Moral distress and moral injury
Recognising and tackling it for UK doctors

Contents

Executive summary

In the last 15 months, the BMA has heard consistently about the moral burden doctors in the UK are facing. The resulting impact on doctors' health from moral distress and moral injury can be significant, with the concepts being linked to severe mental health conditions such as depression and post-traumatic stress disorder (PTSD). This is a result of the institutional and resource constraints healthcare staff face, meaning they often cannot provide the high level of care they want and expect to be able to deliver. This is compounded by not feeling supported in difficult decision-making or when needing to challenge decisions of others. Poor workplace cultures can mean doctors are often discouraged from speaking up on these issues.

This report is based on the findings of the BMA's review of moral distress in the UK medical workforce. This included interviews and discussions with doctors, analysis of academic research, and the first ever pan-profession survey of doctors in the UK on moral distress. Appendix 1 provides the detailed survey results.

Key points:
— Moral distress is defined as the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action. Even without an understanding of the morally correct action, moral distress can arise from the sense of a moral transgression. More simply, it is the feeling of unease stemming from situations where institutionally required behaviour does not align with moral principles. This can be as a result of a lack of power or agency, or structural limitations, such as insufficient staff, resources, training or time. The individual suffering from moral distress need not be the one who has acted or failed to act; moral distress can be caused by witnessing moral transgressions by others;

— Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm. Moral injury can produce profound guilt and shame, and in some cases also a sense of betrayal, anger and profound 'moral disorientation'. It has also been linked to severe mental health issues;

— Both terms are increasingly being applied to physicians in high-resource health settings;

— There are numerous potential causes of moral distress and moral injury, which can depend on doctors' specialty and grade; and

— The COVID-19 pandemic has heightened awareness of moral distress and moral injury.

The key findings of the BMA survey include:
— The terms 'moral distress' and 'moral injury' were new to many respondents. 43.8% had not heard of moral distress and 48.4% had not heard of moral injury;

— 78.4% of respondents stated that moral distress resonated with their experiences at work and 51.1% said the same about moral injury;

— Of the respondents who stated that moral distress resonated with their experiences at work:

  — 96.4% (of those who had worked before and during the pandemic) stated that the pandemic had exacerbated the risk of moral distress;

  — 59.6% (of those who had worked before the pandemic) stated that they had experienced moral distress in the 12 months prior to the pandemic, demonstrative of the fact that moral distress was not a problem created by the pandemic;

— Insufficient staff was the most commonly stated cause of moral distress;

— Most respondents indicated their intention to work fewer hours in the next year; and

— There is clearly an equalities aspect to moral distress, with more doctors from ethnic minority backgrounds having experience of it, as well as doctors with disabilities having differential experiences.

The recommendations the BMA is making with respect to moral distress and moral injury are split into two broad categories. The first category includes structural solutions that would help mitigate the risk of moral distress in UK healthcare staff.

The recommendations here are:
1. Adequate funding and resourcing
2. Increase staffing
3. Empower doctors
4. Develop an open and sharing workplace culture
5. Provide support for employees
6. Streamline NHS bureaucracy

The second category are steps doctors can take themselves to alleviate the effects of moral distress, though the ability of doctors to enact these ideas is highly dependent on their work environment. These are:
1. Talk about moral distress and moral injury
2. Develop support networks
3. Speak out (when possible)
4. Seek advice
5. Develop a self-care plan

Though the risk of moral distress cannot be completely removed from the medical workforce, steps can be taken to moderate its effects. By recognising the inherent emotional strain created by the difficult decisions doctors make every day, building a supportive working environment, and providing them with the tools and resources to do their job confidently, the impact of moral distress on the UK medical workforce can be reduced.

What is 'moral distress' and 'moral injury'?

Many may be unfamiliar with the concepts of 'moral distress' and 'moral injury'. These terms are relatively new, and debate is ongoing in academic circles on the best way to understand them.[1] Some use the two concepts interchangeably.

The BMA defines moral distress and moral injury as follows:

Moral distress — Moral distress refers to the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action. Even without an understanding of the morally correct action, moral distress can arise from the sense of a moral transgression. More simply, it is the feeling of unease stemming from situations where institutionally required behaviour does not align with moral principles. This can be as a result of a lack of power or agency, or structural limitations, such as insufficient staff, resources, training or time. The individual suffering from moral distress need not be the one who has acted or failed to act; moral distress can be caused by witnessing moral transgressions by others.

Moral injury — Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm. Moral injury can produce profound guilt and shame, and in some cases also a sense of betrayal, anger and profound 'moral disorientation'. It has also been linked to severe mental health issues.

1   Brandon J. Griffin, June 2019, 'Moral Injury: An Integrative Review', Journal of Traumatic Stress, vol. 32, no. 3, https://onlinelibrary.wiley.com/doi/epdf/10.1002/jts.22362?saml_referrer

These two definitions are the same as those used in the BMA's survey (more information on which is provided in 'The UK medical workforce and moral distress' section of this report). Despite there being some debate over the terms, for the purposes of the BMA's work, the definitions used here are believed to be suitable and align with contemporary understandings of the phenomena.

These notions are distinct from burnout, which can be understood as the feelings of exhaustion, professional cynicism or reduced professional ability resulting from chronic workplace stress. Though the terms are related, burnout does not necessarily have a moral component.

Moral distress was first conceptualised in the 1980s in relation to nursing by Andrew Jameton. Here, moral distress was understood as the emotional state that arises from a situation where a nurse feels that the ethically correct action to take is different from what they are tasked with doing.[2] The deeply hierarchical nature of medical practice, particularly in hospitals, can limit agency for many medical professionals in their work, increasing the risk of moral distress, as matters are 'out of their control'.[3] Shay introduced the term 'moral injury' in the 1990s in relation to the armed forces[4] but recently it has increasingly been applied to healthcare workers, including those in high-resource medical settings,[5] such as in the UK. Moral injury has been linked to compassion fatigue, burnout, depression, PTSD[6] and even suicide. In themselves, moral distress and moral injury are not regarded as forms of mental illness.

