Revista Bioética
Print version ISSN 1983-8042 On-line version ISSN 1983-8034
Rev. Bioét. vol.28 no.2 Brasília Apr./June 2020
Doi: 10.1590/1983-80422020282398

RESEARCH

Ethics and pharmaceutical services in primary health care: daily challenges

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Abstract

This study aimed to identify and discuss ethical problems experienced by pharmacists in primary health care. Data were collected through semi-structured interviews conducted with 19 pharmacists in Florianópolis, Santa Catarina, Brazil. The content of interviews was analyzed through thematic-categorical analysis in the light of bioethics references. Ten ethical problems were identified related to the political dimension of the working process and health care, involving issues related to the structure of services and work environment, and management of health services. An ethical analysis to solve these questions is an important strategy to improve pharmaceutical services in primary health care.
Keywords: Primary health care. Pharmaceutical services. Bioethics. Ethics, pharmacy. Public health.

Resumo

Ética e assistência farmacêutica na atenção básica: desafios cotidianos

Este estudo buscou identificar e discutir problemas éticos vivenciados por farmacêuticos na atenção básica à saúde. Os dados foram coletados por meio de entrevistas semiestruturadas com 19 farmacêuticos, no município de Florianópolis/SC. O conteúdo das falas foi analisado por abordagem temático-categorial, à luz de referenciais teóricos da bioética. Identificaram-se dez problemas éticos ligados à dimensão política do trabalho e da produção do cuidado, envolvendo questões relativas à estrutura dos serviços, a processos de gestão e à forma de organização da atenção à saúde. Conclui-se que a análise ética comprometida com a resolução dos problemas apontados é importante estratégia para qualificar os serviços farmacêuticos na atenção básica à saúde.
Palavras-chave: Atenção primária à saúde. Assistência farmacêutica. Bioética. Ética farmacêutica. Saúde pública.

Resumen

Ética y servicios farmacéuticos en atención primaria de salud: desafíos cotidianos

Este estudio tuvo por objetivo identificar y discutir los problemas éticos vivenciados por farmacéuticos en la atención primaria de salud. Los datos fueron recolectados por medio de entrevistas semiestructuradas con 19 farmacéuticos, en el municipio de Florianópolis, Santa Catarina, Brasil. Se hizo un análisis temático-categorial de los relatos recopilados utilizando referenciales teóricos bioéticos. Se identificaron diez diferentes problemas éticos entrelazados con la dimensión política del trabajo y la producción del cuidado, envolviendo cuestiones sobre la estructura de los servicios, los procesos de gestión y las formas de organización de la atención de la salud. Se concluye que el análisis ético comprometido con la resolución de problemas es una importante estrategia para la calificación de los servicios farmacéuticos en la atención primaria de salud.
Palabras clave: Atención primaria de salud. Servicios farmacéuticos. Bioética. Ética farmacéutica. Salud pública.

Approval CEP-UFSC CAAE 47114115.9.0000.0121

The authors declare no conflict of interest.

Despite constant ethical conflicts in the context of primary health care (PHC) – considering the complex relationships between workers, users and the health care system – the discussion on this topic is relatively recent [1-7]. Initially, bioethics have not contemplated PHC services, since its main focus was on the hospital environment and high complexity procedures, prioritizing more threshold situations than daily occurrences [1].

In this research, bioethics is understood beyond biomedicine and clinical practice, considering the field must necessarily address social problems and focus on public and collective issues instead of specific, private and individual questions [8].

Based on these assumptions, ethical problems are defined as challenges whose approach should dispense dilemmatic posture, which perceives only two possible courses of action: extreme or irreconcilable. The problematizing stance is assumed here, based on the multiplicity of prudent and responsible alternatives [9]. Therefore, to face ethical problems, conflicts of values and duties should be considered, as well as situations that generate such conflicts [2,10], as a result of social production instead of isolated phenomena. Thus, the dialogue between bioethics and public health becomes necessary [11].

In Brazil, researchers have focused on investigating the practice of family health program (EqSF) professionals, mainly physicians, nurses and community agents, and to a lesser extent nursing technicians and the oral health staff (dentists and dental auxiliaries). Problems experienced by other PHC professionals, including pharmacists [12], have not been well explored.

