Development of a tool to measure moral distress in community pharmacists

Jayne L. Astbury  |  Cathal T. Gallagher  |  Richard C. O’Neill

*Department of Pharmacy, University of Hertfordshire, College Lane, Hatfield*
Executive Summary

Introduction

Moral distress arises from situations in which the individual identifies the morally right action required, but feels unable to act accordingly due to organisational, legal, regulatory, or personal constraints. Pharmacists working in the UK operate within a highly-regulated occupational sphere, and are bound by strict legal frameworks and codes of professional conduct. This regulatory environment creates the potential for moral distress to occur due to the limitations it places on acting in congruence with ethical judgements. The aim of the project was to construct and validate a questionnaire to measure the extent to which UK community pharmacists experience moral distress in their working lives.

Methods

A potential pool of questionnaire items were identified from the findings of an extensive literature search and a review of existing moral distress instruments. A focus group was then conducted with practising pharmacists to explore the relevance of the proposed items whilst also facilitating the generation of additional item domains. The audio recordings of the focus groups were transcribed verbatim and thematically coded using directed content analysis.

Results

The participants raised a number of pharmacy practice scenarios that they associated with the experience of moral distress both of their own accord and in response to the prompts. The most frequently cited constraints on action were legal or regulatory in nature.

Conclusions

A 13-item questionnaire based on the clinical scenarios that were raised has been developed. Each item of the questionnaire is rated on seven-point Likert scale for frequency of occurrence and intensity of distress. The questionnaire has been subject to content validity testing, and has been electronically mailed to a pilot sample including the London North and London North West Local Practice Forums (LPFs).
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1. Background

1.1 What is moral distress?

1.1.1 Overview

Morals can be thought of as standards that govern human co-operation, specifically in relation to how duties, rights, and benefits are allocated (Erwin, 2000). Moral judgement represents an evaluation of an action as good or bad from the perspective of a particular collection of values. Philosophical interest in moral judgement, intention and action has a considerable history. Aristotle used the term ‘akrasia’ to refer to a moral weakness of will that was notable in persons who acted against their own better judgement (Begley & Piggott, 2013). Acting contrary to personal moral judgements and in discordance with one’s moral values has long been associated with negative emotional states such as guilt and anxiety (Williams, 1993).

The implication of moral judgement, and the effects of acts and omissions of professionals within health care settings, has attracted significant interest within this context. The provision of health care has been described as an “ethically-grounded enterprise” with an underlying moral sense dictating that professionals should act in a personal capacity to foster the wellbeing and best interests of their patients (Lützén, Cronqvist, Magnusson, & Andersson, 2003). The inequality inherent in relationships between patients and practitioners places the need to identify, balance and meet moral demands primarily with the practitioner. When the ability to meet this need effectively is obstructed there is a sense of personal accountability for having failed to pursue an act in accordance with a moral good (Corley, 2002).

The term moral distress originates in Jameton’s (1984) work concerning the ethical challenges and moral conflicts inherent in the provision of nursing care. Jameton conducted a number of interviews with nurses regarding their perceptions of the moral dilemmas that they faced in their clinical practice. The findings led Jameton to distinguish between experiences of moral uncertainty, moral dilemma and moral distress. Moral uncertainty refers to a feeling of doubt regarding the best course of action to take in a given situation. Moral dilemmas involve two or more conflicting ethical principles with the possibility of more than one morally acceptable action to choose from. Finally, moral distress arises from situations in which the individual identifies the morally right action required, but feels unable to act accordingly due to organisational constraints within the work place. This early depiction of moral distress has formed the conceptual basis for much of the subsequent research in this area.
A later study by Wilkinson (1988) focused specifically on the experience of moral distress in a sample of critical care nurses. Wilkinson developed and expanded upon Jameton’s definition in order to encapsulate the sensory experience of distress. She defined moral distress as “the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision” (p.16). Jameton (1993) later refined his theory of moral distress to include a sense of having participated in a moral wrong through action or inaction. He also further differentiated between aspects of initial and reactive distress; initial distress occurring at the time the person is first prevented from doing what they feel is right, characterised by feelings of acute anxiety, anger and outrage and reactive distress, often now referred to as moral residue, occurring when the individual fails to respond to their initial feelings of distress and ultimately acts in discordance with their beliefs, characterised by lingering feelings of guilt, low self-esteem and powerlessness.

These initial conceptualisations of moral distress considered constraints on action to arise primarily from institutional policy or the power dynamics inherent within intra-professional hierarchies. Later authors have broadened the definition of moral distress to include situational binds arising from personal failings, insufficient resources, legal requirements, professional regulations and a sense of discordance between individual and role morality that may occur when professional norms conflict with individual moral values (Houston et al., 2013; Nathaniel, 2006). The concept of role morality suggests that individuals may adopt alternative moral codes depending on the occupational role they undertake and that in order to meet the ethical requirements stipulated by their profession, they may be required to act contrary to the core values to which they are personally committed (Gibson, 2003). It is the betrayal of individual beliefs and values and the subsequent fragmentation of self-integrity that is perceived to be at the core moral of distress (Corley, 1995; Laabs, 2007, 2011). Hanna (2005) described moral distress as a response by the self in reaction to a perceived threat to ‘an objective good’ and in doing so also highlighted that this concept encapsulates the individual’s response to both real and perceived wrong doing. It is the individual’s perception of the situation, the values that they feel are at stake and the nature of any situational constraints that influences the degree to which they experience moral distress. In this way two clinician’s facing the same situation may experience markedly different levels of moral distress.

Nathaniel (2006) proposed the following integrated definition of moral distress:

“Moral distress is the pain affecting the mind, body or relationships that results from a patient care situation, in which the [practitioner] is aware of a moral problem, acknowledges moral responsibility and makes a moral judgement about the correct action, yet, as a result of real or perceived constraints,
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participates, either by act of omission, in a manner he or she perceives to be morally wrong” (p.421).

This definition also goes someway to illustrate the process and contextual nature of moral distress by referencing the related concepts of moral awareness, moral responsibility, and moral reasoning that combine to influence moral behaviour.

1.1.2 The Four Component Model

James Rest and colleagues proposed a model of the processes involved in the production of moral behaviour. The four component model (FCM) articulates psychological processes of perceiving and interpreting social problems as moral (sensitivity); cognitive and affective processing about moral issues (reasoning and judgement); evaluating the importance of moral values in relation to other competing goals, needs, or drives (identity or motivation); and formulating an implementation plan, taking into account the interpersonal and social dynamics of the situation (character and competence, or moral implementation). These four processes have since been redefined as: moral sensitivity; moral judgement; moral identity (or motivation); and moral implementation (Bebau, 2002). Rather than the four components representing a four-step, linear process of predicting or explaining behaviour, the FCM represents a complex interaction of cognition, affect, and social dynamics, which form a holistic process (Rest, Narvaez, Bebau, & Thoma, 1999).

1.1.3 Moral Sensitivity

The first component, sensitivity, is the individual’s ability to perceive the moral dimensions of a problem. Clarkeburn (2002) suggested that:

“Ethical sensitivity is the first step in real-life moral decision-making. Without recognising the ethical aspects of a situation, it is impossible to solve any moral or ethical problem, for without the initial recognition no problem exists” (p.439).

Here, interpretation is about awareness: awareness of a situation; awareness of the moral implications; awareness of how others are impacted; awareness of reactions and feelings of others; and awareness of different courses of action (Bebau, 2002; Bebau, Rest, & Narvaez, 1999; Erwin, 2000; Guthrie, 1997; Walker, 2002). For moral deliberation to take place one must first identify that there are morally significant values at stake (VanSandt, Shepard, & Zappe, 2006). The saliency with which the moral aspects of a situation are perceived may differ both within and between individuals depending on circumstances. Individual cognitive attributes and
resources combine with environmental aspects such as ethical climate to influence the degree of accuracy with which the moral features of any given situation are identified and interpreted at any one time (Blum, 1991).

### 1.1.4 Moral Judgement

The second component involves the ability to provide a sound rationale for one’s decision about a moral problem (Bebau, 2002). The challenge would seem to be to prioritise moral values over personal values. Bebeau clarified that “deficiencies in [judgement] are apparent when personal values such as self-actualisation or protecting one’s self or organisation replace concerns for doing what is right” (p.285), while Walker (2002) contended that different types of conflicting moral judgement might be operating at the same time. He also contended that, “having reasoned through a conflict and identified the moral course of action [it] does not necessarily imply that one feels compelled to act in this way” (p.358).

### 1.1.5 Moral Identity

There are two major components related to moral identity. The first component is strength of conviction to follow through with an identified moral decision (Bebau, 2002; Bebau et al., 1999). Bebeau contended that “if the practitioner wilts under pressure, is easily distracted or discouraged, or is weak-willed, then moral failure occurs because of a deficiency in identity and competence” (p.287).

The second component related to moral identity was related to implementation skills (Guthrie, 1997; Walker, 2002). Walker (2002) summed this component up when he indicated that “[this] component in the model entails the personality attributes and cognitive strategies involved in the implementation of actions that are consistent with the moral choice” (p.359).