A key difference between moral distress and moral injury is that the former refers to a situational problem due to the circumstances an individual finds themselves in, while the latter represents an experience of the problem which can cause serious harm to an individual.[7] This, theoretically, means that addressing moral distress is more straightforward, as it involves tackling situational stimuli, as opposed to dealing with the complexity of human experience in response to a situation. It is for this reason that a lot of the BMA's research, and this report, focus on moral distress.

Though moral distress can be found in many professions, there are some causes of it specific to the medical profession. The causes of moral distress in medical staff are varied but they are often consistent across countries. Doctors can experience moral distress due to:
— Lack of agency to make the best decisions for patients
— Insufficient resources or non-existent resources to provide care to suitable professional standards
— Witnessing poor standards of care
— Practical experience of medical care clashing with ethical standards taught at medical school and doctors' own personal ethical standards
— Complicity in wrongdoing
— End-of-life care decisions.

Repeated exposure can increase the likelihood of moral distress.

2   Andrew Jameton, 1984, 'Nursing practice: the ethical issues.'
3   Subha Perni, June 2017, 'Moral Distress: A Call to Action', American Medical Association Journal of Ethics, https://journalofethics.ama-assn.org/article/moral-distress-call-action/2017-06
4   Jonathan Shay, 1994, 'Achilles in Vietnam: Combat trauma and the undoing of character'
5   Carina Fourie, February 2015, 'Moral distress and moral conflict in clinical ethics', Bioethics, vol. 29, no. 2 https://onlinelibrary.wiley.com/doi/abs/10.1111/bioe.12064
6   Haleigh A. Barnes et al., April 2019, 'Moral Injury and PTSD: Often Co-Occurring Yet Mechanistically Different', The Journal of Neuropsychiatry and Clinical Neurosciences, https://neuro.psychiatryonline.org/doi/full/10.1176/appi.neuropsych.19020036
7   Anto Cartolovni et al., January 2021, 'Moral injury in healthcare professionals: A scoping review and discussion', Nursing Ethics, https://journals.sagepub.com/doi/full/10.1177/0969733020966776

The fact there are common themes surrounding moral distress and injury across the world is understandable. The nature of a doctor's job often requires extremely serious decisions about a patient's health and wellbeing. Physicians do not operate in systems with infinite time, resources, and trained professionals. Difficult choices do have to be made, sometimes life-and-death decisions. These are an acknowledged aspect of medical practice. What should not be common elements of modern medical practice are decisions made under the duress of institutional limitations that violate professional standards. It is imperative to mitigate the risks of moral distress and moral injury as much as possible, both for the wellbeing of medical professionals and the patients they treat.

The UK medical workforce and moral distress

There is increasing recognition across the UK of the problem of moral distress in the medical profession, and this began before the COVID-19 pandemic. Years of underfunding, increasing layers of bureaucracy, and less autonomy for doctors contribute to a myriad of problems. As well as the impact on the wellbeing of doctors (such as burnout), many physicians report being forced to make suboptimal decisions for patients based on institutional constraints. This can, in some cases, lead to moral distress and moral injury. Some report the system they work in tends to imply the failing is with the individual and that they lack the necessary resilience.

This is not unique to the UK. Research suggests there is a rising prevalence of moral injury in healthcare workers across many nations. For example, there is evidence linking the significant technological investment in the US healthcare system to reduced autonomy for medical professionals, contributing to moral injury in doctors.[8]

The triggers for moral distress in clinicians can depend on the environment in which they work. This is understandable, given the different pressures faced by doctors across specialties. The role of a GP is significantly different to that of a trainee orthopaedic surgeon which, in turn, differs from that of a consultant psychiatrist. Even within specialties, seniority can impact the causes of moral distress. For example, a recent study of consultants and trainees working in ICUs, suggested that junior trainees in particular found that admitting patients that were unlikely to survive morally distressing, while consultants, who expected increasing demand and resource constraints, predicted rationing-induced moral distress.[9]

In discussions with doctors, the BMA has found that the terms 'moral distress' and 'moral injury' have struck a chord. Senior doctors stated that they had been experiencing moral distress in the NHS (or equivalent organisation) for a number of years but did not know what it was until now, with one doctor noting that they thought they 'just had to accept it' as 'this is the way it has always been' while another described the term moral injury as a 'revelation'.

From March to April 2021, the BMA surveyed doctors throughout the UK on the issues of moral distress and moral injury. It is the first pan-profession survey of its nature in the UK and was open to all doctors, including those who are retired, but not to medical students. More than 1,900 doctors responded. Appendix 1 contains a breakdown of the survey results. Almost half of respondents had not previously heard the terms 'moral distress' and 'moral injury', with 43.8% having not heard of moral distress and 48.4% having not heard of moral injury. However, the overarching affinity many felt with the terms (once defined) is demonstrative of their usefulness, as found both in conversations with doctors and the survey comments. Some examples of comments in the survey are:

8   Wendy Dean et al., September 2019, 'Reframing Clinician Distress: Moral Injury Not Burnout', Federal Practice, vol. 36, no. 9, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6752815
9   Una St Ledger et al, 2021, 'Moral distress in end-of-life decisions: A qualitative study of intensive care physicians', Journal of Critical Care, vol. 62, https://reader.elsevier.com/reader/sd/pii/S0883944120308133?token=B0D46 D8B03F40CAA0140508DA149A7503302F0CBD9BAA391B3C69A270F82E0DF61AF3CA313F416BE742D27647A 462797&originRegion=eu-west-1&originCreation=20210528095340

'I hadn't heard of the [terms] before but they really explain how I've been feeling since I started work as a doctor. We are taught such high ideals to work towards as medical students and told we have the power to make changes. However the reality of working in the NHS is very different and I did become depressed when I struggled to live up to these ideals…'

'I hadn't heard of this before the pandemic but absolutely identify with the concept and realised [retrospectively] that this has been a constant tension on working in child psychiatry…'

