**Abstract**

***Objectives***

This study aims to explore the incidence of moral distress experienced by UK community pharmacists through the deployment of a previously developed and validated survey instrument to a national sample.

***Methods***

An e-mail inviting pharmacists to complete an on-line questionnaire developed to measure moral distress was successfully delivered via the mailing list of a nationwide support organisation for the pharmacy profession. Completed questionnaires were subjected to statistical analysis to determine to what extent common practice scenarios generated moral distress in community pharmacists.

***Key findings***

Time constraints represent the greatest source of moral distress for United Kingdom (UK) community pharmacists, scoring highest for both frequency and intensity of distress. The supply of emergency hormonal contraception (EHC) in opposition to religious beliefs scored lowest. Possible underlying causes of moral distress are discussed in the light of our results, and potential mechanisms for reducing the incidence of moral distress for this professional group are considered.

The reduction in the frequency and occurrence of moral distress is best achieved by the creation of morally habitable workplaces, where possible triggers can be identified and avoided. Structured undergraduate ethics education and accessible postgraduate training and resources could provide a meaningful opportunity to support pharmacists in exercising their moral competency or moral agency.

***Conclusions***

Moral distress provides a reliable indicator of constraints – in the form of policies, legislation, and regulations, and the structural and relational aspects of the working environment in which pharmacists practise. This provides invaluable information in the search for strategies to reduce the recurrence of this phenomenon.

## Introduction

The term ‘moral distress’ was first coined by Jameton to describe the experience of feeling unable to act in accordance with a moral judgment due to the presence of constraints.[1] The experience of moral distress has since been characterised as a distressing feeling of inner discordance or sense of fractured integrity that occurs when an individual’s personal or professional values are compromised due to their action or inaction.[2] Moral distress can be differentiated from feelings of moral uncertainty and moral dilemma, which are characterised by feelings of indecision, by the presence of certitude regarding the morally required action.[2]

Although the phenomenon of moral distress was initially delineated within the nursing literature, the concept has since been identified as relevant to a broad range of healthcare professions.[3-10] Studies have identified the situational binds created by legislation, regulation, and policy as a potential cause of moral distress, alongside internal constraints such as fear and self-doubt.[11-13] Furthermore, moral theorists have noted the impact of the relational and socio-political forces that characterise the workplace, including the inherent power asymmetries and relational structures that can serve to either support or constrain individuals from enacting their moral agency.[14]

Moral distress has been found to engender significant physical, emotional, and psychological consequences for the individual concerned, including headaches, fatigue, nausea, and insomnia, and feelings of anger, frustration, anxiety, sadness, guilt, hopelessness and powerlessness.[15] Moral distress has also been associated with occupational attrition and an intention to leave healthcare professions.[16-18]

Preliminary research concerning moral distress amongst UK-based community pharmacists identified three broad areas of practice associated with this experience: legislative constraints; challenges to professionalism; and commercialism.[19] With regards to legislative constraints, the highly-regulated environment of pharmacy practice was found to engender situations in which pharmacists felt unable to act in accordance with their professional or personal values. Frequently cited examples included feeling unable to lawfully dispense a controlled drug despite the belief that to do so was in the patient’s interest, and feeling compelled to provide emergency hormonal contraception (EHC) despite this conflicting with personal beliefs. The

theme ‘challenges to professionalism’ concerned the experience of feeling unable to assert professional judgement in the face of disagreement from others. This experience was associated with the ongoing shift towards collaborative models of care that increasingly position community pharmacists within complex intra and inter-professional hierarchies and relational networks with pharmacy and non-pharmacy colleagues, health professionals, and patients and customers. Moral distress was found to arise when pharmacists felt unable to successfully navigate these relational and organisational binds and ultimately acted against their professional judgement. The commercial nature of community pharmacy and the perceived pressure to prioritise the generation of revenue over customer needs was also cited as a potential source of ethical incongruence.

This study aimed to explore the incidence of moral distress experienced by UK community pharmacists. This was achieved by the deployment of a previously developed and validated survey instrument to a national sample.

## Methods

Ethical approval for this study was granted by the University of Hertfordshire Research Ethics Committee (Protocol Approval Number: LMS/SF/XX/00006). The instrument was distributed as a self-administered online survey via the Pharmacy Defence Association’s (PDA) mailing list. The PDA is an independent, not-for-profit representative organisation for pharmacists. Its membership spans a number of demographic groups, including the self-employed, pharmacy owners, and the employees of both small and national pharmacy chains.

The survey is comprised of thirteen items relating to the themes and practice scenarios previously identified as sources of moral distress for UK community pharmacists.[19,20] Each item asks the same question, “Have you ever experienced moral distress as a result of a situation that could be described in the following way?”, before presenting a practice scenario in a single statement (**Figure 1**). Participants were required to rate each item for both frequency and intensity using a seven-point Likert Scale. A list of items and statements are provided in **Table 1**. The instrument has previously demonstrated good levels of internal consistency for both frequency and intensity subscales.[19] Principle component analysis (PCA) indicated

that the data yielded by each subscale is unidimensional and representative of a single underlying construct.