### 1.1.6 Moral Implementation

Moral implementation involves deliberating over multiple considerations, deciding which option should be made, justifying that choice, and determining what action is morally right or wrong (Guthrie, 1997; Walker, 2002). It involves the process of implementation of the decision within the social realm, and is often described as moral character as well as moral courage (Rest, 1983). Moral implementation as character is a first-generation operational definition of the fourth component that focuses on personality traits or dispositions including at character, courage, or ego-strength (Rest, 1986). The limitations of this approach alone are that it fails to
acknowledge research that situational factors more strongly correlate with behaviour, and that situational characteristics inhibit or interact with moral traits in inconsistent ways (Mischel, 1968). In studies of moral exemplars, individuals thought of as courageous by others often do not perceive themselves as courageous, but as simply attending to the demands of the situation (Rule & Bebau, 2005).

Rest’s conception of moral implementation, however, carried elements that acknowledged the situational contributions to shaping behaviour. Implementation involves executing and implementing a plan of action, and necessitates the formulation of a sequence of concrete actions, working around impediments and unexpected difficulties, overcoming fatigue and frustration, resisting distractions and allures, and keeping sight of the eventual goal (Rest, 1986). Rest’s operational definition links substantively to the development of communication and leadership capacities, managing the demands of relationships in a pluralist society, and negotiating organisational climate and politics without compromising the moral self. Thus, moral implementation is defined as an anticipatory step in interacting with the social world, involving intra- and interpersonal capacities.

Intrapersonal capacities involve managing internal conflicts arising from imagined or actual implementation of the moral behaviour (e.g. anticipation of positive or negative sanctions, or coping with out-group opposition). Interpersonal capacities intersect with the anticipated or actual reactions from others to moral ideas, which may initiate controversy or conflict. Managing interpersonal communication about moral ideas thus involves persuasion, negotiation, and conflict resolution. Although courage may be required in order to confront an oppositional actor, it may not be sufficient to negotiate a moral resolution to a conflict. Despite the effectiveness of the individual in negotiating a moral agreement, the severity of opposition to a proposed moral behaviour may doom even the most ethically competent. Situational factors within the social environment or the moral agent’s level of competence may block attempts at moral behaviour.

1.1.7 Moral agency

Lutzen & Ewalds Kvist (2012) use the term moral agency to capture the dynamic and integral relationship between these concepts in relation to the experience of moral distress. Moral agency, in this sense, indicates a capability for morally-considered action and embodies an awareness of the moral significance of one’s actions, a sense of benevolent concern and accountability for the wellbeing of others and a process of discernment regarding particular courses of action (K. Lutzen & Ewalds-Kvist, 2013). Enactment of moral agency involves coherence between moral judgement and capacity for implementation. When individuals are ultimately prevented from exercising their moral agency and subsequently act in discordance
with their moral judgements and values there is potential for moral distress to occur (Figure 1).

Figure 1: The onset and development of moral distress.
1.1.8 Ethical work environment – a mitigating factor

Research regarding the relationship between the ethical climate of healthcare environments and the level of moral distress experienced by practitioners has indicated that practitioners working in what they perceive to be positive ethical climates are less likely to suffer from moral distress (Hamric, Borchers, & Epstein, 2012). Healthcare organisations act as moral communities with varying levels of congruence and cohesion between their publicly stated values and the values that patients and employees experience in practice (Webster & Baylis, 2000). Organisations that have positive ethical climates consistently reflect their values in their organisational strategies, priorities, structures, and processes which are evident in promotion of patients’ rights, openness and tolerance towards ethical difficulties, conflict management, and the manner in which multi-disciplinary working is structured and facilitated (Corley, Minick, Elswick, & Jacobs, 2005). The practitioners’ capacity to act as a moral agent is relationally embedded in the network of interactions and relationships that they have with the multi-disciplinary team and organisational administration practices. This network of individuals can operate in a manner that either exasperates or minimises the opportunity for moral distress to arise through the way in which it responds to individuals highlighting situations of moral concern (Rich & Ashby, 2013).

1.1.9 Distinctions: stress, moral stress and emotional distress

The terms moral distress and moral stress are frequently conflated within the literature and not clearly differentiated from experiences of stress and emotional distress. Stress occurs when an individual perceives their adaptive resources to be under strain or exceeded by environmental or situational demands and results in a wide range of physical, cognitive and behavioural symptoms and indicators (Lazarus, 2006). Evolving biomedical advancements continue to generate increasingly complex moral and ethical challenges. Examining ethical principles and resolving moral conflicts and dilemmas within clinical practice can place high demands on practitioners’ cognitive, emotional and physical resources and subsequently presents a potential source of cause specific stress. Moral stress generated through managing the ethical complexities of practice is distinct from moral distress in that whilst responding to ethically and morally challenging situations may be taxing it does not necessarily involve the violation of core values and beliefs that underpins the experience of moral distress. Similarly emotional distress represents a psychological reaction to circumstances or events that may not have a moral dimension (Epstein & Hamric, 2009).
1.1.10 Effects of moral distress

Studies concerning moral distress in the nursing profession have identified significant negative consequences for both the individual clinician and quality of patient care. The initial feelings of anger and outrage that are experienced during the event often develop into enduring feelings of guilt, hopelessness, loss of confidence, decreased self-esteem, exhaustion and burnout (Burston & Tuckett, 2013). Physical symptoms of nausea, insomnia, headaches and fatigue are also reported (Wilkinson, 1988). Coping mechanisms include emotional and physical withdrawal and distancing from patient care and increasing passivity in the face of clinical judgements felt to be contrary to the best interests of the patient (Krishnasamy, 1999; Sundin-Huard & Fahy, 1999). Moral distress has also been found to be associated with leaving positions for alternative posts and leaving the profession (Corley, 2002; Hamric & Blackhall, 2007; Hamric et al., 2012).

Epstein and Hamric (2009) outlined the crescendo effect as both a contributory factor and outcome of moral distress. The crescendo effect posits the relationship between moral distress and moral residue. Moral residue is used to refer to the enduring feelings of reactive distress identified earlier by Jameton. Over time, after each experience of moral distress the intensity of the feelings dissipate, however a level of moral residue remains creating a new base line. It is suggested that increasing incidents of moral distress result in cumulatively increasing levels of moral residue creating increasingly intense crescendos. New incidents of moral distress incite more intense emotional reactions as the person is reminded of earlier experiences as illustrated in Figure 2.

Figure 2: Model of the Crescendo Effect (reproduced from Epstein & Hamric (2009).

Whilst the model has intuitive merit empirical evidence is limited. Whilst some studies do evidence a positive correlation between moral distress levels and post
qualification experience (Elpern, Covert, & Kleinpell, 2005) other studies have found either no significant relationship (Corley, Elswick, Gorman, & Clor, 2001) or an inverse trend (Kälvemark Sporrong, Höglund, Hansson, Westerholm, & Arnetz, 2005). Given that available data has been drawn from different disciplines, specialties and settings, using a variety of instruments, it is not possible to draw any firm conclusions as to the validity of the model from the available evidence.

Moral distress has also been interpreted in a more positive light as an experience that can provide opportunity for personal growth, reflection and increasing resolve to develop personal skills to better handle repeated incidents or motivation to address systemic issues or injustice in the workplace (Hanna, 2004). Similarly the moral outrage experienced during the initial stage of moral distress may provide an energising platform from which to address perceived injustices and find means with which to enact one’s moral agency.

1.2 Who can suffer from moral distress?

The initial emphasis on external constraints within Jameton and Wilkinson’s theories of moral distress contributed to an initially narrow research agenda that focused predominately on the experience of nurses. This was in part due to the historical perception of the profession as subordinate to other disciplines within the medical hierarchy, and therefore the most likely to experience distress as a result of the restrictions imposed by others (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). As the conceptual boundaries of moral distress have developed, so too has the research interest in the experiences of other professional groups. The findings have shown that whilst moral distress was initially delineated within nursing the concept is relevant across other professional healthcare groups as each role carries its own code of ethics, professional regulations, legal requirements, perception of clinical goals and relational position with allied disciplines to be balanced against the individual practitioner’s moral framework (Jameton, 2013). Subsequent studies have suggested that moral distress is relevant to and reported by various disciplines including psychiatric nurses, psychiatrists, podiatrists, psychologists, physiotherapists and respiratory therapists (Austin, Bergum, & L, 2003; Austin, Kagan, Rankel, & Bergum, 2008; Austin, Rankel, Kagan, Bergum, & Lemerreyer, 2005; Carpenter, 2010; Losa Iglesias, Becerro de Bengoa Vallejo, & Salvadores Fuentes, 2010; Schwenzer & Wang, 2006).