'I am so relieved to see these terms used rather than burnout or [physicians'] distress which imply only those with less resilience suffer from these 'mental health' problems…'

The survey indicates there is a concerning prevalence of moral injury among the UK's doctors, with 78.4% of respondents stating that moral distress resonated with their experiences at work and 51.1% saying the same about moral injury. Though the responses were no doubt coloured by COVID-19, when specifically asked about before the pandemic,[10] 59.6% of respondents to that question said they had experienced moral distress in the 12 months before the pandemic. Furthermore, a number emphasised in the free comments that the problems of moral distress and moral injury had existed long before COVID-19.
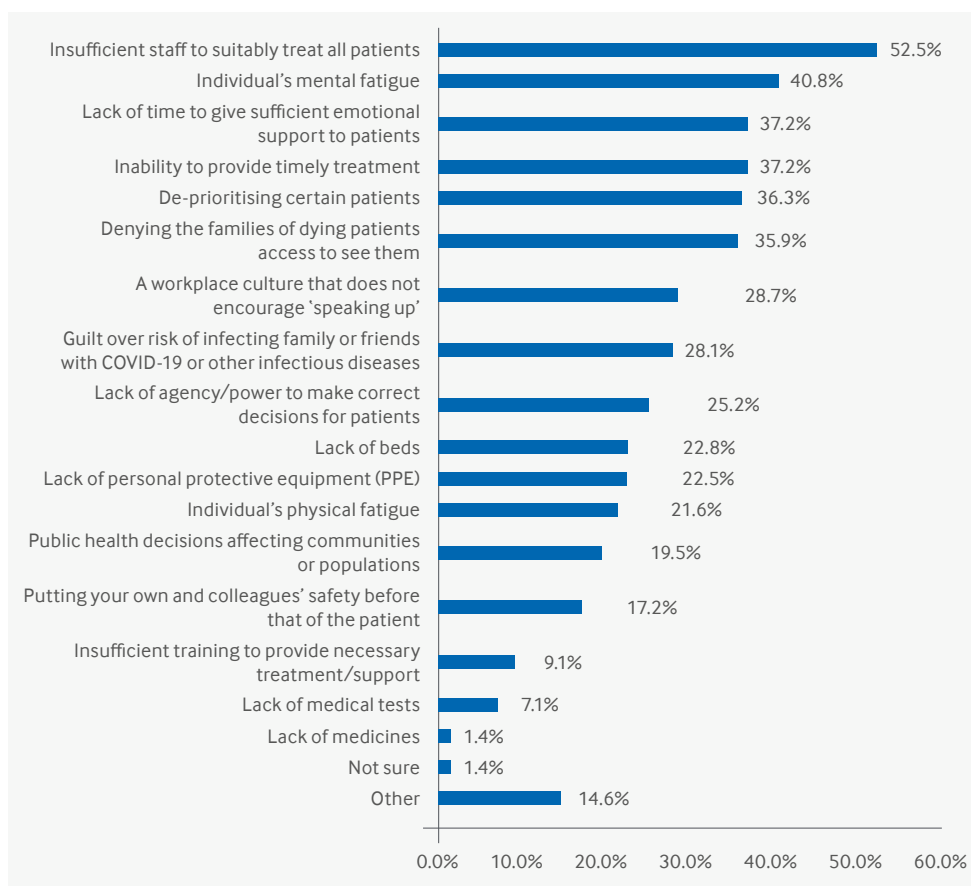
The survey also demonstrates that there are notable contrasts between different groups of doctors. For example, 58.9% of respondents who said they have a disability, or physical or mental health condition or illness (lasting or expected to last 12 months or more), said that moral injury resonated with their experiences, as opposed to 48.4% of those without a disability. There was also a contrast between age-groups. Respondents who were 55 or under were more likely to say that the terms moral distress and moral injury resonated with their experience at work (82.6% and 54.4% respectively) compared to doctors above 55 (67.7% and 42.1% respectively). 88.4% of doctors from ethnic minority backgrounds reported that moral distress resonated with their experiences at work compared with 75.6% of white doctors. 64.6% of doctors from ethnic minority backgrounds felt that the term moral injury aligned with their experiences at work compared with 47.0% of white doctors. Hence, there are notable demographic differences with respect to experiences of moral distress and moral injury at work in the UK medical workforce.

Regarding branches of practice (BoPs), there were sufficient responses from junior doctors, consultants and GPs to allow cross-BoP comparisons, but too few responses from other BoPs. 84.5% of junior doctors reported that moral distress resonated with their experiences at work compared to 78.3% of consultants and 75.3% of GPs. However, a slightly different pattern emerged when looking at moral injury, with 53.7% of consultants stating that moral injury related to their experience at work, compared to 52.1% of junior doctors and 44.1% of GPs. A greater proportion of critical care doctors and foundation year junior doctors stated that moral distress resonated with their experiences at work (88.9% and 88.5% respectively), though this could be related to the impact of the COVID-19 pandemic.

The survey invited respondents to consider the specific day-to-day causes of moral distress in their workplace. The previous section explained many of the recognised direct causes of moral distress in doctors (such as witnessing poor quality of care and end-of-life decisions) and so the factors respondents were asked about mainly referred to structural deficiencies that contribute to moral distress. For example, if there are insufficient staff it could mean staff are overstretched across patients, potentially impacting patient care, and fatigued staff are less effective staff. Also, clinical leaders when facing a lack of personal protective equipment (PPE) may have to make decisions assessing the risks to their healthcare team if treating with inadequate PPE compared to risks to patients of not receiving treatment. The graph below is a summary of a question from the survey asking respondents to list the five most important causes of moral distress in their opinion:

10 This question was asked to respondents who said that moral distress resonated with their experience at work, and had worked in the NHS in the year prior to prior to March 2020.