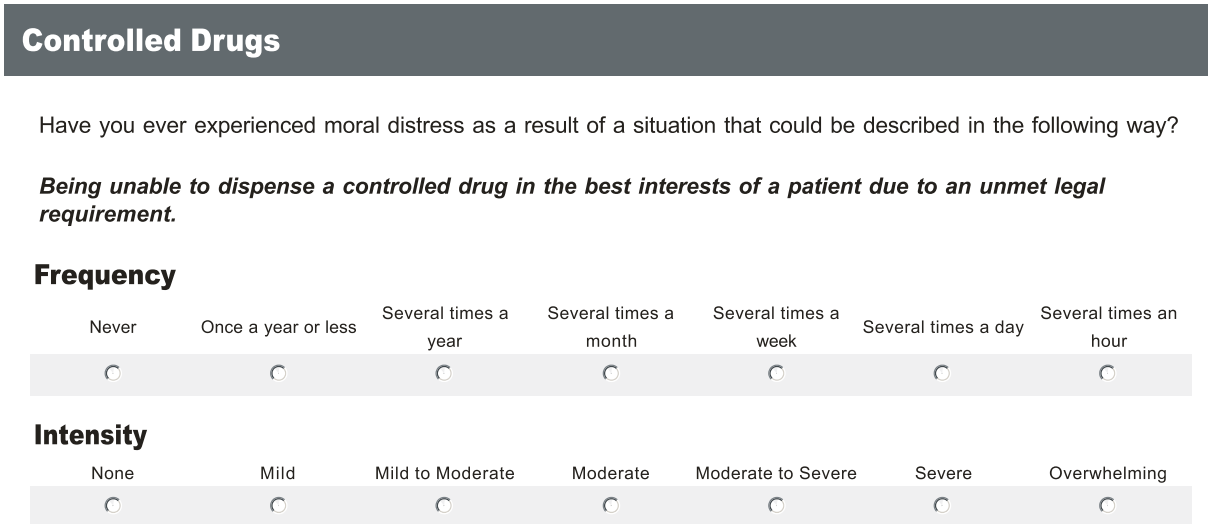


***Figure 1:*** *Item 1 (Controlled Drugs) as it appears on the online pilot survey for the questionnaire. Matching 7-point Likert scales for each of the two dimensions in which moral distress is to be measured are included for each of the 13 items.*

Data analysis included simple descriptive statistics and statistical analysis. The descriptive statistics included basic frequencies with regards to frequency and intensity scores. The Likert item data was considered to be ordinal and as such did not meet the assumptions required for parametric data analysis (e.g. ANOVA). Non-parametric tests including Mann-Whitney,[21] Kruskal-Wallis,[22] and Jonckheere-Terpstra,[23] were subsequently employed to explore the impact of the demographic variables. Stepdown stepwise analyses were used to further investigate statistically significant differences between groups.[24]

Data generated from survey instruments of this type can be interpreted using either individual or cumulative scoring. We have previously contended that due to the nature of Likert-type scales, the later approach is often invalid as the differences between scale intervals cannot be precisely quantified.[19] Furthermore, two identical cumulative scores can be derived from significantly different sets of sub-scores. The frequency and intensity subscales were intended to capture data regarding different dimensions of moral distress and were subsequently analysed separately. Each of

the thirteen items of this questionnaire is reported separately, and items measuring the moral distress associated with different themes in the same category are considered and compared so as to give the most meaningful interpretation of the data with a view to determining which aspects of practice cause the greatest degree of moral distress to this professional group.

## Results

### *Response rate*

An e-mail inviting pharmacists to participate was successfully delivered to the mailboxes of 20,433 recipients in August 2014. Participants were first required to open the email, and then to click on a hyperlink to access the on-line survey. The survey could only be completed once from each e-mail address, and remained live for one month. An email reminder to complete the survey was sent out two weeks after the initial invite. 1618 (7.9%) of the email recipients clicked through to the survey. The expected response, based on experiential data from the PDA, was approximately 450 (2.2%). A total of 1340 (82.8%) pharmacists went on to the survey. Some 421 respondents indicated that they primarily worked in areas other than community pharmacy (hospital, industry, academia, or primary care) and were subsequently parsed from the sample. Inspection of text responses in the additional comments section highlighted a concern that the frequency Likert scale descriptors did not facilitate accurate recording of data for those working on a part-time basis. To ensure accurate representation of frequency of occurrence the sample was restricted to full-time pharmacists and a further 326 part-time pharmacists were subsequently parsed. The final sample of full-time community pharmacists retained for the final analysis totalled 593. At the time the survey was distributed, there were approximately 47,000 registered pharmacists in Great Britain.[25]

### *Demographics*

The demographic characteristics of the sample are displayed in Error! Reference source not found.. A chi-square goodness-of-fit test revealed a significant difference in the proportion of males (47.6%) and females (51.1%) in the sample as compared to the ratio (3:2) documented in the General Pharmaceutical Council (GPhC) registrant survey ($\chi^2 = 16.410$, $df = 1$, $p = <.001$),[26] indicating that females were underrepresented within the sample population. Significant differences were also

revealed between the proportion of pharmacy owners in the sample (0.9%) as compared to that documented in pharmacy registrant survey (11%) ($\chi^2 = 59.864$, $df = 2$, $p < .001$). The under-representation of pharmacy owners within the sample may be reflective of relatively fewer pharmacy owners subscribing to the PDA due to its organisational focus on the needs of pharmacy employees and locums.

The internal consistency of the subscales was reassessed using Cronbach's alpha coefficients.[27] Both the frequency (Cronbach's $\alpha = 0.837$) and intensity subscales (Cronbach's $\alpha = 0.854$) were found to have a high level of internal consistency. Inspection of the item total correlations did not reveal any items for which deletion would have substantially improved scale reliability, consistent with results published following the development of the tool.[20]

Jonckheere-Terpstra tests for ordered alternatives showed that gender was not found to significantly influence the frequency or intensity with which respondents' experienced moral distress across any of the item scenarios.

Pharmacists working in locum roles were found to experience more frequent and more intense moral distress in relation to customer pressure, emergency supply, and whistleblowing, compared to both employee pharmacists and pharmacy owners.

There was a statistically significant downward trend in median moral distress scores as age and years of experience increased. A marked decrease in both frequency and intensity scores in relation to age was observed, with the exception of items concerning the frequency of EHC-related distress and the intensity of distress associated with the inefficient use of NHS resources intensity, both of which were universally low. A downward trend was also observed in relation to years of post-qualification experience for all moral distress frequency and intensity scores, except items concerning both the frequency and intensity of distress associated with divulgence of confidential information, and the intensity of distress related to NHS resources. Again, these items scored low across all experiential groups. This indicates that younger pharmacists and those with less experience typically feel moral distress significantly more frequently and with greater intensity than their older and more experienced colleagues.