1.3 Is moral distress (potentially) a problem for pharmacists?

Whilst it has historically received scant consideration in bioethical discourse, there is an emerging recognition that pharmacy is a value-based profession with a strong ethical grounding (Deans, 2010). During the past several decades, the pharmacy
profession has sought to become more patient-focused and embraced an increasingly expanded role that incorporates the broader aspects of pharmaceutical care. The goal of this is sharing the responsibility for optimal drug-therapy outcomes between pharmacists and patients. This shared responsibility between pharmacists and patients implicitly implies an ethical covenant between the two. Pharmacists play an active and influential role in patient care and are required to make clinical and ethical decisions regarding safe access to medicines and treatment. As pharmacists expand their roles to include pharmaceutical care, there are significantly more opportunities for ethical and moral problems to arise. The commercial nature of community pharmacy presents additional and potentially conflicting pressures that pharmacists must continue to address and resolve.

Pharmacists working in the UK operate within a highly-regulated occupational sphere, and are bound by strict legal frameworks and codes of professional conduct. This regulatory environment creates the potential for moral distress to occur due to the limitations it places on acting in congruence with moral judgements. A number of studies have considered the prevalence of moral distress in Swedish pharmacists: however, to date, no similar studies have been done in the UK. Given that Swedish pharmacists operate within a unique healthcare system it is unclear to what extent the findings of these studies can be generalised to UK pharmacists.

Of particular concern is Kalvemark et al’s (2004) finding that pharmacists knowingly practised outside of regulatory and legal requirements as a means of avoiding situations in which they would have otherwise experienced moral distress. Clearly this approach presents risks for patients in terms of receiving pharmacy care that does not comply with the legal and professional safeguards that work to ensure safe pharmacy practice, and for the pharmacists themselves in terms of the potential repercussions for their continued registration. An enhanced understanding of the extent to which community pharmacists experience moral distress in their working lives, and its antecedent triggers, would enable the development of guidance, supportive resources, targeted interventions, and strategies to reduce such incidences.

2. Review of the Literature

The concept of moral distress has been researched using qualitative, mixed method and quantitative approaches. The qualitative studies have aided the delineation of the concept by illuminating the lived experience of moral distress whilst highlighting the perspectives, views and meanings derived from individual and focus group interview data. Quantitative studies have sought to measure and analyse the causal relationship between moral distress and associated variables. A number of studies
have adopted a mixed methods approach and utilised qualitative approaches to aid subsequent quantitative instrument development.

2.1 Qualitative research

Much of the initial qualitative research relating to this subject emerged from studies in which moral distress was not the primary focus, but in which it later transpired to be a significant theme within the data. Varcoe et al. (2004), for example, conducted 19 semi-structured focus groups to explore nurses’ understanding and experience of ethics and enacting ethical practice. The study sought to illuminate how nurses arrived at, and acted upon, their ethical judgements. The findings indicated that nurses viewed ethical practice as both an intrinsic way of being and an extrinsic process of enactment. The participants described having to constantly work ‘in-between’ competing values and interests, their own values, and those of their patients and their employers in order to exercise their moral agency. Ethical practice and the moral good were seen as dynamic and heavily context-dependant in relation to the patient’s changing wishes, goals and needs. The nurses spoke of feelings of significant distress in situations where they felt unable to provide care that they felt reflected the moral good. Constraints on ethical practice included the corporate ethos of medical settings overriding nursing goals such as care, comfort and dignity and a lack of resources and time to provide quality care.

Gutierrez (2005) conducted semi-structured focus groups with 12 critical care nurses specifically to explore their experiences of moral distress and their perceptions of the consequent impact on patient care. The findings supported the previous work of Varcoe, and indicated that moral distress was often associated with situations in which the nurses felt accountable, yet powerless, and excluded from decision making. Clinical scenarios in which moral distress arose involved aggressive futile medical treatment, disregard for the patient wishes, inappropriate use of health care resources, and the deception or withholding of information from either the patient or their family. The participants described feelings of anger, frustration, fear, disgust, and sadness; and physical sensations of pain, sleeplessness, and fatigue. The nurses highlighted numerous internal and external constraints on moral action, including physician and family expectations of the nursing role, ineffective communication between families and physicians or physicians and nurses, time limitations, feelings of isolation and apathy, fear of reprisal or causing distress to others, and hierarchical power discrepancies and gender roles. Consequences of moral distress included emotional and physical withdrawal from patients and families, provision of less personalised care, reluctance to come to work and refusal to act as primary nurses for particular patients.
Withdrawing from, or minimising exposure to, patient care as a consequence of moral distress was also evident in the work of Fry, Harvey, Hurely & Foley (2002). These authors sought to investigate the phenomenon of moral distress in US military nursing personnel by using semi-structured interviews to gather experiences from 13 nurses who had participated in crisis military deployment. In situations where the nurses identified conflicting values they spoke of a period of appraisal in which they considered their ability to take action within the context of the situation, the positive and negative outcomes for all concerned, and any perceived constraints. In situations where they felt prevented from enacting what they believed to be morally required, they described initial feelings of anger, frustration, anxiety and discomfort. Strategies to resolve situational constraints included increased patient advocacy and consultation with senior colleagues. If attempts at resolution were unsuccessful, the participants described a sense of chronic and enduring distress characterised by tearfulness, loss of sleep, loss of confidence, low self-worth and withdrawal from patients and nursing practice. The nurses’ accounts appear to reflect and support the stages of initial and reactive moral distress that were initially theorised by Jameton and Wilkinson.

The findings of Fry et al. (2002) also reflect the findings of an earlier study conducted by Sundin-Huard and Fahy (1999) concerning nurses’ attempts to use patient advocacy as a means of overcoming constraints in order to resolve feelings of initial moral distress. The authors adopted an interpretive interactionist approach to explore the participants’ experiences of challenging medical treatment decisions that they felt were contrary to the patient’s best interests. The study highlighted issues such as low staffing, inadequate skill mix and expertise within the team, time pressure, goal disparity between medical and nursing staff, and conflicting legal and moral obligations as contributory factors to their feelings of moral distress. Initial moral distress was associated with feelings of moral outrage, anger, sadness, disgust, and frustration. Attempts to advocate were often unsuccessful and carried significant personal risks such as being relocated to other units, being isolated by one’s peers, and subject to complaints or scapegoating. Unsuccessful attempts to advocate were associated with feelings of increased and enduring distress, burnout and decisions to leave the profession.

Studies concerning professions other than nursing have indicated that although the constraints and antecedent sources of moral distress may differ, that moral distress is relevant for other occupational groups. Austin et al. (2008) undertook a hermeneutic phenomenological study of the moral distress experienced by Canadian psychiatrists in their clinical practice. They found that although psychiatrists perceived themselves as relatively autonomous practitioners within the medical hierarchy, they nonetheless felt constrained by the legal requirements of their
profession, organisational policy and practices, and a societal pressure to utilise their professional powers to achieve aims that they felt conflicted with their professional obligation to act in the best interests of the patient. The study highlighted the relational nature of constraints on acting in line with one’s conscience and illustrated that constraints on action are relevant to professions outside of nursing.

A later study by Brazil, Kassalainen, Ploeg and Marshall (2010) explored moral distress in a sample of 18 Canadian healthcare professionals involved in the provision of community-based palliative care including nurses, social workers, physiotherapists, occupational therapists, and speech and language therapists. This descriptive study used a critical incident approach to frame individual interviews. Content analysis of the interview data identified three themes relating to moral distress; the role of informal care givers, challenging clinical situations, and service delivery issues. The role of informal carers was portrayed as a predominately community specific antecedent to moral distress due to the high level of involvement informal carers may have in the hands on provision of care. The findings suggest that research regarding moral distress should be broadened to consider allied healthcare professionals and the varying settings in which they practice including the community.

2.2 Quantitative research and instrument development

Corley, Elswick, Gorman & Clor (2001) developed the first Moral Distress Scale (MDS) to quantify levels of moral distress amongst nurses working in critical care settings. The MDS comprised of a 32 item inventory of clinical situations, which respondents were required to rate with regards to associated levels of distress using a seven-point Likert scale. The questionnaire items were derived from the findings of a literature review and the content analysis of interviews with three critical care nurses. The scale was submitted to an expert panel for consideration of content validity and subject to test retest and group-comparison procedures with a small pilot sample. The questionnaire was mailed out to 214 nurses working in hospitals across the US. Each item yielded scores suggesting moderately high levels of moral distress. The item relating to inadequate patient care as a result of low staffing generated the highest mean score. Factor analysis revealed three factors; individual responsibility, against the person’s best interest, and deception. The scale did not meet unidimensionality criteria, which indicated that an interpretation of an overall score would not be meaningful. The demographic variables of the participants were not found to be significant.

The MDS was later revised (MDS-A) by Corley, Minick, Elswick & Jacobs (2005). Six additional items were derived from a further literature review. Participants were required to rate each item on two seven-point Likert scales, the first scale relating to
intensity of experience and the second scale frequency of occurrence. The instrument was again reviewed by a panel of experts for consideration of content validity. The questionnaire was administered alongside the Ethical Environment Questionnaire (McDaniel, 1997) to a sample of 106 general nurses in two US medical centres. The findings indicated that the item regarding working with unsafe staffing levels yielded both the highest scores in terms of both frequency and intensity of moral distress. The mean moral distress intensity score indicated moderate levels of distress whilst the mean frequency score indicated infrequent occurrence. A low negative correlation was found between age and moral intensity.

