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Original Research

Reliability and validity for the measurement of moral disengagement in pharmacists

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Abstract

Background: Social cognitive theory describes a process in which behavior can be disengaged from moral self control through eight different mechanisms. These mechanisms were used for the development of a new scale for measuring moral disengagement (Moral Disengagement Inventory, or MDI) in pharmacists.

Objectives: The objectives of this study were to assess the reliability and validation of a scale to measure pharmacists' moral disengagement toward patients who exhibit behaviors directly or indirectly leading to their disease condition, such as an asthmatic patient who smokes or a non-compliant asthmatic patient.

Methods: A self-administered survey called the Moral Disengagement Instrument (MDI) was developed for this study. Once the MDI was designed, the items were evaluated for content validity, readability and face validity. The reliability of the developed measures was assessed. The convergent and discriminant validity of the moral disengagement constructs were tested using confirmatory factor analysis.

Results: The reliability coefficient for the MDI for the asthmatic smoker was 0.814 and reliability coefficient for the MDI for the non-compliant asthmatic patient was 0.782. Evidence supporting validity of the MDI was provided in a confirmatory factor analysis.

Conclusions: The Moral Disengagement Instrument (MDI), developed as a tool for measuring pharmacists' disengagement beliefs for a smoker asthmatic patient and a non-compliant asthmatic patient, was found to be reliable and valid.

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Keywords: Professionalism; Pharmacists; Moral disengagement; Decision science; Reliability and validity

Introduction

Traditionally, physicians, not pharmacists, were the health care professionals who held ultimate responsibility for monitoring the progress of a patient and ensuring that the desired outcome was achieved.[1] However the concept of "pharmaceutical care" describes this responsibility in terms of a shared obligation between the prescriber and pharmacist and in terms of a covenantal relationship between the pharmacist and

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the patient.[2,3] The covenantal relationship is the essence of all professional relationships and the foundation of the Code of Ethics that governs pharmacists as well as other health care professionals. Viewing the patient–pharmacist relationship as a covenant implies that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.[4]

One ethical area that is receiving attention concerns whether health care providers should offer care to patients who engage in behaviors directly or indirectly leading to their condition, or so-called lifestyle-related disease, such as whether to counsel/educate or even to treat asthma patients who smoke. Health care professionals are well-educated on the negative consequences of lifestyle-related diseases. However, despite their participation in many educational programs aimed at increasing knowledge of health care providers about such conditions, lifestyle-related disease counseling by health care providers is lacking.[5]

Health care professionals have long honored an ethic of objectivity about their patients. However, there may be some instances where this honored ethic becomes stressed. It is possible that health care professionals may allow their personal opinions about the values, lifestyle, and morality of their patients to influence their professional judgments about the patient's health care needs.[6] Stigmatization influences the judgments of individuals in more subtle ways than overt dislike and frank prejudice. According to Arras and Steinbock, "professionals may disvalue the stigmatized in ways they hardly recognize. Even when professionals believe they are not prejudiced, they may perceive and treat stigmatized persons differently from others".[6] Nursing research has shown nurse's personal values, beliefs, and attitudes play a significant role in patient care, especially in addiction treatment and HIV treatment. Steinberg (1997) found that nursing students had prejudicial attitudes and fears that impeded care toward HIV patients.[7] Relf et al noted that nursing students in the United States were more likely to have attitudes and beliefs that were not consistent with the ethical principles of autonomy, beneficence, non-maleficence and justice in the context of testing, confidentiality, disclosure and the environment of care related to HIV and AIDS when compared to their South African counterparts.[8] The authors noted that without changing of nurse's attitudes and beliefs, it is possible that clinicians may continue to hold negative attitudes and beliefs that may hinder clinical practice that is ethical and supportive of persons living in HIV and AIDS. Similarly, pharmacists are also heavily influenced by their personal beliefs as evident when the Washington Post reported that pharmacists across the country are refusing to fill prescriptions for birth control and the morning-after pills, saying that dispensing the medications violated their personal beliefs.[9] Additionally a majority of pharmacists show interest in smoking cessation counseling, but according to Hudmon et al only four percent of community pharmacists regularly ask their patients about tobacco use.[10] These studies and reports indicate that for certain disease states, personal beliefs may act as a barrier to implementation of patient care.

Compounding the problem of prejudice, health professionals may find the care of patients presenting with lifestyle-related diseases a demanding task. Many patients come from groups or backgrounds with whose lifestyle the health professional may be unfamiliar and even unsympathetic.[6] In general, the caring for patients with lifestyle-related disease may pose notable stress on professionals. Thus as health professionals are exposed to increasing number of patients presenting with lifestyle-related diseases, their sense of responsibility toward these patients may be influenced by their perceptions of the stress involved in caring for such patients and their overt prejudices and covert complicity with stigma.[6]

While one might explain the apparent discrepancy between well-educated health care professionals and the lack of counseling to patients with lifestyle-related diseases, from the perspective of several competing psychological models such as the Models of Self-esteem[11] and Theory of Locus of Control,[12] it is possible that the lack of counseling to patients with lifestyle-related disease may be due to some form of cognitive dissonance. Cognitive dissonance is usually experienced when an individual has two or more cognitions that are dissonant in relation to one another resulting in motivational tension.[6,13] Pharmacists, as health professionals, are held to its profession's Code of Ethics, which serves to guide and set a standard of practice for pharmacists. However, some pharmacists may hold personal values/beliefs that are at odds with the Code of Ethics and the fiduciary

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