PRECEPTING SERIES:

Moral Distress: An Oncology Pharmacy Perspective

by Jason R. Jared, PharmD, BCOP

Inpatient oncology pharmacy practice can provide potentially distressing clinical scenarios on a frequent basis: verifying cytotoxic chemotherapy for an older, frail patient with a less than ideal risk/benefit profile, providing high-dose opioids to an end-of-life hospice patient whose family has a history of opioid diversion, or discharging patients with less than optimal medication regimens due to insurance restrictions. Ensuring pharmacy learners are confident and prepared to manage such distressing scenarios is essential for pharmacy preceptors in all areas of practice.

Moral distress, originally described in 1984 and historically defined in many ways, can be "one or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that is perceived to be morally undesirable".[1-2] Moral distress has been associated with burnout, including moral disengagement and interpersonal conflict as well as intention to leave a position.[3-4] Healthcare provider burnout affects patient care and may contribute to staffing shortages, thereby compounding moral distress. Moral distress was initially identified in nursing, but research has expanded to the multidisciplinary care team, including pharmacy, with improved understanding of its inherent risks. A recent evaluation of pharmacist and student pharmacist views highlighted moral distress as an area of improvement needed for professional and personal well-being.[3,5]

Moral Distress

Healthcare provider moral distress "may be felt…when they believe they know the ethically correct action but cannot follow that action because of some constraint, whether interpersonal (with colleagues, patients or families), institutional, regulatory, or legal".[3] Contemporary research into moral distress has focused on five key components: complicity in wrongdoing, lack of voice, wrongdoing associated with professional values, repeated experiences, and three levels of root causes (patient, unit, system) (Table 1).[6] Because of the subjective nature of moral distress, evidence-based methods for identifying and studying this phenomenon were greatly needed.

TABLE 1. Key Components of Moral Distress[14-17]

Component	*Description*
Complicity in wrongdoing	When a provider believes they are doing something ethically wrong and has little power to change the situation
Lack of voice	When a provider believes they have relevant insights/knowledge that are not heard or taken seriously
Wrongdoing associated with professional values	When professional standards of care (such as minimizing unnecessary suffering) are impossible to carry out
Repeated experiences	When distressing situations repeat, adding to previous levels and increasing distress over time
Root cause levels	Distress can be triggered at one or more of the following levels 1. Patient/family: involve a particular patient or family (family demands overly aggressive treatment) 2. Unit/team: poor communication or inadequate collaboration that impacts patient care (inconsistent messages, witnessing false hope) 3. System: causes outside the unit level (chronic poor staffing, pressure from administrators to reduce cost, lack of adequate resources such as supplies or bed capacity)

The Measures of Moral Distress

Several measures of moral distress have been introduced and evaluated in the last 20 years, predominantly Corley's Moral Distress Scale (MDS) and the revised scale (MDS-R), but were less applicable to pharmacy due to their focus on intensive care nurses and physicians respectively.[7-8] A modified MDS-R scale was recently used at Baylor Health Care System to assess multidisciplinary moral distress.[3] In this survey analysis, 2700 healthcare professionals responded including 57/453 (12.6%) pharmacists at the institution. The pharmacist mean moral distress score (53.98/324) was numerically 5th of the 6 groups surveyed (nurses: 68/324; social worker: 66.51/324; medical resident: 64.33/324; physician: 62.60/324; chaplain: 60.76/324; therapist 51.27/324), but only the difference between nursing and therapists (respiratory, occupational, physical, and speech therapists) was statistically significant.

In 2019, a revised scale entitled the Measure of Moral Distress for Healthcare Professionals (MMD-HP) was devised and evaluated (Table 2).[9] The MMD-HP is a 27-item list of distressing scenarios where the respondent ranks each scenario via a 5-point Likert scale in two dimensions – frequency of occurrence and level of distress the scenario has/would cause you. In the analysis, 653 multidisciplinary practitioners were surveyed using the new tool. The analysis reflected what has been known about moral distress - nurses have the highest MMD-HP scores, those with higher MMD-HP scores were considering leaving their positions, and those who reported a lower ethical climate had higher MMD-HP scores. Pharmacists were excluded in this analysis, but future research is ongoing with this assessment tool.