Incipient studies have addressed the ethical aspects of pharmaceutical practice [13]. Especially in the last decade, researchers have been dedicating themselves mainly to the context of pharmacies that serve the community and the private sector [14-22].

In the Unified Health System (SUS), over the last decade, a greater number of pharmacists have been inserted into PHC, mainly since the creation of the Family Health Support Centers (NASF) – an innovative strategy within the scope of the health system, with the objective of expanding multidisciplinary work at PHC. Thus, the opportunities for pharmaceutical operations with the Family Health Program were expanded, which contributed to improve actions [23]. Nevertheless, the integration of pharmaceutical services into the national health policy is relatively recent and has conflicts of interest; a set of tensions marked by advances and setbacks [24]. In this sense, many obstacles must be overcome to develop these services, especially regarding clinical performance and the need to integrate drug providing services into the health care of users [25,26].

Given the gaps in the literature, this study seeks to identify and discuss the ethical problems experienced by pharmacists of a municipal health care network, focusing on those arising from the relationship of professionals with the health system, considering the organization and management of SUS.

Method

This is an exploratory-descriptive study, with a qualitative approach, carried out in the medium-sized city of Florianópolis/SC,a, Brazil, capital of the state located in the country's Southern region. The city has pharmacies in all health centers, which provide basic medicines for pharmaceutical care – items contemplated by the Municipal List of Essential Medication to treat the most common diseases in the scope of PHC –, except for psychotropic and other controlled drugs, that can only be found in seven district reference centers with full-time pharmacists.

In person or by telephone, the 23 pharmacists working in the PHC network were invited to participate in this study. Of these, three were not working during the research, and we found some difficulties to talk with a fourth professional. Thus, 19 pharmacists participated in the research (profiles described in Table 1).

After the informed consent form was signed by each participant, data were collected through semi-structured interviews [27]. Based on Zoboli and Fortes [1], the interview script was structured to specifically address the ethical problems experienced in their relationship with users, other professionals and, above all, with the organization and management of the SUS, which is the focus of this article.

A pilot interview was conducted with a pharmacist working in PHC to test and improve the script. The other interviews were held in the last quarter of 2015, at a time and place previously scheduled with the participant, in a private environment, without the presence of third parties. Except for a single meeting, held at a university, the workplace was the place chosen by the participants.

 http://dx.doi.org/10.1590/1983-80422020282398

The interviews, which lasted an average of 30 minutes, were recorded and fully transcribed. To ensure anonymity, they were identified by an alphanumeric code: F and numerals from 1 to 19.

Table 1. Profile of the pharmacists interviewed

Characteristics		n	%
Gender	Male	4	21.1
	Female	15	78.9
Age	20 to 29	3	15.8
	30 to 39	12	63.2
	40 to 49	3	15.8
	50 or older	1	5.3
Completion of medical school	Up to 5 years	3	15.8
	6 to 10 years	4	21.1
	11 to 15 years	7	36.8
	16 to 20 years	3	15.8
	More than 21 years	2	10.5
Education level	Medical school	4	21.1
	Academic specialization	7	36.8
	Master's degree	4	21.1
	Doctorate	4	21.1
Time of practice in PHC	1 to 5 years	7	36.8
	6 to 10 years	9	47.4
	More than 11 years	3	15.8
Weekly workload	30 hours	4	21.1
	40 hours	15	78.9
Position/ function	District's reference pharmacy	8	42.1
	Family Health Support Center (NASF)	6	31.6
	Municipal Health Department (central management)	3	15.8
	Health center coordination	1	5.3
	Family Health Program	1	5.3

The researcher who conducted the interviews and analyzed the data is also a pharmacist, with ten years of experience in PHC. Thus, his relationship with the interviewees and the theme were advantages to perceive nuances and review interpretations.

The software ATLAS.ti 7.5.11 was used to analyze the data obtained, according to the thematic-categorical method of content analysis [27,28]. The registration units adopted were composed of interview excerpts that reported situations involving ethical problems and the way the interviewees tried to solve them.

Results and discussion

Considering the relations with the organization and management of the health system, ten central ethical problems were identified, as listed in Chart 1. Subsequently, each of these problems is addressed, with examples extracted from the interviewees' speech.

