trade" and that commercial activities (with goods other than medicines) are only "incidental to the practice of pure pharmacy" was emphasized even in the context of the "old" pharmacy, for instance, in the United States by Wulling in 1918 [53]. However, already in 1913, cases where the business might trump ethics were identified and fought against in the literature [6]. One year later in the same line, Marshall [54] lamented in plastic words the excessive commercialization of pharmacy to the detriment of ethics: "Pharmacy has been led astray. Like the Jews of old, some of its people have set up a Golden Calf to worship and a Moses is needed to lead them back again to better, higher, if not more ethical practices."

A forceful illustration of how the spirit of capital may defeat the ethical demands in an economically advanced society is represented by selling tobacco products in the Canadian pharmacies. Although the negative impact of tobacco consumption on health is today beyond of any residual doubt and despite attempts of the professional leadership to put an end to tobacco sales in Canadian pharmacies (a movement initiated in 1985 and including several active campaigns oriented towards pharmacists), less than half of the pharmacies complied with what is an obvious ethical imperative in the first decade. As a matter of fact, in 1990 the majority of pharmacies (88%) not only sold tobacco products but even actively promoted them. As the president of the Canadian Pharmaceutical Association (CPA) acknowledged, pharmacists looked "at the bottom line," which means that they looked at the financial impact; thus, financial considerations may be in real life more important than professional demands [55]. This might be even more telling when considering that only a small minority of Canadian pharmacies were independent, whereas the majority of them belonged to large corporations, better expressions of the capital and of organizational pressures [55]. It was mainly the gradual statutory intervention of public authorities that ultimately put an end to selling tobacco products in Canadian pharmacies.

The situation was not substantially different in the United States, where community pharmacies not only benefited from selling health risk products such as tobacco and alcohol but also

used advertising materials emphasizing price advantages, although such advertisements were smaller than those used for more healthful products. This was seen as an obvious case where economics tip the scales against ethics and the care for own revenues eclipses the care for the welfare of the patients [56, 57]. In one study in Massachusetts, of 100 pharmacies surveyed, 95 were selling tobacco products and half used advertisements for such products. Moreover, 42 advertised brands considered most appealing to children and 81 were willing to sell (illegally) tobacco products to minors [58]. It should also be emphasized that similarly to the Canadian situation, a minority of pharmacies (mostly independent ones) decided to place the ethics before and above economics, sacrificing the additional revenues generated by the sale of health risk product to be in agreement with their institutional mission of promoting health [56, 57]. Moreover, another US study found that pharmacists from pharmacies selling tobacco were less satisfied with their job, had more job-induced tension and had a higher proclivity to leave those pharmacies than those working in pharmacies not selling tobacco [59].

A cross-sectional study based on 377 questionnaires by pharmacists from two south-eastern US states reported that a proportion of 27% of the respondents felt sometimes conflicts between company interests and personal ethics with respect to providing information (e.g. on adverse effects of medicines) and to giving gifts and kickbacks and 1% felt often conflicts about providing information. Other conflicts between company interests and personal ethics were reported as occurring with some frequency (sometimes) regarding price collusion and pricing practices (23% of the respondents; for 2% such conflicts were frequent), honesty in executing contracts and agreements (23%), honesty in internal communications (16%), receipt of gifts and kickbacks (16%) and honesty in advertising (14%) [18]. The differences in giving and receiving gifts and kickbacks might be related to the different opportunities to give and receive gifts and kickbacks (as the authors hypothesized), but might also be related to the immoral purpose perceived more frequently in giving than in receiving such objects.

Sometimes business difficulties in pharmacy lead to fraud, as illustrated by an Australian pharmacist sanctioned by the professional body for violating professional rules in the attempt to repay business debts [26]. Any violation of the legal rules is inherently unethical, but actions and behaviours satisfying the minimal legal requirements are not necessarily ethical; the "ethical" label is to be applied to behaviours that go "above and beyond" the regulatory framework in force [5].