Both the MDS and MDS-A were developed for use with Registered General Nurses working within hospital settings. A number of subsequent studies have further adapted these instruments for use in other clinical settings or occupational groups. Hamric & Blackhall (2007) modified the MDS-A to gather data regarding the levels of moral distress experienced by nurses and physicians providing end of life care within intensive care units in two US institutions. The study also collected data relating to the respondents' perception of quality of care, the level of collaboration and communication within the multi-disciplinary team, and the ethical climate on the units. The authors adapted the MDS-A by removing items that they felt were inapplicable to end of life care, reducing the number of scale items to 19. Participants were asked to rate both the frequency and intensity of the distress they experienced using a five-point Likert scale. A total of 229 participants responded. The findings revealed that the highest score for intensity of distress across both professional groups related to futile aggressive treatment. Overall scores relating to intensity of experience were similar for both groups: however, nurses reported experiencing moral distress more frequently than physicians. Nurses also rated the ethical climate, quality of patient care, and degree of collaboration to be lower than physicians.

More recently, Hamric, Borchers & Epstein (2012) have proposed a further revision of the MDS-A (R-MDS) which purports to capture levels of initial moral distress and moral residue. Items within the MDS-A which were considered to be outdated were removed and the remaining items reconfigured so as to be broadly applicable across health care disciplines which resulted in a 21 item scale. Respondents were required to rate item for frequency and intensity of experience using 5-point Likert scales. The R-MDS was then developed into six parallel versions, each worded for various disciplines and settings including physicians, nurses and allied health care professionals, in both adult and paediatric environments. The questionnaire was assessed for content validity before being piloted with a sample of 206 nurses and physicians in adult and paediatric critical care units within a US medical centre. The questionnaire was administered alongside the Hospital Ethical Climate Survey
(Olson, 1998). The results indicated that moral distress scores were significantly higher for nurses than physicians and that items relating to futile end of life care yielded the highest mean scores across both professions. Moral distress was also found to be negatively correlated with ethical climate. Number of years of post-qualification experience was found to be positively correlated with moral distress scores for nurses but not physicians.

The MDS has also been adapted to explore moral distress in other allied disciplines. Schwenzer & Wang (2006), for example, modified the MDS to explore the frequency of moral distress in a sample of respiratory therapists. They reworded the items in the scale to reflect respiratory therapy practice, removed inapplicable items reducing the scale to 28 items and adopted a 5 point Likert scale. The revised instrument was trialled with a sample of 57 respiratory therapists from a single US hospital site. Exploratory factor analysis of the data indicated an underlying five-factor structure, which included: individual responsibility; deception; “not in the person’s best interest”; inadequate staffing; and futile care. Items in the “not in the person’s best interests” factor received the highest mean ratings.

Other authors have developed alternative scales to measure moral distress in specific occupational groups. Wiggleton et al. (2010), for example, devised a 55 item survey to capture the intensity and frequency of moral distress experienced by medical students. The questionnaire items were identified primarily from a literature search regarding moral dilemmas and ethical dilemmas in medical education. A number of items from the MDS that were felt to be relevant to students were also included as were six items relating to internal and external constraints on action. Following an initial pilot study the survey was electronically mailed to a sample of 106 medical students of which 60% responded. The results indicated that, on average, the students had experienced approximately half of the scenarios and experienced mild-to-moderate distress in a third of these cases. The results also indicated a gender difference, with female students witnessing distressing events with greater frequency, and male students reported more intense distress.

Wocial & Weaver (2013) have recently developed the Moral Distress Thermometer (MDT) as a means of measuring real-time (rather than cumulative) moral distress levels. The thermometer is an eleven point visual analogue scale with verbal descriptors accompanying each point (Figure 3).
During its development 529 nurses working in various hospital settings rated the level of distress they had experienced over the preceding two weeks using the MDT and completed the R-MDS. The results revealed a low to moderate correlational in scoring between the two instruments.

2.2.1 Moral Distress Research Relating to Pharmacy Practice

Until recently, studies of moral distress in the profession of pharmacy have been limited to three, small scale studies of Swedish pharmacists. Kalvemark et al. (2004) explored levels of moral distress experienced across a range of hospital-based health care disciplines, including pharmacy in a qualitative study that gathered data from a series of semi-structured focus groups held with cardiology, haematology and pharmacy personnel. Content analysis highlighted themes relating to resources, rules versus praxis, conflicts of interest and lack of supporting structures. The results showed that participants from each of the occupational roles voiced frustration and distress in response to the ethical dilemmas that they faced in practice. Ethical dilemmas were seen to arise primarily from the conflicting interests of the patient and the interests of the organisation. Participants also spoke of the stress that they experienced as a result of violating professional rules in order to act in line with their personal beliefs regarding what was right. On the basis of this the authors proposed a revised definition of moral distress as “traditional negative symptoms that occur
due to situations that involve ethical dimensions and where the health provider feels she/he is not able to preserve all interests and values at stake”. This definition indicates that acting morally may still be associated with a feeling of morally-grounded distress. It could be argued however that this broadening of the concepts incorporates and conflates moral stress with moral distress.

The qualitative data and definition of moral distress gathered from this study was then used to inform the development of a questionnaire to measure moral distress in a sample of pharmacy staff working in three different pharmacy practices (Kälvemark Sporrong et al., 2005). The questionnaire included an inventory of fourteen pharmacy-related practice situations and one global question regarding the experience of being forced to act against one’s conscience. Participants were asked to rate each item on a four-point Likert scale with regards to associated levels of stress. A total of 59 pharmacists completed the questionnaire. The results indicated that the pharmacists did experience moral distress as a result of ethical dilemmas in daily practice. There was no significant difference in that reported between staff at the different pharmacies. Prioritising between patients was reported to cause the highest level of distress. The global statement regarding acting against one’s conscience also yielded high scores with younger pharmacists expressing significantly higher levels of distress than their older colleagues in this regard.

Kalvemark Sporrong, Hoglund & Arnetz (2006) went on to develop a questionnaire that could be used to quantify moral distress across various health care settings and disciplines including pharmacy. The questionnaire aimed to capture the degree of moral distress experienced and the level of tolerance and openness towards moral dilemmas. Questionnaire items were developed from data gathered during three semi-structured multi-disciplinary focus groups, which dealt with daily practice situations felt to present stressful ethical dilemmas. Content analysis found that the participants had raised 15 clinical scenarios relevant to pharmacy and 15 relevant to other clinical settings. Eight of the scenarios were believed to be applicable across the disciplines and were subsequently formulated into questionnaire items. Participants were asked rate the extent to which they found the situations stressful on a four-point Likert scale. Four items were also included regarding tolerance towards moral dilemmas which were again rated on a four-point Likert scale.

The questionnaires were then distributed alongside the Quality Work Competence (QWC) psychosocial questionnaire (Arnetz, 1997). Responses were received from 200 clinicians and 59 pharmacists. A two factor structure of moral distress, and tolerance towards moral dilemmas, was predicted and confirmed. Significant differences between clinicians and pharmacists were apparent for both factors with pharmacy workers reporting less moral distress and greater openness towards moral dilemmas than physicians. Older participants across the two groups reported less
distress than their younger colleagues. There was no correlation between moral distress and the QWC questionnaire subscales which the authors interpret as confirmation that the instruments capture different constructs, moral distress and generic stress respectively. The second factor of tolerance towards moral dilemma correlated with the social climate subscale of the QWC indicating that in effect they are quantifying the same issue.

Houston et al. (2013) conducted a large multi-disciplinary study of moral distress in the US that incorporated pharmacists. The study surveyed hospital-based physicians, student physicians, registered nurses, pharmacists, physiotherapists, occupational therapists, speech therapists, respiratory therapist, nutritionists, social workers and chaplains. The authors modified nine items from the MDS which they felt to be applicable across all disciplines and then produced varying numbers of occupational specific questions which were aimed at physicians, student physicians, social workers & chaplains, or registered nurses & therapists. Pharmacists were included in the therapist group. Participants were asked to rate the items for both intensity and frequency on a 7-point Likert Scale. The online survey was completed by 2721 respondents. The moral distress scores were summed and averaged by occupational group. The findings indicated that moral distress scores was high for all disciplines but that the intensity and frequency of moral distress associated with each scenario varied across the occupational groups. Intensity of distress was consistently rated higher than frequency by all disciplines. The results indicate that moral distress is a relevant issue across healthcare occupational groups. From the data presented, it is unfortunately not possible to separate the pharmacists’ responses from those of other occupations included within the therapist group.

2.3 Limitations of moral distress instruments

The various moral distress scales and questionnaires that have been developed to date have been based on varying conceptualisations and definitions of moral distress and, as such, there is a lack of consistency in terms of the concept that they purport to measure. This inconsistency makes aggregation of the existing research data problematic as it is difficult to discern if the various measures are capturing different constructs or different aspects of the same domain (Hamric, 2012).