Chart 1. Ethical problems in the relation with the management of the Unified Health System

1) Work process hampered by deficiencies in the structure of services
2) Failures in user care due to work overload
3) Mew organization of the work process of the Family Health Support Centers teams
4) Pharmaceutical services as an instrument for the medicalization of society
5) Centralized pharmacies as a factor that hinders users' access to pharmaceutical services
6) Centrality and verticalization of decisions in pharmaceutical actions at the central management level
7) Low autonomy of the pharmacist in the local management of pharmacies
8) Communication failures in the network
9) Shortage of medication
10) Demand for access to medication by judicial means

Deficiencies in the structure of the service, which impair the work of the pharmacist, is one of the main problems reported:

"The issue of physical structure is an ethical problem for me… Anyway, you can't have a nice place to work" (F7).

The interviewees describe a common scenario in PHC services in Brazil [29], reporting problems in the physical structure of pharmacies, such as insufficient space (in the internal environment and in the waiting room); inadequate provision of service desks, which hinders communication and does not guarantee user's privacy; ergonomic risks; and pharmacies in areas with high flow or concentration of users waiting for other medical appointments, near receptions, offices or vaccine rooms, for example. These physical limitations create barriers to user care:

"The working condition of pharmacists in public health, which is my case, is very precarious and

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does not favor this issue of orientation (…) *I deliver the medication through a window, with patients standing in line, without privacy"* (F16).

In addition, structure problems in the service favor diseases in professionals. Some interviewees report the problem of frequent leaves for health treatment due to repetitive strain injuries or work-related musculoskeletal disorders: "*We have a strong HR* [human resources] *problem in all pharmacy services of the network*" (F15).

The statement refers mainly to the composition of the team, since there is not a position such as technician or pharmacy assistant in the city. Usually, nursing technicians linked to Family Health Program are those who occupy this role. The main problem is that these professionals often work in the pharmacy in a rotation scheme, which makes training difficult:

"They [nursing technicians] *don't like to be there* [in the pharmacy]*; they do the job carelessly… Not all of them, of course, but most… So, you have always to redo your work… You explain things to them, but they leave all messed up"* (F12).

To improve pharmaceutical services in PHC, the Pan American Health Organization [30] recommends a sufficient number of pharmacists and support staff (auxiliaries and technicians), with adequate competence and training, as well as motivation and commitment. The difficulty in composing the pharmacy team overloads the workers and impairs the service :

"It's one patient after another, right? You can't even greet the person sometimes because you already have a huge line (…) *And so it goes, we can't have a more qualified care"* (F12).

The interviewees explain the conflict of feeling that they neglect the patients' needs because they have to reduce the time of care: "*Often I have to close my eyes to a situation that deserves special care, because I have to meet the demand, because I have to put out the fire*" (F16).

One of the causes of distress is the incompatibility between the structure and capacity of the services and the demands of the population, for example, when there are still users in the pharmacy waiting at the closing time. In this sense, professionals feel pressured both by the population and the system itself, overworking to meet the demands, regardless of the conditions, of all users who are there. PHC must guarantee users' right to medication, but the ethical problem is exactly in the (lack of) understanding of the service limitations, which go beyond the individual responsibility of health professionals.

Pharmacists also report difficulties in the work of NASF, pointing out the rearrangement of teams. One of the explanations would be the very structure of some health centers, which does not favor the interaction between professionals who do not work in the same period. Consequently, there is no effective integration of the teamwork.

In only three health centers in the city one can find reference pharmacies with pharmacists throughout the period of operation. That is, the other PHC units have a pharmacy, but do not have the support of a pharmaceutical professional. Due to these deficiencies, one of the interviewees comments that he "*works with 'harm reduction'*" (F14), showing the impossibility of the NASF pharmacists meeting all demands, which would require their continuous presence, and not only in some periods. The situation forces the professional to assume the role of an auxiliary technician, impairing his support to the Family Health Program, which would allow to expand the clinic in terms of PHC. Moreover, sometimes it is necessary to stop his work to give support in other pharmacies, when other pharmacists are on vacation, for example.