A study carried out in the United Kingdom, based on semi-structured interviews with seven pharmacists, reported several cases of potential conflict between economics or organizational demands and ethical demands. One of the pharmacists was troubled by the promotional activities of the "parent company," one locum pharmacist described the unease caused by the pressures exerted on them to do "what's always been done" but which was unethical, and a third one was worried that a handful of pharmacists with managerial positions would dictate in the future the ethics of the profession, based more on business than on professional considerations [24]. Thus, various behaviours may be found in pharmacy which, although not illegal, are however wide off the ethical mark.

In one of the few studies investigating the actual behaviours of pharmacists in real life, Linn and Davis [8] found that pharmacy owners were more likely to make recommendations of

certain product purchases (instead of referring the patient to a physician) than were non-owners, and pharmacists working in settings losing business or with blooming business had a similar tendency. In all three cases, one might speculate that the economic interest (owners) or pressures (blooming/losing business) exert a direct influence on the professional acts.

Latif drew the attention to the reward systems in place in the community pharmacy setting that could directly collide with the professional ethics, such as rewarding prescription volumes through bonuses, a system sending the (wrong) message to the pharmacist that the volume of dispensing should prevail over patient counselling and care [51]. Unfortunately, this is not a moot consideration, but there is evidence that at least in certain places, such reward systems are implemented, as the authors of this chapter are well aware for the Romanian situation (advertisements for pharmacist jobs often mention that bonuses are conditioned on financial targets per pharmacy). In other countries, such reward systems are also likely to be in place based on our informal discussions with other pharmacists, although no systematic study seems to have ever been published in this sense.

A management oriented towards increasing profit may lead to higher workloads in pharmacy (e.g. by personnel reduction, shortening the time for patient counselling, etc.). Latif [44] reported in a questionnaire-based study that workload seem not to reduce the quality of patient care and clinical decision-making, but this study had a number of limitations, including the potential use of a workload measurement not sensitive enough, a relatively low response rate and a sample of pharmacists from a single city. Business interests may lead to "unreasonable working conditions," with a high volume of work, long working hours and no breaks, which not only are a source of frustration for the employed pharmacists [60] but also have been shown to increase the risk of errors and ethical transgressions [26]. In Australia, dissatisfied pharmacists who gave up practicing in the community setting described the working conditions and atmosphere as "unreasonable" and more similar to a factory than a professional environment, whereas in Romania, for instance, there is a widespread practice of having pharmacists working two full weekends every month, which means that a pharmacist has a full work-break only after 12 days.

In community pharmacies, the most important source of income is represented by dispensing activities. Performing activities related to pharmaceutical care (e.g. by probing deeper in the factors affecting adherence to a certain treatment scheme) takes more time and tends to erode the main revenue generating activity of dispensing [4]. Time spent in patient counselling may be seen as a waste of resources, contributing little to business objectives of the pharmacy (maximization of profit), and this has led to the opinion that high-quality patient advice may soon simply disappear from pharmacies (as illustrated by the occurrence of the mail-order pharmacies where there is no face-to-face counselling) [33]. Printed advice (such as computer printouts provided to patients together with their medications) is no substitute for the oral communication between the pharmacist professional and the patient, but quality counselling is at a high risk of becoming "a casualty in the ongoing war between pharmacy ethics and business objectives" [33]. Spending the time in patient counselling may create ethical dilemmas for each individual pharmacist, for pharmacy managers and for the top management of the pharmacy business organization, as discussed in depth by Resnik et al. [33].

The decision on providing services for drug misusers, often taken by managers, who sometimes are not pharmacists, seems to be heavily influenced by business considerations, much more than patient welfare. Such business considerations include the potential to discourage other customers/patients from entering the pharmacy, the possibility of shoplifting, the distastefulness for both staff and customers and the absence of a long-term financial gain from providing such services [25].

Other situations in which the conflict between ethics and economics may become visible include decisions by pharmacists whether to recommend or dispense unnecessary food supplements and whether to recommend lower cost generic equivalents or filling prescriptions in conditions that may be less advantageous in economic terms (e.g. for Medicaid patients) [33].