The MDS and MDS-A are the most frequently used instruments in quantitative studies concerning moral distress: however, they have been criticised on a number of points; at 32 and 38 items respectively, they are lengthy and time-consuming to complete whilst the level of factorial cross-loading reported indicates that some items measure more than one aspect of moral distress. Follow-up studies have typically utilised small samples drawn from single study sites in specialist clinical areas thereby limiting claims to reliability. The construct validity of the MDS has also been
questioned given its theoretical grounding in Jameton’s theory of moral distress, which does not incorporate the broader constraints, such as personal limitations, that have since been identified (Hanna, 2004). The scenarios contained within the MDS and MDS-A are now also quite dated with many no longer reflecting contemporary healthcare practices. The R-MDS and many of the alternative tools that have been developed have not yet been trialled beyond their development and subsequently evidence regarding their psychometric properties is limited.

The only instruments that have been developed for use with pharmacists have been developed in Sweden and the US both of which operate different models of healthcare provision than the UK. The definition of moral distress adopted during development of the Swedish studies encapsulates and conflates moral distress with moral stress and as such captures data that relates to a broader domain than the construct of interest in this study.

3. Methodology

3.1 Aims & objectives

The aim of the project was to construct and validate a questionnaire to measure the extent to which UK community pharmacists experience moral distress in their working lives.

3.2 Questionnaire development strategy

A potential pool of questionnaire items were identified from the findings of an extensive literature search and a review of existing moral distress instruments. A focus group was then conducted with practising pharmacists to explore the relevance of the proposed items whilst also facilitating the generation of additional item domains.

Once formulated, the questionnaire was validated by a panel of academic and community pharmacy in the Department of Pharmacy at the University of Hertfordshire. The questionnaire was then distributed to a pilot sample.

3.3 Literature search and existing instrument review

A search was undertaken of several electronic databases including PubMed, Scopus, Web of Science and Google Scholar using combinations of the search terms moral, ethics, distress, stress, instrument, scale and questionnaire. The resulting literature and existing moral distress instruments were reviewed for clinical practice issues and scenarios with potential to create moral distress which also held
potential relevance to pharmacists. The findings were compiled into an initial item pool which was then used as a topic guide in the subsequent focus group session.

3.4 Focus groups

Group consultation took place in two stages: an initial, opportunistic group consultation session, followed by two purposively-sampled smaller focus groups.

The focus groups were used to explore whether the practice scenarios highlighted in the literature review were of actual relevance to community pharmacists within their working lives whilst also providing opportunity for the participants to identify any other scenarios or issues for item development. Focus groups can be used to provide an opportunity for participants who are representative of the intended subject group to be involved and consulted in the development, improvement and adaption of surveys (Streiner & Norman, 2008). The language and terminology used by participants during the focus group discussions can also be taken into consideration when formulating and refining wording of scale items (Nassar-McMillan & Borders, 2002).

Focus groups are small structured groups made up of selected participants that are used in research as a means of generating qualitative data (Litosseliti, 2003). The groups enable participants to explore and voice their perceptions, views and experiences of specific topics through group discussion and interaction. The research data is generated through the interactions that occur between participants as they listen to, reflect on and respond to the views of others within the group (Finch & Lewis, 2003). Focus groups provide a unique setting in which participants receive immediate feedback about how other participants feel in response to what they have said. The desire to be understood and to understand others promotes intense exploration of topics and provides opportunities for synergism and interpretive insights as participants consider and build on each other's contributions (Morgan, 1998). The directness, fluidity and versatility of this approach allows for disclosure of information across contexts including feelings, values, opinions and motives resulting in rich contextual data that can illuminate complex influences and nuances (Litosseliti, 2003).

The primary strength of focus groups is their ability to gather different perspectives and experiences regarding the same topic within a relatively short time frame. The interaction of the group enables a variety of responses and promotes greater personal reflection, exploration and development than can be achieved within individual interviews (Kitzinger, 1995). The data is grounded within the group discussion and is therefore comparatively less influenced by the researcher than can be the case in individual interviews (Bowling, 2009).
It should be acknowledged that focus group discussions may not reflect the views of all participants due to a perceived pressure to conform to predominant views within the group rather than raise a dissenting perspective (Kitzinger, 1995). In that sense it can be difficult to differentiate individual and group perspectives. Focus groups have subsequently been criticised for capturing what participants say that they do, believe and think rather than what they actually do, believe and think when outside of the focus group environment (Finch & Lewis, 2003). Due to the discursive nature of focus groups the input from each individual participant is also comparatively limited in comparison to alternative methods of gathering qualitative data such as individual interviews. It can be countered, however, that the individual detail that may be lost in focus groups is balanced against the benefits of data that includes active comparison of experiences (Morgan, 1998).

Focus group data should be considered as illustrative and indicative as opposed to supporting broad interpretative generalisations (Bowling, 2009). The data gathered during the following focus group makes only limited claims regarding the experiences of those who participated. The primary purpose of the group was to orientate and assist in the development of the questionnaire.

### 3.4.1 Initial group consultation

During the introduction, the (seventeen) participants were briefed as to the underlying objectives of the study and informed as to how the session would be recorded and reported with reference to confidentiality. It was made clear that all views and perspectives on the topic were of interest and that there was no expectation that a consensus of opinion would be reached. The topic guide was used to stimulate discussion but participants were also encouraged to raise any other issues they felt were relevant.

The group was initially split into two smaller groups (of eight and nine members, respectively) to reduce the artefacts described by Finch & Lewis (2003). After 45 minutes, the groups were brought together. At this point, the facilitators introduced items raised in each sub-group for open discussion. The session lasted for approximately one-and-a-half hours and was recorded using SMOTS™, an audio-visual recording & broadcast system (Scotia UK plc, 2009).

The audio recordings of the session were transcribed verbatim and thematically coded using deductive content analysis. NVivo 10 (2013), a computer software platform for the analysis of unstructured data, was used to record and assist in the development and organisation of the subsequent coding and themes. Qualitative content analysis is one of a range of approaches, including ethnography, phenomenology, and grounded theory, that can be used to analyse text data.
Content analysis focuses upon the contextual meanings stored within the text and enables large amounts of text data to be classified into categories that are representative of a common meaning (Graneheim & Lundman, 2004). The systematic process of coding, and identifying and classifying emerging themes and patterns, facilitates rigorous and replicable subjective interpretations of the text data with the aim of increasing knowledge and understanding of the concept in question (Hsieh & Shannon, 2005).

Content analysis can be either inductive or deductive in its approach. An inductive approach is recommended when the existing knowledge base is in the early stages of development or believed to be fragmented in some respect. Themes are derived from the data using open coding, grouping and categorising to enable abstraction and conceptual mapping to create a resonant description of the phenomenon (Elo & Kyngas, 2008). In contrast, the deductive approach requires the coding of data to be made with reference to a preconceived analysis framework which is developed from existing literature. Key principles or variables are identified and operationally defined as initial coding categories for use during analysis. This approach is most frequently used to validate or extent a prevailing theory or model (Hsieh & Shannon, 2005).

As the existing evidence base regarding moral distress in community pharmacy is limited an inductive approach to data analysis was adopted.

The transcript was read through in its entirety several times before being subject to open coding. During this stage headings and labels were used to describe all aspects of the content. These initial codes were then organised into categories and then further categorised into category clusters and themes. The category content was re-examined and compared at various stages throughout the analysis and codes or categories felt to capture the same entity within the data were merged and reconfigured.

Analysis of the consultation group demographics revealed significant under-representation from young and newly-qualified pharmacists. In order to gather data from a more representative sample using a method that would facilitate greater depth and personal input from each participant two smaller focus groups were convened.

### 3.4.2 Purposive focus groups

Participants for the focus groups were recruited using a purposive sampling strategy that targeted pharmacists with less than ten years post-qualification experience and pharmacists less than thirty years of age. Participants were recruited using the University of Hertfordshire’s pharmacy alumni mailing list. As a newly-accredited
pharmacy school, all alumni are – by definition – members of the former
demographic group, and most are members of the latter. Two focus groups were
convened. Transcripts were collected and analysed as described in Section 3.4.1.

4. Results

4.1 Focus group demographics

4.1.1 Initial group consultation

An invitation to attend the consultation group was made to members of the
Hertfordshire Local Practice Forum (LPF). The initial group was comprised of 17
participants, all of whom were pharmacists; and included community pharmacy
owners, employees and locum tenens, hospital pharmacists and pharmacists
working in an industrial setting. The characteristics of the group are presented in
Table 1.

Table 1: Characteristics of the consultation group participants.