Potential Mitigation Strategies

Due to the difficult nature of identifying and studying moral distress, very few researchers have studied methods to mitigate the detriment it causes such as provider burnout. In a recent publication

TABLE 2. Measures of Moral Distress for Healthcare Professionals (MMD-HP) - Scenarios[9]

1. Witnessing healthcare providers giving "false hope" to a patient or family.
2. Following the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.
3. Feeling pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.
4. Being unable to provide optimal care due to pressures from administrators or insurers to reduce costs.
5. Continuing to provide aggressive treatment for a person who is most likely to die regardless of this treatment when no one will make a decision to withdraw it.
6. Being pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it.
7. Being required to care for patients whom I do not feel qualified to care for.
8. Participating in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.
9. Watching patient care suffer because of a lack of provider continuity.
10. Following a physician's or family member's request not to discuss the patient's prognosis with the patient/family.
11. Witnessing a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.
12. Participating in care that I do not agree with, but do so because of fears of litigation.
13. Being required to work with other healthcare team members who are not as competent as patient care requires.
14. Witnessing low quality of patient care due to poor team communication.
15. Feeling pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.
16. Being required to care for more patients than I can safely care for.
17. Experiencing compromised patient care due to lack of resources/equipment/bed capacity.
18. Experiencing lack of administrative action or support for a problem that is compromising patient care.
19. Having excessive documentation requirements that compromise patient care.
20. Fearing retribution if I speak up.
21. Feeling unsafe/bullied amongst my own colleagues.
22. Being required to work with abusive patients/family members who are compromising quality of care.
23. Feeling required to overemphasize tasks and productivity or quality measures at the expense of patient care.
24. Being required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.
25. Working within power hierarchies in teams, units, and my institution that compromise patient care.
26. Participating on a team that gives inconsistent messages to a patient/family.
27. Working with team members who do not treat vulnerable or stigmatized patients with dignity and respect.
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investigating mitigation strategies in an inpatient oncology nursing staff, Bruce and colleagues provided some possible interventions.[10] Debriefing sessions were performed quarterly and as needed by a chaplain/certified nurse specialist team where futile care and perceptions of providing false hope were found to be the most common themes discussed. Additionally, nurses were taught communication skills-building tools, such as the SPIKES and NURSE models of communication to promote patient and family understanding of end-of-life care planning.[11-12] Nurses were also provided the End-of-Life Nursing Education communication resources on laminated cards in order to help frame difficult patient discussions. Finally, a 60-second pause was implement at the time of a patient's death in order to honor and humanize the patient while acknowledging death as a part of life. These interventions were evaluated with the MDS-R reporting scale and, as compared to pre-intervention scores, post-intervention moral distress scores were lower but did not reach statistical significance.

Moral Distress & Inpatient Oncology

At UW Health, our inpatient oncology educational experience accommodates rotations for all levels of pharmacy learners, including introductory pharmacy practice experience (IPPE) and advanced pharmacy practice experience (APPE) students, as well as various PGY1 and PGY2 pharmacy residents. Some learners come into our rotation having a variety of clinical and life experiences pertinent to oncology and end-of-life care, while others are limited to their didactic teaching from pharmacy school. It can be challenging for our preceptors to ensure that all learners feel confident and prepared to manage complex clinical scenarios and the moral aspects of oncology patient care. As moral distress has become more widely investigated and published, we have worked to implement awareness and mitigation strategies into our rotation experience.

Pre-rotation Discussion

During my pre-rotation meeting with pharmacy learners, we discuss the standard requirements and expectations that are tailored to their level (IPPE/APPE/PGY1/PGY2) and their prior experience with oncology patients. However, most of our discussion focuses on our patient population and the unique challenges they can present with regard to moral distress. For some learners, this is their first exposure to oncology patients, goals of care discussions, and difficult psychosocial aspects of care that must be addressed to ensure optimal physical and mental patient care. Discussing goals of care, hospice/palliative care, and other potentially distressing aspects of the rotation ahead of time prepares the learner for the reality of inpatient oncology care. I also provide case examples of historically morally distressing scenarios from our rotation, such as patient/family triggers, and discuss appropriate responses taken by our precepting team. Lastly, I always encourage the learner to come to me with any concerns or issues within the rotation (including moral distress) and emphasize appropriate self-care, which can be as simple as not partaking in daily rounds for a certain patient that they have found to be distressing.