When the business side of pharmacy prevails over the professional side by an exclusive or excessive focus on profit, employed pharmacists may feel deep dissatisfaction, to the point of leaving the profession. In the words of a female pharmacist from Australia, formerly working in a community pharmacy and currently having a PhD in a non-health discipline: "I think within community pharmacy… it was very profit motivated rather than, service orientated… the job was quite isolating professionally…Very much the focus of the owner was on profit motivation rather than on, you know excellence in professional service. So very much you spend your time, obviously to please your boss" [60]. Such feelings seem not to be particular for this pharmacist, "the absence of a professional environment to work in and the challenges they face in a profit-motivated profession" being described in this study based on interviews with former pharmacists that left the profession as a "recurring topic."

10. Knowledge gaps and conclusions

It has been argued that a financial dimension exists in all professions, but in the case of pharmacy, this is more prominent, chiefly because in this case, the professional (pharmacist) sells non-pharmaceutical products in a setting that is more similar to a retail outlet than to a typical professional office [8]. In the ethical clash between business and ethics, the latter should be the winner, but day-to-day practice shows that even in countries with sophisticated and modern regulations (such as Germany), the interaction between the two remains a delicate balancing exercise. Economics may outweigh ethics in crude forms such as selling health risk products (as it was in the past for tobacco or alcohol) or in more subtle ones, such as longer work hours and higher workloads, dispensing unnecessary healthcare products (e.g. food supplements), not recommending/providing lower cost generics, etc.

It may seem surprising that empirical and theoretical research of this conflict has been so limited, when considering that its manifestation is assumed to be frequent, even daily [25]. A review of the papers published in the field of pharmacy ethics in 12 years (1990–2002) found that the volume of research carried out till now was very limited, with research on meta-ethics close to none, there was no dedicated journal of pharmacy ethics and the majority of materials published were represented by codes or statements of professional bodies, views and reflections published in manuals or debates taking place in a limited number of publications [25, 61]. Some advancement has been made in the meantime, but the overall impression when

examining the available literature is not fundamentally different. It is therefore not surprising that the issue of the ambiguity of role of the pharmacist has not been explored as extensively as it deserves.

In the memorable formula of M. Brazier, there is in the academic world still too much emphasis on "ethical dilemmas of high drama and low incidence," which are of little relevance to the majority of pharmacists (as cited by Cooper et al. [62]). For community pharmacists the tension between the business and professional aspects of pharmacy might be felt considerably more often, and empirical research in this field is unjustifiably scarce. Even when available, the literature has mainly used samples of students (not fully formed or experienced pharmacists), and when pharmacists were studied, they were Anglophone, in particular from the United States, and practising outside the community pharmacy settings (chiefly hospital pharmacists) [62].

It becomes obvious then that large areas of the subject have remained not systematically investigated, whereas some of the investigations have been carried out in old times, and their relevance may be questionable today in different regulatory and economic frameworks. It would be especially useful to have data from several continents regarding the experience of community pharmacists and regarding the ways in which the conflict between economics and ethics becomes manifest and quantitative data regarding the extent of the phenomenon.

Criticizing the arguments of Denzin and Mettlin, Dingwall and Wilson insisted that the former had no empirical data on the everyday work of pharmacists and that the only evidence advanced by those authors was derived largely from "surveys, attitude studies and occupational propaganda," and emphasized the need for a research programme intended to explore the real contexts in which pharmaceutical services are provided [19]. A similar observation regarding the lack of "empirical investigations of what pharmacists actually do" had already been formulated by Linn and Davis [8]. In the United Kingdom, the Nuffield committee did not have the necessary resources for performing its own research and, noting the scarceness of the available research work, observed that what was lacking was especially "information on what pharmacists actually do—as distinct from what they say they do" [3]. After more than 30 years, things are not substantially different: most of the sparse research available in the field of pharmacy ethics is still based either on theoretical considerations or on opinions and attitudes (through qualitative or quantitative questionnaires) rather than on objective investigations of what pharmacists do in real life (although one has to acknowledge that such objective investigations are very hard to implement).

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