### *Most distressing scenarios*

The item with the highest median frequency score and the highest median intensity score concerned time constraints, with moderate-to-severe moral distress being reported in relation to this scenario several times a day (**Tables 3** and **4**). It is notable that 14% of respondents rated the distress associated with this scenario as overwhelming. Being unable to dispense a controlled drug in the best interests of a patient due to an unmet legal requirement was found to typically generate moderate levels of moral distress several times a month. Three scenarios which fell under a general theme of challenges to professionalism (i.e. Asserting Professional Judgement; Patient Autonomy; and Whistleblowing, **Table 1**) were found to generate moderate levels of moral distress at a frequency of several times a year. The practice of "linked selling" of products was also found to provoke moderate levels of moral distress several times a year.

### *Least distressing scenario*

The lowest median frequency and intensity scores were generated by the item concerning the issue of EHC; with respondents indicating this scenario did not typically arise, nor generate any distress when it did occasionally do so.

## Discussion

### *Response rate*

The analysis of the results highlighted several limitations inherent with the distribution of surveys via mailing list. We were unable to determine how many of the 20,000 pharmacists to whom the invitation to participate was sent received or opened the e-mail: however, we were able to show that, of the 1,600 pharmacists who subsequently opened the survey, 83% completed it. This compares very favourably with the reported average (2.2%) There are a very small number of organisations in the UK that retain a mailing list containing significant numbers of pharmacists, and those that do are very protective of them. The GPhC, for example, maintain a mailing list of all registrants: however, they limit its use to GPhC business (e.g. informing registrants to renew their licensure) and research that they have commissioned. The phenomenon of survey fatigue is cited in the literature as being responsible for increasing rates of refusal,[28] and so it is understandable that

organisations that use mailing lists as part of their business are reticent to share these resources.

### *Locum pharmacists*

Locum pharmacists were found to experience more frequent and more intense moral distress in relation to distressing scenarios compared to both employee pharmacists and pharmacy owners. The transitory nature of locum contracts may serve to expose locum pharmacists to an increased susceptibility to situational pressures and organisational demands, due to a heightened levels of personal risk associated with asserting oneself in each new workplace. It is also possible locums are unable to engage in the process of socialisation and habituation to individual workplace environments and cultures, engendering a more acute awareness and sensitivity to suboptimal practices, and thereby increasing the frequency with which moral impasses are encountered. The Public Interest Disclosure Act 1998 does provide legislative protection for whistleblowers:[29] however locum pharmacists remain vulnerable due to the difficulty in establishing causation in respect of lost or reduced employment opportunities. The *Freedom to Speak Up* report highlighted the difficulties experienced by locum practitioners in respect of raising concerns regarding practices that occur within the NHS.[30] Locum workers have previously been found to experience isolation and marginalisation within the workplace, and are less likely to have established relational networks within the workplace from which to access support and guidance.[31]

### *Age and years of experience*

The demographic categories of “age” and “years of post-qualification experience” represent associated – although not analogous – dimensions, and it is unsurprising that a parallel trend emerged across the data set in relation to both factors. The finding that younger pharmacists and those with less experience typically feel moral distress significantly more intensely than their older and more experienced colleagues is consistent with the trend for age previously reported by Kalvemark Sporrong et al. for Swedish pharmacists and physicians.[8,32] This is also aligned with Haddad’s finding that younger and less experienced pharmacists are more likely to encounter ethical problems relating to their work and experience greater difficulty in resolving such issues.[33] Although Haddad’s study does not directly consider moral

distress, it can be argued that pharmacists that encounter more frequent ethical dilemmas and attribute greater difficulty to securing a satisfactory resolution are at an increased risk of moral distress. The qualitative data gathered during the earlier phase of the current study identified age and relative inexperience as an issue that was seen to work against pharmacists and add to the situational pressures they experienced.[19] Novice pharmacists also spoke of the risk of being ostracised by their colleagues at a time in their professional life when support and guidance was most crucial. This reflects existing research indicating that novice community pharmacists report feeling isolated from their peers and lacking the skills and confidence to effectively influence colleagues and exercise their autonomy.[34]

The evidence concerning age and post-qualification experience in the context of other healthcare disciplines is mixed. Several authors have reported a positive correlation between moral distress scores and years of post-qualification experience,[17,35] whilst others have found no such correlation in respect of years of post-qualification experience or age.[36] None have reported a negative correlation as observed in this study. The evidence supporting a positive correlation between these factors was used to underpin Epstein and Hamric's model of moral distress known as 'the crescendo effect'.[37] The model predicts a longitudinal increase in moral distress intensity over time as each new experience adds cumulatively to the unresolved emotional residue from previous experiences. The trend concerning age and years of post-qualification that emerged within the current study is incompatible with this model. The Crescendo Model was developed as an explanatory model based upon the findings of several studies exploring moral distress in the context of critical care nursing. It is likely that the nature of the care provided within critical care units positions nurses in exceptionally close spatial-temporal proximity to patients. This level of proximity may not allow nurses to morally disengage to the same degree as community pharmacists occupying less intimate roles. An inability to adopt strategies by which to reduce the inner dissonance experienced due to moral distress may account for the cumulative effect described by the model. Community pharmacists typically occupy positions and work within environments that position them at the opposite end of the spatial-temporal continuum. Previous research has drawn attention to the notable isolation that community pharmacists experience in their relationships with peers, other healthcare professionals, and patients and

customers.[38] This isolation is believed to be exacerbated by the relatively remote and largely solitary working conditions that characterize community pharmacies and the largely transient nature of the interactions between pharmacists and patients or customers. This has raised concerns that this sense of isolation may prevent the development of meaningful ethical discourse among community pharmacists, and contribute to a perceived lack of proximity to patients and customers. It is possible that these factors work to facilitate ethical disengagement in response to the experiences of moral distress.