Providing Context of Patient Wishes

During their rotation experience, the busy day-to-day aspects of patient care and rotation assignments can cause learners to blind themselves from the larger context of an individual patient's scenario – their unique history, goals and expectations, and family/social pressures. During the pre-rotation discussion, as well as periodically throughout the experience, I emphasize findings from a recent survey of over 1000 Americans assessing the public's views and experiences on death and dying in the United States.[13] In this survey, 71% of those surveyed believed that 'helping people die without pain, discomfort and stress' is the most important aspect of healthcare at the end of people's lives. Additionally, 71% of respondents would prefer to die at home as compared to in a hospital (9%), in a hospice facility (7%), or a nursing home/not sure (6%). These facts help to emphasize what most patients believe and, during difficult aspects of patient care, can refocus a pharmacy learner's goals towards helping to resolve acute hospitalization needs and devising practical interventions that can be implemented in the outpatient setting.

Feedback Friday

Throughout the learner's inpatient oncology experience, we meet semi-formally to discuss their clinical progress and highlight areas of focus for the coming weeks. After learning more about moral distress, I have incorporated discussion points that focus on pertinent aspects of the MMD-HP (Table 2), such as concerns for excessive work load (Scenario 16), patients with unclear or inconsistent treatment plans or lack goals of care (Scenario 24), or patient care suffering due to poor team communication (Scenario 14). Feedback Friday sessions allow the learner to debrief on potential concerning areas of clinical practice and serve as an opportunity to discuss any morally distressing scenarios in depth. This has served to provide structure to not only the clinical aspects of patient care but also moral distress and continues to be a highly regarded aspect of the rotation experience by all learners.

Conclusion

Moral distress, an area of ongoing investigation for healthcare providers, is a very practical concern for the inpatient oncology experience at UW Health due to our various learner levels, complex patient scenarios, and proximity to end-of-life care. Several assessments and mitigation strategies have been proposed, but further research is needed to provide a clearer picture of hazards to both patients and healthcare providers. Preceptors should strive to provide support for moral distress to all learners and continually improve their practices to stay up to date with the most contemporary research on the topic.

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References

1. Jameton A, Nursing Practice: The Ethical Issues. Englewood Cliffs, NJ: Prentice-Halll 1984
2. Campbell SM, Ulrich CM, Grady C. A broader understanding of moral distress. *Am J Bioeth*. 2016;16(12):10
3. Houston S, Casanova MA, Leveille M, et al. The intensity and frequency of moral distress among different healthcare disciplines. *J Clin Ethics*. 2013;24(2):98-112
4. Allen R, Judkins-Cohn T, deVelasco R, et al. Moral distress among healthcare professionals at a health system. *JONAS Healthc Law Ethics Regul.* 2013;15(3);111-118.
5. Schommer JC, Gaither CA, Goode JV, et al. Pharmacist and student pharmacist views of professional and personal well-being and resilience. *J Am Pharm Assoc*. 2020;60(1):47-65.
6. Hamric AB. A case study of moral distress. *J Hosp Palliat Nurs*. 2014;16(8)457-463.
7. Corley MC, Elswick RK, Gorman M, et al. Development and evaluation of a moral distress scale. *J Adv Nurs*. 2001;33(2)250-256
8. Hamric AB, Borchers CT, Epstein EG. Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research.* 2012;3(2)1-9.
9. Epstein EG, Whitehead PB, Prompahakul C, et al. Enhancing understanding of moral distress: the measure of moral distress for health care professionals. *AJOB Empir Bioeth*. 2019;10(2):113-124.
10. Bruce SD, Allen D. Moral distress: one unit's recognition and mitigation of this problem. *Clin J Oncol Nurs*. 2020;24(1):16-18.
11. Baile WF, Buckman R, Lenzi R, et al. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist.* 2000;5(4):302-311.
12. Back AL, Arnold RM, Baile WF, et al. Approaching difficult communication tasks in oncology. *CA Cancer J Clin*. 2005;55(3)164-177.
13. Hamel L, Wu B, Brodie M. Views and experiences with end-of-life medical care in the US; Kaiser Family Foundation; April 2017
14. Hamric AB, Blackhall J. Nurse-physician perspectives on the care of dying patients in intensive care units: collaboration, moral distress, and ethical climate. *Crit Care Med.* 2007;35(2):422-429.
15. Bosslet GT, Pope TM, Rubenfeld BL, et al. An official ATS/AACN/ACCP/ESICM/SCCM policy statement: responding to requests for potentially inappropriate treatments in intensive care units. *Am J Respir Crit Care Med*. 2015;191(11):1318-1330.
16. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. *J Clin Ethics*. 2009;20(4):330-342.
17. Hamric AB, Epstein EG. A health system-wide moral distress consultation service: development and evaluation. *HEC Forum.* 2017;29(2):127-143.