<table>
<thead>
<tr>
<th>Pharmacist</th>
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<td><strong>Employment:</strong></td>
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<td>Community (locum)</td>
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<td>Hospital</td>
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<td><strong>Post-qualification experience (years):</strong></td>
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<td>11 – 20</td>
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<tr>
<td>Over 20</td>
<td>12</td>
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</table>
4.1.2 Purposive Focus Groups

Six pharmacists responded positively to the invitation to participate in the follow-on focus group sessions. The participants were split into two groups, characterised by age, as this allowed for one member of each of the three lowest categories of post-qualification experience to participate in each group. The demographic characteristics of each group are presented in Tables 2 and 3.

**Table 2:** Characteristics of focus group A.

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<td><strong>Post-qualification experience (years):</strong></td>
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Table 3: Characteristics of focus group B.

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4.1.3 All participants

The demographic characteristics of all participants of the item development focus groups are presented in Table 4.
### Table 4: Demographic characteristics of all focus group participants.

<table>
<thead>
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<td><strong>Post-qualification experience (years):</strong></td>
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<td>Over 20</td>
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#### 4.2 Focus group findings

The participants raised and discussed a range of pharmacy practice scenarios that they associated with the experience of moral distress both self-initiated and in response to the topic guide developed from the literature review. Content analysis of the data identified 13 themes relating to moral distress that were broadly categorised into three groups; dispensing of medicines, sale of medicines, and practice issues. The most frequently cited constraints on action were legal or regulatory in nature: however, contractual obligations, self-interest, and resource shortages were also cited.
4.3 Dispensing of medicines

4.3.1 Controlled drug dispensing

The practice scenario that appeared to be most significantly associated with the experience of moral distress concerned situations in which the pharmacists were required to make a decision as to whether or not to supply controlled drugs in situations where to do so would be unlawful. The Misuse of Drugs Regulations 2001 lay down procedural requirements for the storage, supply, and use of medicines falling within controlled drug categories. The pharmacists described situations in which they felt confident that the request made by the patient was legitimate but that the required procedural aspects of dispensing could not be complied with due to absent or incorrectly written scripts presented at a time when sourcing a replacement was logistically difficult e.g. Saturday or out of hours services. In these situations the needs of the patient and the pharmacists’ intention to prevent suffering conflicted with the professional requirement to act within legislative guidelines and an awareness of the potential personal consequences of acting unlawfully. The pharmacists spoke of an acute awareness of the possible consequences for the patient of not supplying and their distress at being unable to do what they felt was in the patient’s best interests.

“If I don't supply this guy he’s going to start using [heroin], I want to keep the guy clean, if he starts using again he goes backwards and that’s no use to anyone”.

4.3.2 Emergency hormonal contraception (EHC)

A number of studies have highlighted the variation of opinion within the pharmacy profession regarding the sale of EHC (Cooper, Wingfield, & Bissell, 2008). Religious and moral views indicating that EHC represents a form of abortion render the transaction particularly ethically problematic for some pharmacists. At present pharmacists are permitted to decline EHC sales by referring to General Pharmaceutical Council conscience clause, which requires that they must direct patients to an alternative supplier (Gallagher, Holton, McDonald, & Gallagher, 2013). For some pharmacists, this conscience clause continues to present moral difficulty as it is perceived as facilitating the individual’s access to and use of EHC. The participants within the focus group did not identify any specific incidences whereby they had experience moral distress in this context; however, one participant outlined a scenario in which she had sold EHC not against her moral beliefs but contrary to her clinical judgement due primarily to persistent pressure from the customer.

1 (Misuse of Drugs Regulations 2001 (SI 2001/3998))
“I had one the other day wanting EHC, she came to see me, it had happened two days previously, the incident, she’s on St. John’s Wort, her periods were all irregular, she menopausal, I felt that she needed to go and see a doctor, she didn’t want to see a doctor….tried to set up an appointment for her, she refused, I just didn’t feel comfortable selling it to her but you know…moral distress!”

4.3.3 Emergency supplies

Pharmacists are permitted, under the Human Medicines Regulations 2012,\(^2\) to dispense limited supplies of prescription only medication in the absence of a valid script if they are satisfied that the patient has previously received a prescription for that medication and that there is an immediate need for the medicine in question. During the focus group one participant raised a situation in which he had not dispensed an emergency supply requested by a patient’s representative due his concerns regarding procedural compliance.

“I had one case, I didn’t dispense, but it was somebody who came in for their Aunt, who was, he said that she was having an asthma attack, he was explaining on behalf of the patient and the patient couldn’t come into the pharmacy … and they were on my records but I didn’t dispense because I felt I needed to see the patient.”

The participant went on to indicate that his decision not to dispense in this situation because of regulatory constraints created a feeling of enduring unease due to a concern for the patient’s welfare.

4.4 Sale of medicines

4.4.1 Off licence indications

Previous studies have highlighted pharmacists concerns regarding patient’s requests for medicines in the absence of an appropriate licensed indication (Cooper, Bissell, & Wingfield, 2006). In instances whereby patients persist in requesting the medicine after being informed that it is not licensed for the treatment of their particular symptoms pharmacists have described conflicting concerns regarding whether to respect the individual’s autonomy against a personal desire not engage in professionally poor practice. This was echoed by a number participants in the focus group with one person raising the following example:

\(^2\) (Human Medicines Regulations 2012 (SI 2012/1916))(reg.225)
“What about occasions when a medication is licensed but not for them, say a lady over 60 wanting Canesten®? The guidance is you must refuse her but what if she insists ‘I’ve used it before, it works for me and I need it now’.”

Refusing the request on the basis of licensing was associating with concern and anxiety for the customer’s welfare particularly when circumstances suggested that accessing their GP would be difficult.

4.4.2 Commercial incentives

Participants indicated that the perception of the individual as an autonomous consumer and awareness of company policy to promote commercial incentives was felt to conflict with a professional duty not to facilitate the sale of a medicine thought to be contrary to the person’s best interests. In May 2001, a decision in the Restrictive Practices Court ended the exemption from the general ban on resale price maintenance enjoyed by branded over-the-counter medicines (Appelbe & Wingfield, 2009, p. 292). Pharmacies are now permitted to offer promotions – such as three-for-two offers – that were previously prohibited. This was considered to be ethically problematic by some of the pharmacists, who described a sense of responsibility for generating and influencing purchases that were not necessarily medically required or advised.

“The big pharmacy groups they put out offers “three for two”, so the customer, I won’t say patient, the customer sees the offer as a financial benefit, when you’re working as a clinical person, the patient is looking for three packs of whatever and you know that clinically only one pack is the right one thing for them.”

4.4.3 Link selling

Commercial values and a pressure to link sell to generate additional sales were highlighted by several participants who indicated that contractual constraints and workplace policy created a pressure to incorporate link selling strategies regardless of their personal views or the actual needs of the customer.

“The thing is as an employee you sign a contract and with that contract are obviously terms and conditions and selling or link selling may be one of those terms and conditions.”

4.4.4 Selling unregulated products

The sale of unregulated products including e-cigarettes and homoeopathic products were also raised with concerns regarding their diverse quality and efficacy. The
pharmacists indicated that they were under pressure from employers and customers to sell such products despite their personal views on their appropriateness.

4.5 Practice issues

4.5.1 Confidentiality

The participants raised the example of terrorist legislation as being illustrative of a scenario in which they might be compelled to breach patient confidentiality. One participant also related a suspected safeguarding incident in which she felt compelled by company policy to breach a customer’s confidentiality, but felt a sense of discomfort which was heightened when, following investigation, the allegations were deemed to be unfounded.

4.5.2 Whistleblowing

A number of participants highlighted the challenges inherent in raising concerns regarding the practices of colleagues, employers and other health care professionals. The General Pharmaceutical Council’s Standards of Conduct, Ethics and Performance (Wiggleton et al., 2010) (ss.2.4 & 7.11) stipulate that pharmacists have a professional duty to alert the relevant authority to incidences of conduct that threaten public safety. Scenarios in which concerns were not reported due to competing concern for the professional in question and concerns of self-interest relating to job security and working relations with other colleagues and managers were easily envisaged.

“If you are employed by a pharmacist or a group of pharmacies and you feel practices are unsafe and you feel certain things that are done are inappropriate, then you’re sort of weighing it against your job.”

4.5.3 Asserting clinical judgement

Actively challenging prescribers regarding prescriptions that contained medicines or doses thought to be inappropriate or likely to cause negative interactions was described by participants as being particularly difficult. The participants described situations in which they had acted against their clinical judgement and dispensed prescriptions that they felt were questionable and not in the best interests of the patient. One participant became quite visibly distressed when recounting a situation in which she had dispensed a prescription against her clinical judgement following numerous unsuccessful attempts to challenge the prescriber.

“I’ve had a situation where a lady’s on lithium... she comes into me to buy ibuprofen, so I know she’s on lithium, refused to sell it to her, she’s adamant that
Moral Distress in Community Pharmacists

she wants it, she won't leave the pharmacy until she gets her Ibuprofen, so I say to her I'll write you a little note to take to the doctors saying “she’s on lithium she wants to buy ibuprofen, I don't think it’s appropriate”, … She goes to see her doctor who writes her a prescription for ibuprofen 300mg three times a day! [I] rang the doctors’ up – “No, her lithium levels are fine, she’s absolutely fine”. I obviously counselled the patient saying I don’t believe it’s right that you take this, told her about the side effects, she’s adamant that she wants them, she’s getting really very upset … it turns out she got lithium toxicity.”