One possible explanation for the reduction on moral distress among older pharmacists is that, as age and years of tenure increase, there is a corresponding growth in professional and ethical competence.[39-41] This ethical development may enable pharmacists to overcome the situational binds they experience more effectively. As experience increases, it is also likely that the individual is afforded some degree of career progression, which may in turn serve to lessen the intensity and breadth of the relational and situational constraints they perceive to be inherent within the workplace. These factors may combine to lessen the incidence with which pharmacists feel unable to act in accordance with their judgement and subsequently reduce the frequency with which they experience moral distress. Alternatively, it is possible that as newly-qualified pharmacists enter the environment of the workplace and encounter repeated experiences of moral distress they begin to employ self-protective strategies to lessen the emotional impact of failing to enact their moral judgements in practice. Strategies such as ethical desensitisation and dissonance reduction may offer a mechanisms by which to maintain a sense of positive self-regard despite repeated exposure to scenarios evoking moral compromise.[42(p. 10)] This interpretation suggests that the negative correlation observed across the data set is due to increasing ethical disengagement as opposed to increasing ethical competency.

The existing moral distress and pharmacy ethics literature lends greater support to the latter explanation. Wilkinson has previously reported that repeated exposure to experiences of moral distress led nurses to cultivate a sense of detachment from their work as a mechanism to restore and preserve their psychological equilibrium and minimise future experiences of distress.[43] The *Grounded Theory of Moral Reckoning* has also drawn attention to the impact of moral distress upon the ethical

identity of novice practitioners as they underwent a process of professional socialisation within the workplace and habituation into their new role.[44] Experiences of moral distress engendered a stage of reflection in which practitioners sought to make sense of, and accommodate, the discrepancies between their personal and professional values and their behaviour in practice. Kelly noted a stage of disorientation in which novice practitioners struggled to assimilate the professional ideals advocated during their training with the realities of the workplace.[45] The perceived importance of establishing and maintaining positive and supportive relationships within the workplace during this stage of professional development was believed to heighten the challenge of adhering to previously established professional values. Kelly described an ongoing process of rationalization in which practitioners revised and amended their professional identity and values in order to bridge the perceptual gap between their previous conception of a good practitioner and the reality of their practice. The *Personal Ethical Threshold* model formulated by Comer and Vega draws attention to the role that protective psychological strategies play in enabling individuals to maintain a sense of integrity whilst accommodating behaviour that was previously perceived to be unethical.[42] These mechanisms facilitate the reinterpretation or reframing of ethical issues as less significant or morally intense, whilst the repetitive engagement in moral transgressions enables a process of desensitisation and acclimatisation to behaviour previously considered to wrong.

Latif has previously posited that the retrogressive trend in moral reasoning scores amongst US community pharmacists was indicative of a process of occupational socialisation that undermined pharmacists' ability to recognise and evaluate the ethical aspects of their practice.[46] This research reasoned that pharmacists who chose to remain in community pharmacy began to cultivate a stance of ethical ambivalence and experienced a reduction in ethical cognition as a mechanism of adapting to the competing tensions of professional and commercial values that characterised the retail sector. Themes of ethical insensitivity and disengagement have also previously been identified in relation to community pharmacists practicing in the UK: Cooper, Bissell and Wingfield highlighted examples of ethical inattentiveness, moral deference, ethical passivity, and a failure to consider the ethical dimensions of daily practice;[38] and Deans has identified a lack of ethical literacy and engagement amongst UK pharmacists.[47]

The development of moral competency would be expected to reduce the frequency with which pharmacists experience moral distress, while having little effect on its intensity. A reduction in sensitivity caused by disengagement would have the effect of reducing both intensity and frequency. The reduction in intensity scores observed here suggests, rather, that there is a perceived decrease in the moral significance of the scenario, which is indicative of the processes of dissonance reduction and moral desensitization outlined by Cromer and Vega.[42]

### *Time constraints*

The results indicate that time constraints represent the greatest source of moral distress for UK community pharmacists. This finding reflects those previously reported by Corley,[48] who noted that workload pressures yielded the highest frequency and intensity scores in a study of critical care nurses. Previous research indicated that time constraints for community pharmacists are related to the parallel pressures of managing a high dispensing workload whilst also meeting targets concerning pharmaceutical services and commercial revenue.[19] Participants in semi-structured focus groups discussed how feeling unable to provide optimal patient care is associated with a sense of compromised professional identity and integrity and a concern for the efficaciousness and safety of the services provided within the pharmacy. This issue has been framed as one of substantial moral intensity due to the potential for significant harm to occur, particularly in the form of medication errors. It is possible that high workloads also serve to exacerbate the frequency with which moral distress is experienced in relation to other practice scenarios by reducing the time that is available to consider, resolve, and reflect upon ethical difficulties that are identified.

### *Possible remedies*

A reduction in the intensity of moral distress is not necessarily indicative of an increased ability to resolve moral conflicts, and may instead reflect reduced sensitivity to the moral dimensions of practice, a retrogression in reasoning skills, and moral disengagement. As such, the aim of any proposed interventions should not be solely to effect a reduction in the triggers for moral distress, nor to provide practitioners with strategies to cope with repeated experiences of moral compromise: rather, it should seek to enable systemic developments that promote moral

competency, support the enactment of moral agency, and enhance the moral habitability of community pharmacy environments.

### *Ethical Environment*

The scenario that generated both the highest frequency and the highest intensity of distress was that involving time constraints. This is in spite of the introduction of standards, which mandate governance arrangements safeguarding the health, safety and wellbeing of patients and the public.[49] Standards of this type set the minimum requirements against which pharmacy owners may be held accountable: however, each business-owner is responsible for ensuring the safe and effective provision of pharmacy services and the extent to which they wish to extend beyond the benchmark. Community pharmacies in the UK are businesses, which are paid to provide services to the National Health Service (NHS) under a standard contract. Pharmacies are generally paid on the basis of the number of service units provided (e.g. number of prescribed items dispensed; number of Medicines Use Reviews carried out). This necessarily creates a dilemma between providing maximum levels of patient care and maximising the profits of the business.

The General Pharmaceutical Council (GPhC), which regulates the profession of pharmacy in Great Britain, has recently updated their standards for registered pharmacies and published guidance concerning safe and effective pharmacy teams.[50] The guidance outlines the responsibility of pharmacy owners and directors in creating a working environment and culture that empowers pharmacists to demonstrate their professionalism and raise concerns in the absence of compromising targets and incentives. Although the guidance refers to the provision of appropriate staffing levels and skill mix, it stops short of establishing minimum staffing levels. Given the frequency and intensity of distress associated with time constraints and rising workloads, further evaluation of this issue and the degree of autonomy afforded to pharmacy owners and directors in this regard is warranted.