Figure 1: In your experience, what factors do you think contribute to moral distress? Please select the five you think are most important

One clear outcome from this question is the impact of insufficient staff, with over half of respondents believing it is one of the top five causes of moral distress. The BMA has raised the UK's medical workforce shortages repeatedly and this is further evidence of the need for stronger recruitment and retention strategies from governments.

There were interesting demographic trends regarding the causes of moral distress. Doctors from ethnic minority backgrounds were more likely to say:
— 'A workplace culture that does not encourage 'speaking up' (39.5%) compared to white doctors (25.2%)
— 'Guilt over risk of infecting family or friends with COVID-19 or other infectious diseases' (36.8%) compared to white doctors (25.6%)
— 'Lack of personal protective equipment (PPE)' (32.0%) compared to white doctors (19.7%)
— 'Individual's physical fatigue' (30.4%) compared to white doctors (18.7%).

Contrasts along gender lines were notable also:
— 27.1% of male respondents stated 'lack of beds' compared to 20.1% of female respondents
— 41.9% of female respondents highlighted 'lack of time to give sufficient emotional support to patients' compared to 30.9% of male respondents.

The contrasting experiences above indicate there is an equalities aspect to moral distress.

BoP and specialty trends from the survey include:
— Junior doctors were more likely to select 'insufficient staff to suitably treat all patients' (61.9%) compared to GPs (48.2%)
— 50.7% of GPs chose 'lack of time to give sufficient emotional support to patients' compared to 29.8% of consultants
— Critical care doctors were also significantly more likely than other doctors to select 'denying the families of dying patients access to see them' (70.5%) and 'insufficient staff to suitably treat all patients' (77.1%). This could be a result of the impact of COVID-19 on ICUs.
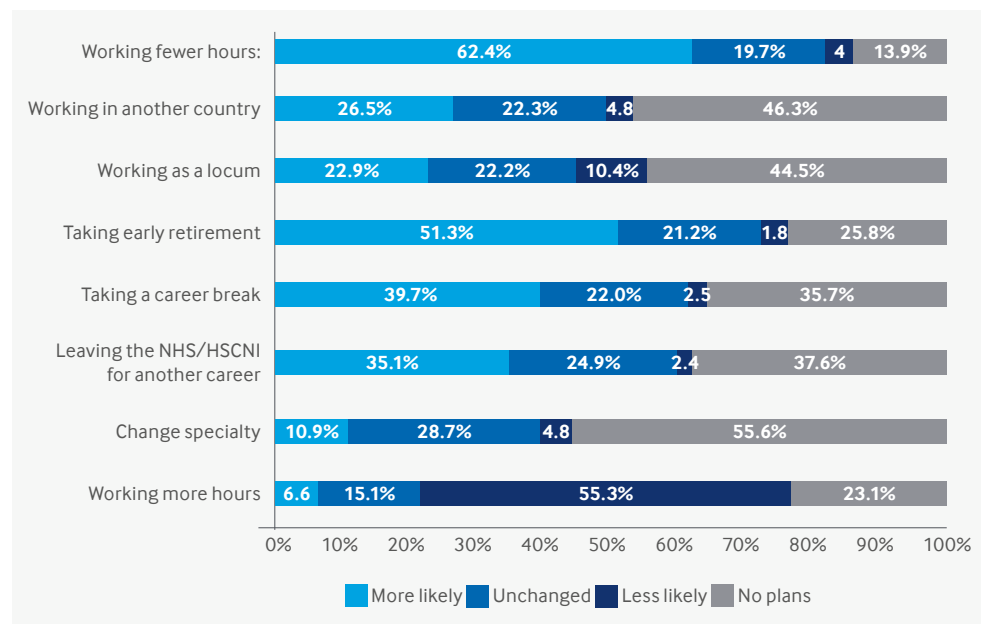— 65.7% of emergency medicine doctors stated 'lack of beds', significantly more than the average.

Other causes of moral distress that respondents noted were the response of the government to the pandemic and the (lack of) support given to doctors. Bullying and a generally poor workplace culture were also noted as were leadership and management in the NHS.

The survey findings are consistent with existing UK research on causes of moral distress and moral injury among healthcare staff, which has noted correlations between moral distress and end-of-life care, staffing/resource issues, and decision-making concerns.[11]

Some research has also linked the issue of moral distress to conscientious objection.[12] It has been argued that some healthcare systems can undermine individuals' values and moral reasonings, which can be damaging for healthcare professionals' sense of conscience. One study, for example, found that nurses whose ethical beliefs were most heavily influenced by religious convictions, and who were generally more sympathetic to conscientious objection than other nurses, scored higher in levels of moral distress.[13]

The BMA survey on moral distress and moral injury also asked respondents if they have changed their career plans. The results are shown in the graph below.

Figure 2: How, if at all, have you changed your career plans for the next year?

11 GA Colville et al., 2019, 'A survey of moral distress in staff working in intensive care in the UK' Journal of the Intensive Care Society, vol. 20, no. 3, https://journals.sagepub.com/doi/pdf/10.1177/1751143718787753
12 Mary Kathleen Deutscher Heilman & Tracy J Trothen, 2020, 'Conscientious objection and moral distress: a relational ethics case study of MAiD in Canada', Journal of Medical Ethics, vol. 46, no. 2, https://jme.bmj.com/content/46/2/123
13 Shoni Davis et al., June 2012, 'Influencers of ethical beliefs and the impact on moral distress and conscientious objection', Nursing Ethics, vol. 19, no. 6, https://journals.sagepub.com/doi/full/10.1177/0969733011423409#

As can be seen, a majority of respondents to this question said that they are more likely to work fewer hours and/or take early retirement. This is alarming, given the relationship between insufficient staff and moral distress. It could potentially lead to a 'vicious circle', wherein doctors work less due to insufficient staff, thus compounding the problem.

Moral distress and COVID-19

One of the numerous impacts of the COVID-19 pandemic has been to highlight and aggravate existing deficiencies in the UK health system. This applies to resources, staff numbers and, of course, the related issue of staff wellbeing. Many doctors have found themselves working under extraordinary, constantly evolving conditions during the pandemic, thrust into situations which do not complement their expertise, and often with inadequate equipment and protection.