The reports confirm the reality observed in a study on the work of pharmacists in the NASF, which discusses the *dilemma of the pharmaceutical professional* (...) *in the definition of the activities to be performed, sometimes being a supporter of the EqSF, sometimes being a pharmacist more restricted to pharmacies* [31]. The research also highlights the limitations imposed by the daily routine of services, given the impossibility of the pharmacist responsible for multiple EqSF and health centers to perform activities and attributions recommended in the NASF guidelines for pharmaceutical services.

Working under a biomedical model that is still hegemonic, pharmacists suffer the impacts of an organizational structure that prioritizes only the availability of medication:

"I feel like I only give drugs to people (…) *We tend to never decrease the medication… We never work like this…"* (F18).

 http://dx.doi.org/10.1590/1983-80422020282398

"We are an instrument for the medicalization of people" (F2).

Some pharmacists see themselves as part of the phenomenon of medicalization in society [32], characterized by the prescription of pharmacological therapies or inappropriate or unnecessary medical procedures, with greater potential for harm. Thus, professionals experience the ethical conflict of feeling that they collaborate with medicalization while they can not, due to the service structure and working conditions, stimulate the safe and appropriate use of medicines. As the interviewees report, sometimes access to drugs prolongs cycles of dependence and alienation. This is the case, for example, of the abusive use of medications that alleviate symptoms, but do not treat the causes of the disease and might generate serious adverse effects.

In addition to issues related to the local reality, discussing the problem of medicalization requires recognizing its connection with a complex sociocultural process that propagates the ideology of the drug as a consumer good, favoring the profit of the pharmaceutical industry and the medical-industrial complex over the needs of the population [33]. In this sense, bioethics comprises the health-disease process in a broader way and draws attention to the need for intervention with social determinants of health [8,11,34]. Therefore, the awareness manifested by some pharmacists regarding the predominance of medicalization is necessary, for one cannot strive to transform that which one cannot yet perceive.

The availability of some drugs only in centralized pharmacies was also identified by professionals as an ethical problem: "*The issue of reference pharmacies* (…). *People sometimes need to take two, three buses to take this medication.*" (F3)

In the city, two district reference pharmacies serve specific programs, such as STD/AIDS, and one specialized pharmacy provides drugs for certain diseases according to the criteria defined by the Clinical Protocols and Therapeutic Guidelines (PCDT) established by the Ministry of Health. Thus, some users need to go to up to four pharmacies to get all their drugs. Although all pharmacies are under municipal responsibility, the logistics management of some services is done by the state or federal government, with distinct – and incommunicable – systems of inventory management.

The pharmacists point out that, in addition to the difficulties of access to medicines due to communication failures between services, there is the problem of care fragmentation. For example, with the lack of integration between PHC and other pharmacies (specialized and antiretrovirals), a health center may refuse medicines without knowing they are antiretrovirals for HIV. Thus, the evaluation of the prescription is compromised, and the patient may not receive the necessary guidance. That is, PHC pharmacies are not organized to meet, together with the Family Health Program, the guidelines for care management, monitoring and organization of the flow of users in the various services provide by the network.

Regarding the municipal management of pharmaceutical services, the interviewees pointed out several problems:

"Rules or protocols are decided by management in a closed, undemocratic way, but you have to assume it as a guideline and pass on these guidelines (…)*. So it is something that has this burden, that the decisions that management makes have a lot of repercussion on our daily lives"* (F14).

"I think we also get into this question of responding to a leadership, to a coordination, and this can result in some problems" (F8).

In this sense, the professionals have little participation in the decision-making process, regulations or protocols that may affect the routine of pharmacy services. Even the technical management of pharmaceutical care is subordinated to an PHC board and, in some cases, there is also interference of bureaucratic and political processes external to the Municipal Health Department, regarding, for example, resources for purchasing medicines.

Such a context makes the interviewees perceive a confrontation of their principles and work views with the institutionally established guidelines and decisions. The professionals report having little autonomy to suggest changes in work organization, and this scenario explains the need to democratize the decision-making process, in order to ensure greater participation of pharmacists in PHC.