EHC was found to generate low levels of moral distress in terms of both frequency and intensity. At the time this research was carried out, the GPhC provided guidance for registrants which required those not wishing to supply EHC to refer patients to "an alternative appropriate source of supply available within the time limits for EHC to be effective".[51] Earlier, qualitative research among UK community pharmacists highlighted several potential barriers to enacting the conscience clause, including:

the timing of the customer's request and likelihood that they would be able to access alternative services; unsupportive co-workers or managers; and a fear of negative reprisals.[19] This has not been reflected in the levels of moral distress associated with this scenario, which is low among all groups, irrespective of their religious affiliation.

In 2017 the GPhC published new guidance which stipulated that pharmacists must *"take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs"*.[52] The revised guidance does not prevent pharmacists from being able to refer patients or customers to an alternative pharmacist or pharmacy provider, however, they will only be able to do so when this course of action does not hinder or deny the individuals access to person-centred care. The proposals signify a significant shift that places additional emphasis upon the needs and rights of the patient and adds a further qualification upon the circumstances in which pharmacists may decline to provide services based upon their religion, personal values and beliefs. The amended guidance places an onus upon pharmacy professionals to avoid placing themselves in situations "where refusal to provide services would result in a person not receiving the care or advice they need". The guidance emphasises the need for pharmacy professionals to be open with their employer and proactive in terms of making them aware of any personal values or beliefs that prevent them from providing certain pharmacy services. If pharmacists are to assume greater levels of personal responsibility with regards to proactively managing the occurrence of prospective value conflicts, this must be accompanied by a corresponding duty levied upon employers to create morally habitable workplaces in which open communication regarding religious affiliation, personal values, and beliefs are encouraged, respected, and fairly accommodated.

***Education***

Educating students and pharmacists about the issue of moral distress and its characteristics would enable practitioners to recognise and identify experiences of moral distress as they arise. Two temporal aspects of moral distress have been identified: initial distress and reactive distress.[2] Initial distress is experienced at the time that the individual becomes cognizant of feeling constrained from acting on their moral judgement and is typically characterised by feelings of acute anxiety, frustration, anger and outrage. Reactive distress is experienced in instances

whereby attempts to resolve the identified conflict or circumnavigate the constraints are unsuccessful, and the individual ultimately enacts the behaviour that they believed to be wrong and is characterised by enduring feelings of guilt, low self-esteem and powerlessness.

An ability to recognise initial moral distress provides opportunity for purposeful reflection, evaluation, and intentional action, thereby potentially reducing the frequency with which reactive distress is encountered. Several approaches and tools have been developed to assist and guide practitioners through real time experiences of moral distress.[53,54] Awareness of these approaches may enable practitioners to more proactively and effectively address experiences of moral compromise without employing the protective strategies of desensitisation and moral disengagement. Although moral distress was found to be most prevalent amongst newly-qualified pharmacists, the implications and strategies remain relevant for pharmacists at all stages of their working lives. As such, the scope and opportunity for accessible postgraduate training and resources concerning this area of interest warrants consideration by educational institutions.

Commentators, such as Wintrup, have criticised undergraduate training programmes for focusing upon moral theory at the expense of preparing graduates for the ethical tensions they are likely to encounter within the workplace.[55] It is argued that current educational approaches enhance students' abilities in respect of identifying ethical concerns and formulating reasoned arguments about how they ought to respond, but that is does not equip students with the necessary skills to enact the requisite action in practice. Reasoned judgement does not reliably equate with congruent action, and that even those practitioners who exhibit morally sensitivity and possess intact reasoning skills may struggle to act in accordance with what they believe to be right. The longitudinal trend revealed within this study indicates that newly-qualified pharmacists experience more frequent and intense experiences of moral distress than their more experienced colleagues. It has been argued that newly-qualified pharmacists are particularly vulnerable to experiences of moral distress due to the nature and scope of the situational pressures and personal risks they face in taking a stand during this transitional phase of their professional life. This finding poses implications for pharmacy education and indicates that pharmacy educators may be

ideally situated to support prospective pharmacists in developing the requisite skills necessary to enact morally congruent action in practice.

Truog et al. have argued for the inclusion of more embedded approaches to ethical analysis within medical education programmes.[56] Such approaches consider not only the 'outside in' perspective of traditional theoretical analysis, but also the 'inside out' view that sheds light on the evolving relational space that occurs between relevant actors as each unique situation unfolds. Conceptualising the 'inside out' enables consideration of theory within the context of practice, and provides opportunity for students to identify and consider the dynamic influence of situational and relational pressures on subsequent behaviour. Situating ethical issues in the context of where they unfold is also advocated by Wintrup.[55] Situated analysis expands the locus of evaluation to include the structural properties of the environment, the distribution of power, and the social processes that bear influence over the agent. It is argued that a more in-depth understanding of the ways in which these aspects operate enables agents to not only navigate these forces with greater fluency, but to influence and direct interactions and situations more effectively, engendering less incidence of moral compromise. The process of guided introspection encourages students to not only become more ethically sensitive, but more ethically self-aware. Gentile suggests that students are provided with structured opportunities to develop and practice arguments, positions, and scripts that they can utilise and draw upon in scenarios that are anticipated to provoke compromise.[57] Rehearsing a stance that is consistent with professional values has been found to render the skills and behaviour necessary to enact a position of integrity during instances of threat more accessible to the individual.[58]

Experiences of moral distress are grounded within the relational constraints that characterise the workplace. Divisions, conflict, and power imbalances, both within and between professions, impede meaningful dialogue and act as a barrier to safe comprehensive patient care. A greater level of inter-professional collaboration may serve to increase the ease with which such disputes are raised and resolved, whilst lowering incidence of moral distress and improving patient care. The recent policy initiatives to integrate pharmacy services into primary care settings and G.P. practices are evidence of a growing shift towards collaborative working. The introduction of inter-professional undergraduate ethics education sessions and inter-

professional ethics initiatives has also been proposed as a means of improving inter-disciplinary communication, facilitating shared understanding, and reducing professional isolation.[59]