This impact is reflected in both research and the media. Numerous papers have been published[14] some of which have focused on what healthcare professionals can do themselves to tackle moral distress[15] during the pandemic while others are addressed to care leaders.[16] Mainstream media organisations, including the BBC[17] and Guardian,[18] have also recognised the impact of moral injury on healthcare staff during the pandemic. This is helping move the terms, from relatively obscure academic and psychological concepts, into common usage.

In discussions, doctors have informed the BMA that, in some specialties, there has been a loss of team-building and sense of isolation that the pandemic has produced, as a result of different ways of working. This has meant many medical professionals have felt 'alone' when making difficult decisions, without the peer support that comes from working as part of a team, increasing the likelihood of moral distress. Added to this, phone consultations can be deeply frustrating, while referring those who have potentially serious conditions to ever-growing waiting lists contributes to discomfort.

It is little wonder, therefore, that the risk of moral distress has considerably increased for many doctors during the pandemic. In the BMA survey we asked respondents who said that moral distress resonated with their experiences at work and had or were working during the pandemic, if they had experienced moral distress in relation to their ability to provide care during the pandemic. 86.2% of respondents said they had and 70.8% felt that during the pandemic they had experienced moral distress in relation to a colleague's ability to provide care. This compares with 59.6% of respondents, who were working prior to the pandemic (and said that moral distress resonated with them) who said they had experienced moral distress at work during the 12 months prior to the pandemic. Though already at an unacceptably high rate, the substantial rise in doctors experiencing moral distress during the pandemic is concerning.

14 Roger D. Williams et al., May 2020, 'Moral Injury in Times of COVID-19', Journal of Health Service Psychology, vol. 46, https://link.springer.com/article/10.1007/s42843-020-00011-4

15 Fahmida Hossain & Ariel Clatty, October 2020, 'Self-care strategies in response to nurses' moral injury during COVID-19 pandemic', Nursing Ethics, vol. 28, no. 1, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7604672/

16 Suzanne Shale, July 2020, 'Moral injury and the COVID-19 pandemic: reframing what it is, who it affects and how care leaders can manage it', BMJ Leaders, vol. 4, no. 4, https://bmjleader.bmj.com/content/4/4/224

17 Lucy Ballinger & Anna Palmer, April 2020, 'Coronavirus: NHS staff mental health hotline expands', BBC, https://www.bbc.co.uk/news/uk-wales-52302066

18 Mariam Alexander, April 2021, The Guardian, 'NHS staff are suffering from 'moral injury', a distress usually associated with war zones', https://www.theguardian.com/commentisfree/2021/apr/12/nhs-staff-moral-injury-distress-associated-with-war-zones-pandemic

Breaking down the responses above further, those who saw only COVID-19 patients reported highly alarming levels of moral distress – 96.6% stated they had experienced moral distress (as opposed to 84.7% of those who saw non-COVID-19 patients and 87.7% of those who saw both COVID-19 and non-COVID-19 patients) in relation to their own ability to provide care during the pandemic. 88.1% of those who only saw COVID-19 patients indicated they had experienced moral distress in relation to a colleague's ability to provide care (compared to 62.9% of those not working with COVID-19 patients and 73.9% of those working with both COVID-19 and non-COVID patients).

The extent of moral distress in those working with COVID-19 patients is significant and could demonstrate a lack of support given to those working in environments like ICUs, as well as the UK's general lack of preparedness for the pandemic, which has been well-documented. Moral distress is common in critical care due to high patient mortality, morbidity and the need to make constant difficult ethical decisions. Research published in 2016 indicates moral distress reaching rates of 80% in critical care nurses.[19] These challenges increased during the pandemic. The expectation of a 1:1 patient to specialist trained nurse ratio in ICUs for patients on a ventilator, the minimum standard in the UK, was sometimes relaxed during the pandemic. A survey from the Faculty of Intensive Care Medicine found that 60% of members who responded indicated that their unit is still attempting to follow the Guidelines for the Provision of Intensive Care Services, though 54% indicated this 1:1 standard had been relaxed.[20] Specialist professionals were spread thinly over multiple patients, while those staff redeployed to the ICU who did not have the suitable training did the best they could. One doctor, who was redeployed to an ICU during the first wave of the pandemic, informed the BMA that the ICU they were working in probably had one specialist nurse for every four patients during the height of the pandemic, and other units in the region had ICU specialist nurse to patient ratios of up to 1:6. While on the face of it the overall staff to patient ratio of 1:1 was generally met (using the redeployed ward nurses, surgeons and so on as ICU support staff), the staff by the bedside were not all ICU trained nurses. This, doubtlessly, was a situation that could easily create moral distress in all healthcare staff involved. In particular, ICU nurses found themselves having to oversee the complex care of a novel disease in far more patients simultaneously than they would expect, but also constantly instruct colleagues who were not used to working in such environments.

The table below summarises respondents' views to the BMA survey on what causes of moral distress had become more of a problem during the pandemic. The increase in pertinence of some factors due to the pandemic is almost inevitable. These includes those situations that were rare before COVID-19 (such as denying families access to see dying relatives, which 94.0% thought had become much worse due to the pandemic) or factors that were non-existent (the risk of infecting others with COVID-19). Nevertheless, it is important to observe the significant increases in other problems such as a lack of beds, doctors' mental and physical fatigue and the inability to provide timely care.