According to the assumptions of the National Humanization Policy, the indissociability between management and health care implies creating new practices and processes in the daily routine of services, with participatory management (or "co-management"), involving professionals, managers and users [35]. This reorientation is essential, because health *praxis* demands *workers with an important degree of autonomy and responsibility with one another and with the institutions* [36]. Moreover, the strategic planning of PHC teams must be considered as an ethical requirement [37] – a process from which pharmacists cannot be excluded.

Failures in communication between management, health units and workers were also reported:

"*The worst critical aspect is communication, because information does not reach those who need it most*" (F17).

Data analysis revealed a lack of information among professionals about other services of the municipal network, including pharmacy-related information, which generates problems and increases conflicts with users. In addition to communication failures, there is a lack of transparency in some processes, also a reflection of a traditional and verticalized management model. Pharmacists mentioned, for example, having little knowledge about the progress of the bids and the process of acquiring drugs; they only become aware of shortage when finding that a particular item did not arrive at the pharmacy in the monthly delivery. The situation generates several difficulties in the daily services:

"Sometimes drugs are lacking and the one who needs to face the user is you, not the management, right? So this is a big problem" (F12).

Problems generated by the unavailability of medication in the health unit are very common, especially for users who need analgesia or immediate treatment, such as antimicrobial or antipyretic therapy. Regardless of the cause of the problem, unavailability is always a violation of the user's right, and is even more critical when no therapeutic alternatives are available or when unassisted users are in a situation of vulnerability, that is, *are unable to protect themselves or do not have any support that comes from the family, the group to which they belong, the State or society itself* [38].

These situations affect the work routine, impairing relationships with users and, occasionally, with the health team. To meet users' needs, it is necessary to involve the pharmacist, checking if there is stock available in other units, analyzing if therapeutic alternatives are available or discussing the case with the EqSF or the physician who prescribed the medicine. When professionals are unable to meet these demands properly, conflicts are generated, increasing the list of ethical problems that arise from the structure of services and work overload.

Handling situations in which there is lack of medicines also brings other ethical conflicts, involving decisions regarding alternatives and available resources. For example, when antibacterial medication in capsule shells are lacking, one may choose to distribute the suspension, at risk of consequently harming possible child patients. When a drug is missing, but there is still a stock in a pharmacy, what is the best approach? Is it possible to establish criteria for rationing the dispensation and to focus on priority cases? In the studied municipality, decisions usually take place individually or, at most, involve some debate with the health unit team. The central management has not coordinated this dialogue.

Medicines obtained through judicial means are also reported by the interviewees as a cause of conflicts:

"One of the most frequent [ethical problems]*, for example, are the cases in which the patient receives a prescription outside the list of standardized drugs in SUS and is instructed by the physician himself, sometimes by another employee of the service, to file a lawsuit"* (F13).

This excerpt highlights one of the results of the research: the concern of pharmacists with the judicialization of health [39]. Understanding that judicialization generates inequities and impairs the integrality of services, the interviewees are bothered by the fact that professionals from the system itself guide users to file lawsuits. In the routine of pharmacy services in PHC, it is complex to evaluate cases of prescription of drugs not standardized by SUS, because it is necessary to analyze in detail the health condition and the history of the user. On the one hand, the logic of medicine as a consumer good persists, with the

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influence of strategies for promoting and expanding sales by the pharmaceutical industry, but on the other, it is important to note that judicialization can also be a legitimate resource to guarantee comprehensive care when the drug is not available in the SUS services [39,40].

Regarding the impacts of the ethical problems explained, the data indicate some level of moral distress [41] by pharmacists:

"If we are going to try to do everything according to what is ethically recommended, we will get sick, because we can not do much (…) *The situation in which we work is highly unethical, highly unethical!"* (F16).

"It also reflects even on our will to work, in our productivity and so on… But in the end you lose… You devalue yourself. So you lessen the urge to do a job that you think is right; there is this very negative aspect both on the personal and even the professional side" (F17).

In a review, Astbury, Gallagher and O'Neill [41] show that ethical challenges in the routine of pharmacists in the UK are factors of moral distress, when the professional knows what is the right action from a moral standpoint, but feels unable or prevented from performing it. The authors state that the theme is practically unexplored in the area, emphasizing the importance of researches that identify the causes of the problem and its impacts on the pharmaceutical practice.