## Conclusions

Austin has likened moral distress to an “ethical canary”, which offers a warning as to presence of misaligned values, systems, or practices.[60] Moral distress provides a reliable indicator of constraints – in the form of policies, legislation, and regulations, and the structural and relational aspects of the working environment in which professionals practice. Improvements are needed in respect of the moral habitability of the community pharmacy workplace, including reconsideration of workload and staffing levels, to enable community pharmacists to enact person-centred practice within the confines of the current regulatory framework. Additionally, pharmacy curriculums with an increased emphasis on developing moral competency or moral agency, as described by Latif and others,[46,61] together with strong inter-professional communication, should be considered as a means to reducing the incidence of moral distress. This requires a systemic approach to further enquiry and evaluation that seeks to promote the competency and confidence of pharmacists as moral agents whilst addressing the structural barriers to morally congruent practice.

## References


1. Jameton A. *Nursing Practice: The ethical issues.* Englewood Cliffs: Prentice-Hall.; 1984.
2. Jameton A. Dilemmas of moral distress: moral responsibility and nursing practice. *AWHONN's clinical issues in perinatal and women's health nursing.* 1993;4(4):542-551.
3. Austin WJ. Moral Distress and the Contemporary Plight of Health Professionals. *HEC Forum.* 2012;24(27-38).
4. Austin WJ, Bergum V, Goldberg L. Unable to answer the call of our patients: mental health nurses’ experience of moral distress. *Nursing Inquiry.* 2003;10(3):177-183.

5. Crnjanski T, Krajnovic D, Stojkov-Rudinski S, Tadić I. Ethical dilemmas and moral distress in pharmacy: A qualitative study. *HealthMed.* 2012;6(7):2485-2493.
6. Førde R, Aasland OG. Moral distress among Norwegian doctors. *Journal of Medical Ethics.* 2008;34:521-525.
7. Gutierrez K. Critical Care Nurses' Perceptions of and Responses to Moral Distress. *Dimensions of Critical Care Nursing.* 2005;24(5):229-241.
8. Kälvemark Sporrong S, Höglund AT, Hansson MG, Westerholm P, Arnetz B. "We are White Coats Whirling Round" – Moral Distress in Swedish Pharmacies. *Pharmacy World and Science.* 2005;27(3):223-229.
9. Losa Iglesias ME, Vallejo RB, Salvadores Fuentes P. Moral distress related to ethical dilemmas among Spanish podiatrists. *Journal of Medical Ethics.* 2010;36:310-314.
10. Schwenzer K, Wang L. Assessing moral distress in respiratory care practitioners *Critical Care Medicine.* 2006;34(12):2967-2973.
11. Nathaneil AK. Moral reckoning in nursing. *Western Journal of Nursing Research.* 2006;28(4):439-448.
12. Austin WJ, Kagan L, Rankel M, Bergum V. The balancing act: psychiatrists' experience of moral distress. *Medicine, Health Care and Philosophy.* 2008;11(1):89-97.
13. Austin WJ, Rankel M, Kagan L, Bergum V, Lemermeyer G. To Stay or To Go, To Speak or Stay Silent, To Act or Not To Act: Moral Distress as Experienced by Psychologists. *Ethics & Behavior.* 2005;15(3):197-212.
14. Peter E. Fostering Social Justice: The Possibilities of a Socially Connected Model of Moral Agency. *Canadian Journal of Nursing Research.* 2011;43(2):11-17.
15. Burston AS, Tuckett AG. Moral distress in nursing: contributing factors, outcomes and interventions. *Nursing Ethics.* 2013;20(1):312–324.
16. Corley MC. Nurse Moral Distress: a proposed theory and research agenda. *Nursing Ethics.* 2002;9(6):636-650.
17. Hamric AB, Blackhall LJ. Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine.* 2007;35(2):422-429.

564 18. Hamric AB, Borchers CT, Epstein EG. Development and Testing of an
565 Instrument to Measure Moral Distres in Healthcare Professionals *AJOB*
566 *Primary Research.* 2012;3(2):1-9.
567 19. Astbury JL, Gallagher CT. Development and validation of a questionnaire to
568 measure moral distress in community pharmacists. *International Journal of*
569 *Clinical Pharmacy.* 2015;39(156-164).
570 20. Astbury JL, Gallagher CT, O'Neill RC. The issue of moral distress in
571 community pharmacy practice: background and research agenda.
572 *International Journal of Pharmacy Practice.* 2015;23(5):361-366.
573 21. Mann HB, Whitney DR. On a Test of Whether one of Two Random Variables
574 is Stochastically Larger than the Other. *The Annals of Mathematical Statistics.*
575 1947;18(1):50-60.
576 22. Kruskal WH, Wallis WA. Use of Ranks in One-Criterion Variance Analysis.
577 *Journal of the American Statistical Association.* 1952;47(260):583-621.
578 23. Jonckheere AR. A Distribution-Free k-Sample Test Against Ordered
579 Alternatives. *Biometrika.* 1954;41(1/2):133-145.
580 24. Hocking RR. A Biometrics Invited Paper. The Analysis and Selection of
581 Variables in Linear Regression. *Biometrics.* 1976;32(1):1-49.
582 25. A Strategic Review of the Future Pharmacist Workforce: Informing pharmacist
583 student intakes. London: Centre for Workforce Intelligence; 2013.
584 26. Phelps A, Agur M, Nass L, Blake M. *General Pharmaceutical Council*
585 *Registrant Survey 2013.* London: General Pharmaceutical Council; 2014.
586 27. Kline P. *The Handbook of Psychological Testing.* 2nd ed: London: Routledge.;
587 1999.
588 28. Porter SR, Whitcomb ME, Weitzer WH. Multiple surveys of students and
589 survey fatigue. *New Directions for Institutional Research.* 2004(121):63-73.
590 29. Public Interest Disclosure Act 1998. Chapter 23. London: HMSO; 1998.
591 30. Francis R. *Freedom to speak up: an independent review into creating an open*
592 *and honest reporting culture in the NHS.* London: Department of Health; 2015.
593 31. Shann P, Hassell K. Flexible working: Understanding the locum pharmacist in
594 Great Britain. *Research in Social and Administrative Pharmacy.*
595 2006;2(3):388-407.
596 32. Kälvemark Sporrong S, Höglund AT, Bengt A. Measuring Moral Distress in
597 Pharmacy and Clinical Practice. *Nursing Ethics.* 2006;13(4):416-427.

