VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Moral distress in hospital doctors

David Oliver consultant in geriatrics and acute general medicine

Berkshire

The concept of “moral distress” in nurses was described by Andrew Jameton in 1984. He has defined it as occurring when
one knows the right thing to do for a patient but institutional
constraints make it impossible to pursue that course of action. The medical literature has plenty on physician burnout, poor
working conditions, and their effects on doctors’ wellbeing. We
haven’t tended to discuss moral distress as much as nurses
do, although we clearly experience it too.

The Point of Care Foundation has worked with over 180
organisations throughout the NHS, specifically supporting
clinical teams. The foundation’s director, Jocelyn Cornwell,
told me, “I have learned that moral distress is widely felt by
doctors and nurses but also porters, ward clerks, paramedics—and by managers, when they are aware of the
pressure and unable to mitigate it. In short, everyone who works
close to or directly with patients is at risk.”

Moral, engagement, and wellbeing in clinical staff affect quality
of care, sickness absence, and retention—described especially
clearly by Michael West and Jeremy Dawson for the King’s
Fund. The 2018 British Social Attitudes survey of 3000
citizens showed a sharp drop in public satisfaction with the
NHS. Short staffing, underfunding, worsening access, and
waiting times were the biggest issues raised. The 2017 annual
NHS staff survey showed deteriorating morale and engagement,
with work pressures and staffing gaps cited. And NHS
Improvement’s recent workforce report showed that one in 11
NHS clinical posts is unfilled, including 8% vacancies for
doctors—higher by far in some pressurised specialties or
regions. In recent months we’ve had reports of short staffing, lack of
capacity, and unmanagable demand putting care quality and
patients at risk, such as in general practice, emergency medicine,
psychiatry, paediatrics, and intensive care. This, in turn,
leaves doctors feeling unable to give the standard of care they
were trained to or that patients want. Rushed, missed, or risky
care will inevitably lead to fear and feelings of loss of control
among conscientious medics.

Resilience should be for the difficult emotional burden
of caring, responsibility, and carrying risk—not for unacceptable, dangerous working conditions.

Interest is growing in resilience training for NHS staff. But I’m
not convinced that there is good evidence for its benefit. And,
surely, resilience should be for the difficult emotional burden
of caring, responsibility, and carrying risk—not for unacceptable and
dangerously working conditions.

The Point of Care Foundation has had success in introducing
Schwartz rounds, now formally evaluated in a longitudinal
National Institute for Health Research study with positive results
for staff morale. During these rounds staff can share the
difficult emotional effects of providing care while retaining
compassion in a facilitated safe space.

Jocelyn Cornwell cited as key factors in improving working
conditions: shared values and mutual support in teams; managers being willing to talk openly and honestly about pressure (and
finding ways to mitigate it); and low tolerance for poor
behaviour. She also emphasised the behaviour of senior
clinicians and managers—in role modelling, valuing, and
engaging clinical teams—as being crucial to frontline staff.
Maybe the starting point in handling moral distress in doctors
and other health practitioners is to speak its name rather than
play down its existence.

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