In line with this discussion, Crnjanski and collaborators [42], in a survey conducted in Serbia, also identified ethical problems related to the structure of services and working conditions, mainly due to the overload generated by the insufficient number of professionals. The authors point to this and other problems as a common cause of moral distress, corroborating the results of the current study.

The ethical conflicts reported by the interviewees also appear in situations described by studies on the family health program, especially regarding the limitations imposed by the structure of services, work overload and excessive demand [1-5]. Such problems of pharmaceutical services in PHC can be situated and understood in the light of the concept of programmatic vulnerability as an explanatory category of ethical problems in PHC [43].

In addition to the vulnerability caused by social conditions, structural failures of the healthcare network and the fragmentation of care increase this vulnerability even further. In the present study, it is explicit that this type of vulnerability affects not only users, but also professionals, given the interdependence between the health system and the social context.

Final considerations

Although this study investigated the reality of a single city, the situations occur in most of the country. Moreover, despite the specificities of pharmaceutical services and Brazilian public health policy, the data presented here are close to the results of studies conducted in other countries, especially in Europe with pharmacists working in community pharmacies [14-22,41,42].

With the expansion of their scope of action in PHC, pharmacists have contributed significantly to the care of the population. However, the various problems that emerge from its *praxis* reveal the complexity of the ethical dimension of this work. Regarding issues related to the structure and service management, such problems become intertwined with the political dimension of health care. Recognizing, analyzing and discussing them is essential to improve PHC. These challenges need to be faced by strengthening pharmaceutical services as a public policy and the defense of the principles of universality, integrality and equity [44].

The results of this research also contribute to the discussion about the deficiencies in the training of health professionals. In view of the various conflicts in the daily life of pharmacists in PHC, it is essential to promote the study of bioethics, an important field of reflection and action in higher education.

Finally, since the theme is still little explored, more studies on the subject should be carried out, contributing to enhance the knowledge about the ethical dimension of pharmaceutical practices. The focus could be on the daily pharmacy services in SUS, at all levels of care, including auxiliaries and technicians, managers and users, as well as other NASF professionals. In addition to identifying problems, it is important to explore the moral values involved to understand ethical conflicts and how they are managed.

This article is part of a master's thesis entitled "Ethical problems experienced by pharmacists in primary health care in a municipality in southern Brazil," written by Leandro Ribeiro Molina and defended in the Graduate Program in Public Health of the Federal University of Santa Catarina.

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Research

Participation of the authors

Leandro Ribeiro Molina conceived the research and worked in all stages. Juliara Bellina Hoffmann participated in the discussion of the results. Mirelle Finkler contributed to the research design and data analysis. All authors wrote the article.

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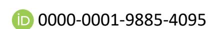 0000-0001-9885-4095

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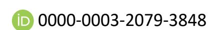 0000-0003-2079-3848

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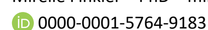
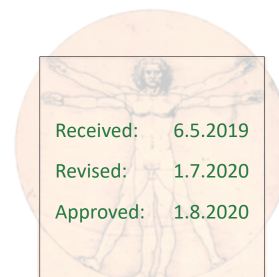
 0000-0001-5764-9183



Received: 6.5.2019

Revised: 1.7.2020

Approved: 1.8.2020

Appendix

Interview script

Profile of the interviewee

Gender:

Age:

Year of graduation/completion :

Postgraduate education: If yes, what kind and in what field?

Time of practice in the city

Experience in primary health care:

Link: ( ) statutory ( ) pharmacist-resident

Weekly workload: ( ) 30 h ( ) 40 h

Workplace and workload distribution (in case of working in more than one health unit):

Guiding questions

1. Considering your work routine and your experience in primary health care, report to me facts, cases or situations that involve doubts or difficulties in decision-making (or even anguish or other feelings of discomfort) that may refer to the relationship with users and/or families; relationship with the health team; relations with the organization and the health system.
2. Among all these questions already reported in relation to your daily professional life, what are the situations that you identify as ethical problems? (Explore the reasons that lead to this thinking.)
3. How do you usually cope or what strategies do you use to solve these problems?
4. Could you explain about the influences or possible impacts of these problems for you and/or your work process?
5. What would be the consequences of these ethical problems for the quality of health care?

Research