33. Haddad. A. Ethical Problems in Pharmacy Practice: A Survey of Difficulty and Incidence. *American Journal of Pharmaceutical Education.* 1991;55:1-5.
34. Magola E, Willis SC, Schafheutle EI. Community pharmacists at transition to independent practice: Isolated, unsupported, and stressed. *Health & Social Care in the Community.* 2018;26:849–859.
35. Elpern EH, Covert B, Kleinpell R. Moral distress of staff nurses in a medical intensive care unit. *American Journal of Critical Care.* 2005;14(6):523-530.
36. Corley MC, Minick P, Elswick RK, Jacobs M. Nurse Moral Distress and Ethical Work Environment. *Nursing Ethics.* 2005;12(4):381-390.
37. Epstein EG, Hamric AB. Moral Distress, Moral Residue, and the Crescendo Effect. *Journal of Clinical Ethics.* 2009;20(4):330-342.
38. Cooper RJ, Bissell P, Wingfield J. 'Islands' and 'doctor's tool': the ethical significance of isolation and subordination in UK community pharmacy. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine.* 2009;13(3):297-316.
39. Latif DA. The influence of pharmacy education on students' moral development at a school of pharmacy in the USA. *International Journal of Pharmacy Practice.* 2009;17(6):359-363.
40. Sitkin SB, Sutcliffe SM. Dispensing legitimacy: the influence of professional, organizational, and legal controls on pharmacist behavior. *Research in the Sociology of Organizations.* 1991;8:269-295.
41. Gallagher CT. Assessment of levels of moral reasoning in pharmacy students at different stages of the undergraduate curriculum. *International Journal of Pharmacy Practice.* 2011;19(5):374-380.
42. Comer DR, Vega G. The Personal Ethical Threshold. In: Comer DR, Vega G, eds. *Moral Courage in Organizations. Doing the right thing at work.* New York: M.E. Sharp; 2011.
43. Wilkinson JM. Moral distress in nursing practice: experience and effect. *Nursing Forum.* 1987/88;23:16-29.
44. Nathaniel AK. *A Grounded Theory of Moral Reckoning in Nursing* [PhD Thesis]: School of Nursing, West Virginia University; 2003.
45. Kelly B. Preserving moral integrity: a follow up study with new graduate nurses. *Journal of Advanced Nursing.* 1998;28(5):1134-1145.

631 46. Latif D. Ethical Cogntion and Selection-Socialization. *Journal of Business*
632 *Ethics.* 2000;25:343-357.
633 47. Deans Z. Ethical issues in pharmacy practice as discussed by pharmacists'.
634 *International Journal of Pharmacy Practice.* 2005;13:R95.
635 48. Corley MC, Elswick RK, Gorman M, Clor T. Development and evaluation of a
636 moral distress scale. *Journal of Advanced Nursing.* 2001;33(2):250-256.
637 49. General Pharmaceutical Council. Standards for registered pharmacies.
638 London: General Pharmaceutical Council; 2012.
639 50. General Pharmaceutical Council. Guidance to ensure a safe and effective
640 pharmacy team. London: General Pharmaceutical Council; 2018.
641 51. Guidance on the provision of pharmacy services affected by religious and
642 moral beliefs. London: General Pharmaceutical Council; 2010.
643 52. General Pharmaceutical Council. In practice: Guidance on religion, personal
644 values and beliefs. London: General Pharmaceutical Council; 2017.
645 53. Dudzinski DM. Navigating moral distress using the moral distress map.
646 *Journal of Medical Ethics.* 2016;42(5):321-324.
647 54. McCue C. Using the AACN framework to alleviate moral distress. *Online*
648 *journal of issues in nursing.* 2010;16(1):9.
649 55. Wintrup J. The changing landscape of care: does ethics education have a
650 new role to play in health practice? *BMC Medical Ethics.* 2015;16(1):22-29.
651 56. Truog RD, Brown SD, Browning D, et al. Microethics: The Ethics of Everyday
652 Clinical Practice. *Hastings Center Report.* 2015;45(1):11-17.
653 57. Gentile MC. Giving Voice to Values: Building Moral Competence. In: Comer
654 DR, G V, eds. *Moral Courage in Organisations. Doing the right thing at work.* .
655 New York: M.E.Sharpe; 2011.
656 58. Gentile MC. Keeping your colleagues honest. *Harvard Buisiness Review.*
657 2010;88(2):114-117.
658 59. Monrouxe LV, Rees CE, Endacott R, Ternan E. "Even now it makes me
659 angry": health care students' professionalism dilemma narratives. *Medical*
660 *Education.* 2014;48:502-517.
661 60. Austin WJ. Moral Distress and the Contemporary Plight of Health
662 Professionals. *HEC Forum.* 2012;24:27-38.

61. Gallagher CT. Building on Bloom: A paradigm for teaching pharmacy law and ethics from the UK. *Currents in Pharmacy Teaching and Learning.* 2011;3:71-76.