19 Meredith Mealer & Marc Moss, October 2016, 'Moral distress in ICU nurses', Intensive Care Medicine, vol. 42, no. 10, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5683387/#:~:text=Moral%20distress%20is%20 especially%20common,critical%20care%20nurses%20%5B%5D.&text=Long%2Dterm%20consequences%20 of%20moral,of%20burnout%20syndrome%20%5B8%5D

20 The Faculty of Intensive Care Medicine, November 2020, 'Voices from the Frontline of Critical Care Medicine', https://www.ficm.ac.uk/sites/default/files/voices_from_the_frontline_of_critical_care_medicine.pdf

Figure 3: Thinking about the factors you think might contribute to moral distress, which ones have become more or less of a problem during the pandemic compared to before the pandemic? (Respondents given the five factors they listed as most important causes of moral distress)

Factors	Percentage of respondents who stated this was one of the top 5 causes of moral distress	Percentage of respondents who thought the factor was much more of a problem than before the pandemic
Insufficient staff to suitably treat all patients	52.5%	62.6%
Individual's mental fatigue	40.8%	78.0%
Inability to provide timely treatment	37.2%	78.2%
Lack of time to give sufficient emotional support to patients	37.2%	58.5%
De-prioritising certain patients	36.3%	72.8%
Denying the families of dying patients access to see them	35.9%	94.0%
A workplace culture that does not encourage 'speaking up'	28.7%	39.0%
Guilt over risk of infecting family or friends with COVID-19 or other infectious diseases	28.1%	88.2%
Lack of agency/power to make correct decisions for patients	25.2%	45.3%
Lack of beds	22.8%	62.4%
Lack of personal protective equipment (PPE)	22.5%	82.0%
Individual's physical fatigue	21.6%	72.1%
Public health decisions affecting communities or populations	19.5%	79.1%
Putting your own and colleagues' safety before that of the patient	17.2%	81.1%

This experience is not isolated to the UK. Both the Canadian and American Medical Associations have recognised the increased threat of moral distress during the pandemic, partly as a result of difficult decisions concerning critical care.[21, 22] Indeed, it is likely that such feelings are prominent amongst healthcare professionals worldwide. Medical staff in India, which at the time of writing is going through a particularly severe second wave of COVID-19, are feeling immense pressure: one recent story involved the agonising decision that an Indian ICU doctor faced, where six COVID-19 patients' oxygen saturation had fallen below 80%, meaning that they might not survive until the end of the day, but there was only space on his ICU for one patient.[23]

21 Canadian Medical Association, 'COVID-19 and Moral Distress', https://www.cma.ca/sites/default/files/pdf/Moral-Distress-E.pdf
22 Timothy M. Smith, December 2020, '7 ways to cope with moral distress during COVID-19', American Medical Association https://www.ama-assn.org/practice-management/physician-health/7-ways-cope-moral-distress-during-covid-19
23 Anna Isaac, May 2021, 'Who gets to live? COVID-19 is causing moral distress among India's doctors', The News Minute, https://www.thenewsminute.com/article/who-gets-live-covid-19-causing-moral-distress-among-india-s-healthcare-workers-148811

It is important to recognise that COVID-19 has not just caused moral distress in those directly dealing with COVID-19 patients. Those who have not been able to see their patients directly, limited for example to telephone consultations, or the de-prioritisation of certain patients could lead to moral distress in those not directly dealing with COVID-19 patients, such as GPs or gastroenterologists.

Research considering the experience of mental healthcare workers in the NHS, during the COVID-19 pandemic, noted that many suffered from moral injury. This was due to their perceived failure in providing the quality of care that patients required, meaning people suffered, and mental health professionals feeling they had 'let them down' as a result.[24]

In the BMA's discussions with doctors, several remarked that they had recovered a certain degree of autonomy during the pandemic, that they felt had been eroded over years in the health system. The nature of the constantly evolving situation allowed doctors to make decisions they thought were best given the circumstances - one of the very few silver linings of the pandemic. Some BMA members report that, unfortunately, steps are now being taken to re-establish restrictive bureaucratic structures that limit doctors' agency.

The impact of COVID-19 on moral distress in the UK has been felt differently by different groups of doctors as shown by the BMA survey.[25] 68.5% of white doctors experienced moral distress during the pandemic in relation to a colleague's ability to provide care, as opposed to 78.6% of doctors from ethnic minority backgrounds (this rises to 83.2% of doctors from an Asian (Indian/Pakistani/Bangladeshi) / Asian British background). There are a number of potential reasons related to this. For example, an issue that the BMA has raised repeatedly,[26] the concerningly disproportionate rate at which people from ethnic minority backgrounds died from COVID-19, could increase awareness of colleagues' decisions in doctors from ethnic minority backgrounds. Alternatively, the difficulty doctors from ethnic minority backgrounds have in speaking out due to racism in the NHS could also play a role.

The survey suggests that moral distress was more prevalent among emergency doctors prior to the pandemic compared to other specialties. 81.0% of emergency medicine doctors stated they had experienced moral distress prior to the pandemic as opposed to the average of 59.6% across all specialties. Though the reason behind this cannot be ascertained from the survey, a few emergency medicine doctors suggested that the winter crises are a cause of moral distress in emergency medicine doctors. This was also brought up in BMA discussions with physicians. Two comments from the survey on this were:

'I have honestly experienced less 'moral distress' in the last 12 months than I normally do. I have not seen the corridors of A and E full of patients waiting to be seen or to be admitted like I have done every other winter for the last 30 years…'

'In Emergency Medicine we're used to the moral injury year on year of lack of beds, undignified conditions of having no adequate space to see patients and the feeling of providing an inadequate service. I'm really pleased people are talking about it now because it wears us all down and will contribute to burn-out and people leaving the profession…'