The participants cited professional hierarchy, pressure from patients, concerns for commercial and professional reputation and fears regarding loss of business as factors constraining clinical assertion.

4.5.4 Time constraints

Feeling unable to provide an adequate level of service due to time constraints was cited as a significant factor in the experience of moral distress. Awareness that the service being provided was below what was professionally felt to be required was coupled with a feeling of responsibility yet hopelessness due to the high workload and number of customers coming to the pharmacy.

“Do you spend twenty, thirty minutes or do you just give them what they want so that you can serve the rest?”

4.5.5 Customer autonomy

The participants highlighted a number of instances in which their professional judgement had conflicted with the preferences and wishes of the customer. Customers were perceived as both capacitous adults who were at liberty to make unwise choices and as empowered consumers who would simply take their custom elsewhere if they were refused a product. The pharmacists indicated that they felt the influence of their professional expertise was diminishing and that they were becoming increasingly disempowered in this respect. Examples were also given of acquiescing to a customer’s request as a means to pacify them in light of their increasing anger or upset at having their request questioned or refused.

4.5.6 NHS

Dispensing medication that was felt to represent a misuse of NHS resources was raised by one participant as a source of discomfort. Challenging the prescriber or patient in this instance was described as being difficult for the same reasons as asserting clinical judgement. In this scenario it was depicted as particularly difficult as the outcome of dispensing was not potentially detrimental to the patient. The
pharmacist perceived their intervention in this instance as being on behalf of the NHS or taxpayer.

“For example, we are talking about one customer who insists on collecting all of her medication on a regular basis knowing they are not going to use them at a cost of something like a hundred pound to the NHS every month.”

4.6 Themes not related to moral distress

A number of themes also emerged from the focus group data that were not directly related to the experience of moral distress or concerned scenarios that occurred outside of the community practice setting. These themes were subsequently discarded from further consideration for item development.

4.6.1 Hospital pharmacy issues

Participants highlighted a number of issues that they felt were specific to hospital based pharmacy and not likely to be relevant in community practice settings predominately concerning licensing.

P1: “The question is sometimes, do you give them for instance, we might say tablets or dispersible tablets if they may not take them or aren’t capable of doing so or do you pay however many hundred odd pounds for a bottle of something else.”

P2: “Potentially that’s what happens in hospitals, the advice is always to crush and flush which of course makes something is unlicensed, if there is only an expensive liquid alternative.”

The participants indicated that hospital pharmacists experienced different pressures with regard to cost of medicines, formulations and hospital policies than community pharmacists.

4.6.2 Pharmacy as a profession

Two overarching and diametrically opposed themes appeared to pervade the discussions relating to the participants perception of the profession of pharmacy itself, namely: the identification of pharmacists as “guardians of medicine”; and the disempowerment of the profession. These beliefs in turn appeared to influence views as to the plausibility of moral distress as a relevant concept for pharmacy.
4.6.2.1 Pharmacists as guardians of medicine

A number of participants spoke of their belief that pharmacists could and should use their expert knowledge and clinical judgement to actively consider and engage with the ethical complexities of pharmacy practice. They highlighted their views that pharmacists should feel accountable for ensuring good practice by using their knowledge to influence the decisions of allied professionals, patients and customers without acquiescing to the demands of the medical hierarchy.

“If you perceive yourself to be, as I do, as a guardian of medicine and of the patient’s best interests and as having an expertise within medicine, the fact that you’ve got a legal prescription doesn’t oblige you to dispense it necessarily. It obliges you to make a professional assessment, if after you’ve done your assessment you think it inappropriate to dispense then you don’t dispense.”

Pharmacists were seen as ‘involved’ and influential with a clear sense of responsibility regarding their acts and omissions and the consequences thereof. Moral distress in this context was a significant threat or reality as pharmacists talked of their distress at being constrained from doing what they felt was the right thing due to the individual sense of accountability that they felt for the impact of their decisions and actions on the patient or customer.

4.6.2.2 Pharmacists as passive and disempowered

The opposing perspective saw pharmacists as ultimately having little scope to influence or impact on the behaviours of prescribers or customers. Pharmacists were perceived as disempowered and largely ignored by prescribers and patients. Patients were seen as consumers who could simply choose to take their business elsewhere if they did not get the response they wanted from a pharmacy. There was appeared to be an attitude of deference to prescribers and an unwillingness to question or consider the moral implications of decisions or practices and a sense of distance between the pharmacist and any potential outcome.

“If they have got a prescription, I dispense it and that is that.”

“There are other pharmacists who will sell these products if I don’t.”

4.6.3 Breaking the rules to avoid moral distress

In common with Kalvemark et al’s (2004) study the participants spoke of incidences whereby they had acted against regulatory and legal requirements in order to act in congruence with what they felt was morally right.
“I’m prepared to dispense, for the benefit of the patient, and that overrides everything … and I’ve done that before and I’d do it again, I’m sure it’s illegal and I accept that, but at the end of the day I have a duty of care to that patient.”

“[An] addict hadn’t picked up for a few days and we’re then not supposed to dispense and the pharmacist took the decision, it’s a weekend again, to give a reduced dose, made a calculation – and that, of course, is illegal because you’ve got to give the dose on the prescription or nothing [at all].”

The most frequently cited motivating value for deciding to act against regulatory requirements was a concern for the patient's welfare. Participants spoke of an awareness of the potential personal consequences of their actions in terms of their professional registration, employment, personal reputation and loss of business but expressed a sense of conviction that their actions were justified.

5. Questionnaire development

5.1 Issues of Specificity

Instruments and scales can be constructed to capture data of varying levels of specificity or generality depending on whether the tool is intended to relate to a specific construct or provide a more general measure (DeVellis, 2011). Scale specificity can be set on a number of dimensions such as content domain, setting or population. The greater the level of specificity the lower the degree of generalizability the scale will hold. Scales high in specificity limit the extent to which data can be compared across groups: however, those high in generalizability have fewer items per included domain, and subsequent data can be less sensitive to variation (McDowell, 2006). Cronbach (1990) used the analogy of bandwidth to illustrate this relationship. Receivers that can detect a wide bandwidth of radio waves lack acoustic clarity with respect to individual stations. Those that only detect one station with resounding clearness will be largely unreceptive to other frequencies. Scale specificity should reflect the data required to meet the individual research question.

The aim of this study was to create an instrument that could be used to explore and quantify levels of moral distress within community pharmacists. The findings of the focus group suggested that significant differences exist between community and hospital pharmacy practice in terms of work tasks, patient groups and type of service provision including the additional commercial aspect inherent in community pharmacy. A high level specificity was subsequently felt to be justified and the instrument was developed solely for use with community pharmacists.
5.2 Scale construction

Each of the 13 themes identified were developed and worded as a statement that described a practice situation that could be rated in terms of frequency of occurrence and intensity of associated distress.

Likert scales are a form of attitude gauge often used as an overt measuring instrument in surveys. Respondents are invited to indicate their views, opinions or experiences within a given range (Streiner & Norman, 2008). The scale enables the respondent to indicate the degree to which they are in agreement or disagreement with the item statement. Likert scales include graduated response points anchored on a continuum by semantic descriptors (Oppenheim, 1998). Scales can comprise any number of points: however, scales with less than five intervals have been argued to lose subtle but discernible differences between participant responses (McDowell, 2006). Scales of seven or more intervals provide statistical advantages by increasing score variability: however, too large a scale can create inconsistency in interval selection as the differences between intervals becomes less tangible (Bowling, 2009). The ideal number of scale intervals selected for a given survey should attempt to maintain the instruments reliability whilst maximising its discriminatory power.

Scales with an even number of intervals have no middle point thereby forcing respondents to express a positive or negative stance on the item statement. Preventing a neutral response has been suggested to lead to lowered response rates or response bias and unreliability for participants that are genuinely unable to locate their viewpoint on the scale provided (Oppenheim, 1998). Selection of a neutral response has been found to be associated with the coarseness of the scale with respondents less likely to choose a neutral option on expanded finer scales where the negative or positive points either side of the middle interval represent a less extreme attitudinal belief than on shorter scales (Jacoby & Matell, 1971). A seven point (zero to six) Likert scale was chosen for this instrument with each item being rated for both intensity and frequency. An introductory paragraph was constructed which instructed respondents to select zero if the item concerned a scenario they have not experienced in their pharmacy practice in order to limit the possibility for hypothetical scoring.

Likert scales are presented as linear scales with the equidistant differences between interval points however this cannot be assumed given that the differences in attitudinal intensity between intervals cannot be truly quantified (McDowell, 2006). Scores for each item can be reported separately or summed to a total overall score. Interpreting only cumulative scoring has been argued to be disadvantageous given
that two identical total scores are often made up of significantly different sub-scores. Including an interpretation of individual item responses has been suggested to provide more a more meaningful reading of the data (Bowling, 2009).