**Tables**

| Item | Scenario |
|---|---|
| 1. Controlled Drugs | Being unable to dispense a controlled drug in the best interests of a patient due to an unmet legal requirement. |
| 2. NHS | Being pressured to supply an expensive unlicensed medicine or formulation on an NHS prescription, rather than provide a cheaper, but equally appropriate, licensed alternative. |
| 3. Asserting Professional Judgement | Dispensing a prescribed medication against my clinical judgement because I feel unable to challenge the prescriber. |
| 4. Time Constraints | Being unable to provide the degree of patient care I would like due to time constraints. |
| 5. Patient Autonomy | Suppling a medicine at the insistence of a customer though this conflicts with my professional judgement. |
| 6. Linked Sales | Being pressured to offer related, but unnecessary, items for sale (i.e. linked selling) though I feel this is unprofessional. |
| 7. Emergency Supply | Being unable to make an emergency supply in the best interests of a patient due to an unmet procedural requirement. |
| 8. Off License | Being pressured by a patient to supply a medicine though I suspect it is likely to be used outside its licensed indications. |
| 9. EHC | Dispensing emergency hormonal contraception though this conflicts with my moral beliefs. |
| 10. Whistleblowing | Feeling unable to raise my concerns about the professional practice or competency of others. |
| 11. Confidentiality | Being forced to breach patient confidentiality (e.g. by the police, or under terrorism legislation). |
| 12. Commercial pressures | 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). |
| 13. Unregulated products | 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. homoeopathics). |

**Table 1:** The thirteen scored items from the online survey, together with their single-statement scenarios.

| Demographic | |
|---|---|
| ***Gender:*** | |
| Female | 303 (51.1%) |
| Male | 282 (47.6%) |
| Missing | 8 (1.3%) |
| | |
| ***Age (years):*** | |
| 25 and under | 41 (6.9%) |
| 26 – 35 | 197 (33.2%) |
| 36 – 45 | 132 (22.3%) |
| 46 – 55 | 143 (24.1%) |
| 56 – 65 | 73 (12.3%) |
| Over 65 | 4 (0.7%) |
| Missing | 3 (0.5%) |
| | |
| ***Area of work:*** | |
| Community locum | 155 (26.1%) |
| Community employee | 433 (73%) |
| Pharmacy owner | 5 (0.9%) |
| Missing | 0 (0%) |
| | |
| ***Years of experience:*** | |
| 5 or less | 129 (21.8%) |
| 6 – 10 | 108 (18.2%) |
| 11 – 15 | 80 (13.5%) |
| 16 – 20 | 53 (8.9%) |
| 21 – 25 | 221 (37.3%) |
| Over 25 | 2 (0.3%) |
| Missing | 0 (0%) |
| | |
| ***Religious affiliation:*** | |
| Christian | 253 (42.7%) |
| Jewish | 4 (0.7%) |
| Muslim | 42 (7.1%) |
| Hindu | 41 (6.9%) |
| Sikh | 18 (3%) |
| Other | 14 (2.4%) |
| None/no preference | 172 (29%) |
| Prefer not to say | 45 (7.6%) |
| Missing | 4 (0.7%) |

**Table 2:** Demographic characteristics of survey participants (n = 593).

| | Scale descriptor | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Scenario** | **Never** | **Once a year or less** | **Several times a year** | **Several times a month** | **Several times a week** | **Several times a day** | **Several times an hour** | **Missing** |
| Controlled Drugs | 5% | 21% | 48% | **18%** | 6% | 2% | 0% | 0% |
| NHS | 34% | **22%** | 25% | 12% | 4% | 2% | 0% | 1% |
| Asserting Professional Judgement | 25% | 23% | **32%** | 11% | 6% | 2% | 1% | 0% |
| Time Constraints | 2% | 1% | 8% | 14% | 22% | **39%** | 14% | 0% |
| Patient Autonomy | 19% | 19% | **25%** | 18% | 14% | 5% | 0% | 1% |
| Linked Sales | 32% | 9% | **17%** | 16% | 13% | 10% | 4% | 0% |
| Emergency Supply | 19% | 19% | **25%** | 18% | 14% | 5% | 0% | 1% |
| Off Licence | 16% | 18% | **31%** | 18% | 10% | 5% | 1% | 1% |
| EHC | **85%** | 3% | 3% | 4% | 3% | 1% | 0% | 1% |
| Whistleblowing | 25% | 21% | **23%** | 14% | 10% | 6% | 2% | 0% |
| Confidentiality | **67%** | 24% | 7% | 1% | 0% | 0% | 0% | 0% |
| Commercial Pressures | 47% | **17%** | 17% | 10% | 6% | 3% | 1% | 1% |
| Unregulated Products | 47% | **15%** | 15% | 12% | 8% | 3% | 1% | 0% |

**Table 3:** Table showing frequency of occurrence of moral distress caused by each scenario (n= 593; median category in bold).

| | Scale descriptor | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Scenario** | **None** | **Mild** | **Mild to moderate** | **Moderate** | **Moderate to severe** | **Severe** | **Overwhelming** | **Missing** |
| Controlled Drugs | 7% | 9% | 12% | **27%** | 31% | 13% | 2% | 0% |
| NHS | 34% | **15%** | 17% | 17% | 10% | 5% | 1% | 2% |
| Asserting Professional Judgement | 23% | 8% | 10% | **21%** | 22% | 12% | 4% | 1% |
| Time Constraints | 2% | 2% | 9% | 19% | **32%** | 21% | 14% | 0% |
| Patient Autonomy | 17% | 8% | 13% | **24%** | 22% | 12% | 4% | 1% |
| Linked Sales | 32% | 9% | 13% | **14%** | 15% | 9% | 7% | 2% |
| Emergency Supply | 25% | 11% | **16%** | 20% | 15% | 9% | 3% | 2% |
| Off Licence | 16% | 16% | **19%** | 21% | 17% | 8% | 3% | 1% |
| EHC | **83%** | 3% | 3% | 3% | 3% | 2% | 3% | 3% |
| Whistleblowing | 24% | 8% | 13% | **14%** | 17% | 15% | 8% | 0% |
| Confidentiality | **65%** | 11% | 5% | 6% | 5% | 4% | 2% | 2% |
| Commercial Pressures | 48% | **15%** | 12% | 13% | 6% | 4% | 1% | 1% |
| Unregulated Products | 46% | **14%** | 10% | 12% | 9% | 4% | 3% | 2% |

**Table 4:** Table showing intensity of moral distress caused by each scenario (n= 593; median category in bold).