24 Elisa Liberati et al., May, 2021, 'A qualitative study of experiences of NHS mental healthcare workers during the Covid-19 pandemic', BMC psychiatry, vol. 21, https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03261-8
25 As a reminder these questions were only asked to respondents who said that moral distress resonated with their experiences, and who worked or are working during the pandemic.
26 https://www.bma.org.uk/advice-and-support/covid-19/your-health/covid-19-the-risk-to-bame-doctors
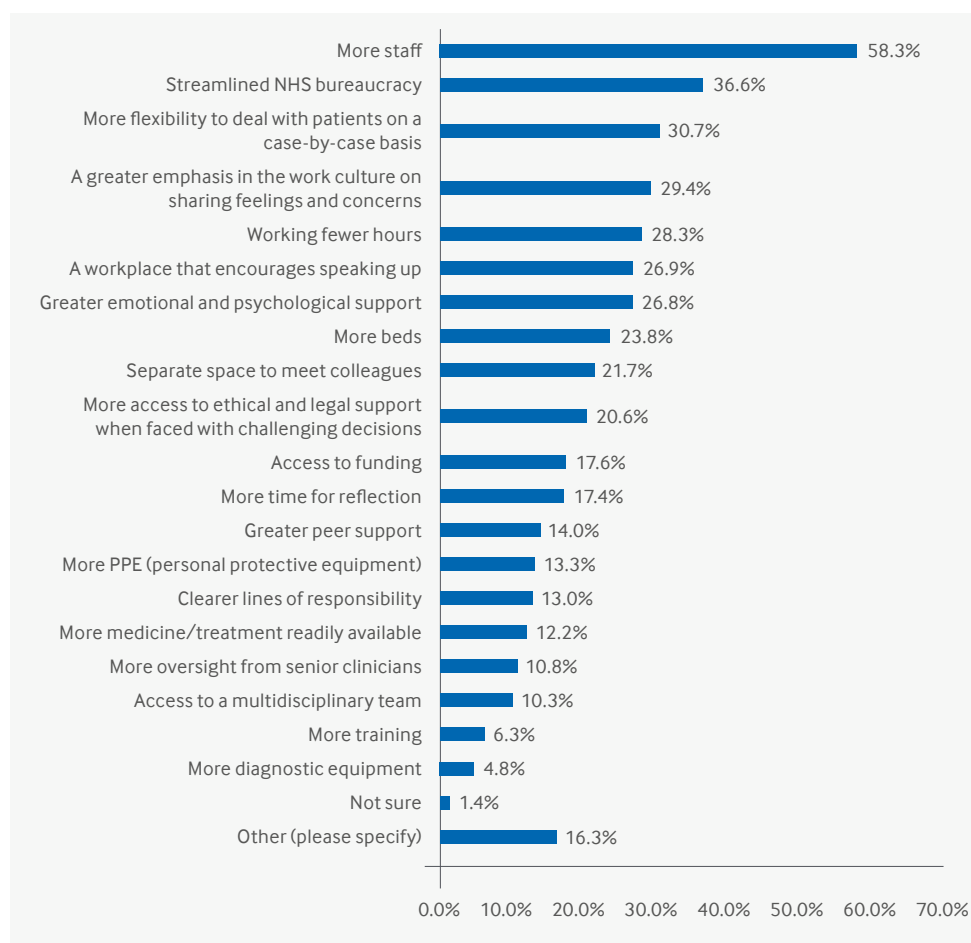
While COVID-19 may have exacerbated and aggravated the issue of moral distress for many in the UK medical workforce, it did not create it. The issue existed before the pandemic and undoubtedly will exist after. Though 82.7% of BMA survey respondents[27] thought it was much more likely and 96.4% thought it was more likely to some extent due to the pandemic, 59.6% acknowledged experiencing moral distress prior to COVID-19.[28] The pandemic has shone a light on the issue and perhaps given the impetus to take action to lessen its impact. As one survey respondent said:

'This was a serious problem way before the pandemic; the pandemic has merely highlighted the problem.'

Recommendations

The BMA survey asked respondents to indicate the five most important changes necessary to help alleviate moral distress in their workplace. The findings are summarised in the table below.

Figure 4: What would help alleviate the risks of moral distress in your current (or most recent) workplace? Please select the five you think are most important

Response	Percentage
More staff	58.3%
Streamlined NHS bureaucracy	36.6%
More flexibility to deal with patients on a case-by-case basis	30.7%
A greater emphasis in the work culture on sharing feelings and concerns	29.4%
Working fewer hours	28.3%
A workplace that encourages speaking up	26.9%
Greater emotional and psychological support	26.8%
More beds	23.8%
Separate space to meet colleagues	21.7%
More access to ethical and legal support when faced with challenging decisions	20.6%
Access to funding	17.6%
More time for reflection	17.4%
Greater peer support	14.0%
More PPE (personal protective equipment)	13.3%
Clearer lines of responsibility	13.0%
More medicine/treatment readily available	12.2%
More oversight from senior clinicians	10.8%
Access to a multidisciplinary team	10.3%
More training	6.3%
More diagnostic equipment	4.8%
Not sure	1.4%
Other (please specify)	16.3%

27 Only respondents who had worked before and during the pandemic and said that moral distress resonated with their experiences at work were asked if they thought the risk of doctors experiencing moral distress has changed during the COVID-19 pandemic.
28 Again only respondents who were working prior to the pandemic and said that moral distress resonated with their experiences at work were asked this question.

The most consistent other suggestion on alleviating moral distress raised by respondents was better management. Two survey comments on management were:

'I have found when I had opportunities to talk to senior management, they have been patronising and [publicly] dismissed my thoughts in front of our colleagues. I find their lack of interest or engagement with front line colleagues hugely distressing.'

'I believe the powers that be or the people who make management decisions are far removed from the reality of what happens on the floor.'

In separate discussions with public health doctors, some have raised concerns regarding the restructuring of services. It has been argued these have been management decisions without understanding of frontline workers.

The recommendations are split into two broad categories. The first category is structural recommendations. These are largely derived from the suggestions given in the survey as well as existing BMA research into staff wellbeing and structural shortcomings in the UK health system. The BMA strongly believes that taking action on these recommendations is key to tackling moral distress as they pertain to limiting the situations in which moral distress can arise.

The second category of recommendations is steps doctors can take themselves. These relate to existing research on how to alleviate moral distress and moral injury,[29] including suggestions from other medical associations around the world. The BMA recognises, however, that what is fundamental is changing the environment within which doctors work that create these problems and that some of these recommendations for individuals may not be very effective (or even possible) in some working cultures. This is why the structural recommendations are of paramount importance. Nevertheless, the BMA also acknowledges that there are actions that doctors can take themselves and this second category of recommendations should equip our members with the tools to do so whilst appreciating the structural limitations that may exist in the environments in which they work.