5.3 Assessments of content validity

The validity of a scale relates its adequacy as a measure of the specific variable it intends to quantify (Streiner & Norman, 2008). Content validity concerns the degree to which a set of items reflects the construct domain in question.

The item pool and questionnaire format was submitted for review to a panel of 10 academics working in the Department of Pharmacy at the University of Hertfordshire. The reviewers were asked to consider and comment on the clarity of the introduction text and general layout of the questionnaire. They were also asked to evaluate the relevance of each item to the concept of moral distress along with the clarity and conciseness of each item. Suggestions for additional item domains were also encouraged to ensure that the item set reflected the construct of moral distress in its totality. The characteristics of the expert review panel are presented in Table 5.

Table 5: Characteristics of the expert review panel.

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A number of changes were made in response to the feedback received in terms of general format; the item statement was highlighted rather than the question header.
as it was felt to draw the reader’s attention towards the question itself and the scales were reordered so that frequency was presented before intensity. No additional item domains were proposed.

6. Pilot survey

6.1 Response rate

The questionnaire was then piloted with a small sample of community pharmacists using a self-administered online survey. A link and invitation to take part in the survey was emailed to members of two LPFs.

Mailing lists of LPF members are held by the Royal Pharmaceutical Society (RPS). Distribution of the survey to members is a two-step process: A group e-mail is sent to all members of the LPF informing them that there is a link to the questionnaire on the local network area of the RPS website. Members can then go to the RPS website (by a direct hyperlink in the e-mail) to complete the questionnaire. However, e-mails regarding items that may be of interest are routinely sent to members at a rate determined by, for example, the number of RPS partner groups to which they subscribe. There are currently more than thirty such groups, many of which have overlapping remits (e.g. British Oncology Pharmacy Association (BOPA) and Faculty of Cancer Pharmacists (FCP)), or are structured in such a way that one group is, by definition, a subgroup of another (e.g. Palliative Care Pharmacist Network (PCPN) and United Kingdom Clinical Pharmacy Association (UKCPA)).

The London North and London North West LPFs have a combined membership totalling approximately 3,100: however, as at 4 November 2013, only 51 pharmacists had viewed the posts on their respective websites linking to the questionnaire. Of these, 21 pharmacists (11 from London North and 10 from London North West) completed the questionnaire. This can be interpreted as a response rate of either 0.06% (21/31,000) or 41% (21/51). In this case, the latter is probably the correct choice, as e-mails alerting LPF members to various surveys, news items and forum entries are sent on a daily basis, and anecdotal evidence suggests that the frequency of these e-mails is such that many members ignore them, and do not click on the embedded hyperlink to the LPF website. This highlights the need to reconsider the use of LPFs as a method of distributing the questionnaires in a regional or national survey.

6.2 Reliability

The overall $\alpha$ value for the questionnaire was 0.855, while the $\alpha$ value if any item is eliminated ranged between 0.833 and 0.854. These results suggest that none of the
13 items should be eliminated. Indeed, removal of any one item led to only a minimal improvement in the reliability coefficient. The overall value of $\alpha = 0.855$ demonstrates high reliability according to the criterion of Graham and Lilly (1984).

7. Feedback

An additional response box was added at the end of the pilot questionnaire inviting comments regarding the content and structure of the questionnaire. Feedback indicated that the wording of the item entitled “Snake Oil” lacked clarity and required rewording. Only one participant did not complete every aspect of the questionnaire, indicating that the scenarios held relevance for the respondents.

The sample used for the pilot study was not large enough, nor was the response rate sufficiently high, to allow any meaningful statistical analysis to be conducted: however, it did allow for statistical protocols intended to be used for the proposed future research to be tested and refined.

8. Future Research Strategy

The next stage of this research is to distribute the questionnaire to a large probability sample of community pharmacists. To that end, and giving consideration to the issues raised in Section 6.1, we are currently engaging with several bodies that represent community pharmacists with a view to employing their membership mailing lists directly.

9. Acknowledgements

The authors are grateful to Pharmacy Research UK for funding the development of this tool, and we acknowledge the University of Hertfordshire for agreeing to fund the large-scale survey of community pharmacists that naturally follows on from this initial success.

10. Ethical Approval

Ethical approval for this project was granted by the University of Hertfordshire Research Ethics Committee (Protocol Approval Number: LMS/SF/UH/00006).
11. References


Moral Distress in Community Pharmacists


Moral Distress in Community Pharmacists


Misuse of Drugs Regulations 2001 (SI 2001/3998).


Olson, L. L. (1998). Hospital Nurses' perceptions of the ethical climate of their work setting Image, 30(4), 345-349.


Appendix: Questionnaire

Moral Distress Questionnaire

Thank you for agreeing to participate in this survey, which seeks to measure moral distress in pharmacists.

Completing the Questionnaire

This questionnaire should take no more than 5-10 minutes to complete, and no personally identifiable information about you will be collected (i.e. your participation is anonymous).

You will be presented with some short descriptions of situations that pharmacists have identified as causing moral distress, followed by some non-personal information relating to your age, gender and experience. The questionnaire measures your perceptions of moral distress on two dimensions, namely:

1. the intensity of the moral distress; and
2. the frequency of its occurrence.

Please indicate (on a scale of 0-6) for each of the following situations, the extent to which such situations cause moral distress for you in your day-to-day practice, and how frequently you suffer from it. If you have not had experience with any one of the situations, please indicate "0" for both intensity and frequency.
## Moral Distress Questionnaire

**Controlled Drugs**

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being unable to dispense a controlled drug in the best interests of a patient due to an unmet legal requirement.*

### Frequency

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## Moral Distress Questionnaire

**NHS**

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being pressured to supply an expensive unlicensed medicine or formulation on an NHS prescription, rather than provide a cheaper, but equally appropriate, licensed alternative.*

### Frequency

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Moral Distress Questionnaire

Doctor Knows Best?

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Dispensing a prescribed medication against my clinical judgement because I feel unable to challenge the prescriber.*

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# Moral Distress Questionnaire

## Time Constraints

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being unable to provide the degree of patient care I would like due to time constraints.*

### Frequency

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Moral Distress Questionnaire

**Patient Autonomy**

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Suppiling a medicine at the insistence of a customer though this conflicts with my professional judgement.*

**Frequency**

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Moral Distress Questionnaire

Linked Sales

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being pressured to offer related, but unnecessary, items for sale (i.e. linked selling) though I feel this is unprofessional.*

**Frequency**

<table>
<thead>
<tr>
<th>Never</th>
<th>Once a year or less</th>
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### Moral Distress Questionnaire

**Emergency Supply**

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being unable to make an emergency supply in the best interests of a patient due to an unmet procedural requirement.*

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# Moral Distress Questionnaire

## Off License

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being pressured by a patient to supply a medicine though I suspect it is likely to be used outside its licensed indications.*

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Page 9
## Moral Distress Questionnaire

### Morning-After Pill

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Dispensing emergency hormonal contraception though this conflicts with my moral beliefs.*

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### Moral Distress Questionnaire

**Whistleblowing**

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Feeling unable to raise my concerns about the professional practice or competency of others.*

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Moral Distress Questionnaire

Confidentiality

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being forced to breach patient confidentiality (e.g. by the police, or under terrorism legislation).*

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## Moral Distress Questionnaire

**BOGOF**

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being pressured by a customer to supply medicines that are less clinically-suitable due to the presence of financial incentives (e.g. buy one, get one free).*

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### Moral Distress Questionnaire

**Snake Oil**

Have you ever experienced moral distress as a result of a situation that could be described in the following way?

*Being expected to use my professional standing to promote or supply products that have not been proven effective (e.g. nutraceuticals), or that have been proven ineffective (e.g. homoeopaths).*

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### Moral Distress Questionnaire

#### Demographic Information

**Gender:**
- [ ] Male
- [ ] Female

**Age:**
- [ ] 25 or under
- [ ] 26-35
- [ ] 36-45
- [ ] 46-55
- [ ] 56-65
- [ ] Over 65

**How many years have you been a qualified pharmacist?**
- [ ] 5 years or less
- [ ] 6-10 years
- [ ] 11-15 years
- [ ] 16-20 years
- [ ] More than 20 years

**Do you work full- or part-time in the profession of pharmacy?**
- [ ] Full-time
- [ ] Part-time

**In which area of pharmacy do you primarily work?**
- [ ] Community (owner)
- [ ] Community (employee)
- [ ] Community (locum)
- [ ] Hospital
- [ ] Industry
- [ ] Academia
- [ ] Other (please specify)
Moral Distress Questionnaire

Do you, in addition to the above, regularly (more than 5 days per year) in any of the following areas? (Please tick all that apply)

☐ Community
☐ Hospital
☐ Industry
☐ Academia
☐ Other (please specify)

What is your religious affiliation?

☐ Prefer not to say
☐ None, no preference
☐ Christian
☐ Jewish
☐ Muslim
☐ Hindu
☐ Sikh
☐ Other (please specify)