A fundamental aspect to addressing moral distress is acknowledging the individual clinician's conscience. Though clinicians throughout the country must always adhere to professional standards and expectations, this does not mean what a particular doctor believes to be right or wrong is invalidated. This is recognised by the GMC already, who note 'We recognise that personal beliefs and cultural practices are central to the lives of doctors and patients, and that all doctors have personal values that affect their day-to-day practice. We don't wish to prevent doctors from practising in line with their beliefs and values, as long as they also follow the guidance in *Good medical practice*'.[30] Doctors should be able to practise in line with their beliefs as long as their beliefs do not contravene Good Medical Practice guidance.

As a doctors' organisation, the recommendations below are focused on physicians in the UK. Nevertheless, the BMA recognises that moral distress is not unique to doctors. It can be found across healthcare staff, in social care, and a variety of other professions in many forms. A multidisciplinary and multi-professional approach to understanding and addressing moral distress should certainly be encouraged. Some of the recommendations below may have applicability in other fields.

Fundamentally, many principles that medical professionals apply to patient care, such as compassion, humanity, and fairness, must also be applied to medical professionals themselves. Doctors should look after themselves and decision-makers should look after them also. This is for their own sake, to mitigate the potential for moral distress, as well as to ensure that they are able to continue to give the best possible care for patients.

29 Victoria Williamson et al., April 2020, 'COVID-19 and experiences of moral injury in front-line key workers', Occupational Medicine, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7184422
30 General Medical Council, 'Personal beliefs and medical practice', https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice

Perhaps one comment from the BMA survey summarises this best:

'By their nature, doctors always want to do the right thing and find solutions to problems. When you cannot [do] that, due to circumstances beyond your control, it is extremely distressing.'

On a structural level, changes that can be made to reduce the likelihood of moral distress and moral injury include:

1. **Adequate funding and resourcing**
   It is apparent from the BMA survey that many of the causes of moral distress in the UK medical workforce stem from problems of insufficient resources, whether they be beds or time. Substantially increased levels of investment in our health system are essential to ensure doctors are satisfied with the level of care they are able to provide for their patients.

2. **Increase staffing**
   Heavily linked to the first recommendation on this list, many doctors report the reason why they struggle is because there simply are not enough doctors and other healthcare staff to meet patient demand. The problem is likely to get worse, as this survey (and others from the BMA) indicate more doctors are intending to reduce hours and/or retire early. The number of medical vacancies in the UK have become notorious. The BMA continues to raise issues surrounding recruitment and retention with governments as well as lobbying on safe staffing.

3. **Empower doctors**
   As noted, the term moral distress originated in nursing due to nurses' perceived lack of agency. It is little wonder, therefore, that doctors experience the same consequences as a result of the perception that decisions around patient care are being taken out of their hands. It is believed these decisions are now being made by those who may not necessarily have clinical expertise, including non-clinical managers. This is a common cause of frustration and distress among doctors who generally value clinical autonomy.

4. **Develop an open and sharing workplace culture**
   Medical professionals need to feel that they can raise issues without fear of reprisal. They can therefore voice concerns and constructively challenge problematic systems. This also provides a more supportive workplace. Many respondents to our survey indicated that a change of workplace, with a different culture, greatly reduced their exposure to moral distress. This should be applied to all staff working in NHS Trusts or equivalent organisations. Further work the BMA has undertaken in this area can be found [here](#).

5. **Provide support for employees**
   In the UK, all employers have a duty of care to their employees and that can include a duty to provide support to employees who have been through emotionally stressful experiences. This includes, for example, Specialist Occupational Health Services. It is imperative that consistent and clear lines of emotional and psychological support are provided to healthcare workers. Services should be accessed in a timely manner. Staff should be encouraged to seek and should be signposted to suitable support at an early stage.

   The BMA has produced a number of pieces of guidance on staff wellbeing. For example, the BMA recently developed a junior doctor wellbeing checklist which includes simple measures that organisations can implement to improve junior doctor wellbeing. Though aimed at junior doctors, several recommendations have applicability across branches of practice. The wellbeing checklist can be found [here](#).

6. Streamline healthcare bureaucracy
A common complaint is that the bureaucracy in the NHS and equivalent organisations is overly complex, which can delay patient care, and make the reasoning for some patient decisions unclear. Streamlining this system could help resolve this. Further exploration of exactly how bureaucracy in the UK healthcare system can be streamlined to mitigate moral distress is required.

Action by doctors is heavily dependent on having a supportive culture within the workplace. However, steps that doctors can take themselves are:

1. Talk about moral distress and moral injury
As BMA research shows, many doctors are unfamiliar with the terms, but find it a great relief when the concepts are explained to them. It helps people to know that their feelings are not unique and are (unfortunately) common throughout the workforce. This can help lessen the burden the individual feels. Furthermore, we cannot address problems that we do not acknowledge exist. By talking about moral distress and moral injury, we recognise these issues and can look to tackle them. This becomes easier as the concepts become more mainstream.

2. Develop support networks
It is important for people to be able to reach out when they're struggling without fear of judgement and to know colleagues support them. Schwartz Rounds, CPD groups, Doctors' Messes, groups led by a trained facilitator such as Balint groups, or more informal spaces can all be helpful to provide this environment. It is essential that doctors are given the time to participate in such activities.

3. Speak out (when possible)
If doctors are uncomfortable with decisions or resourcing, it can help both the situation and the individual to speak out on this in suitable environments. This can not only encourage others to do the same, but build a more healthy working culture wherein doctors feel empowered to discuss decisions that they think are not optimal for patient care.

The BMA recognises, though, that this is not always possible. 28.7% of respondents who had experienced moral distress stated that 'a workplace culture that does not encourage 'speaking up' is one of the top five causes of moral distress. It is incumbent on organisations to build these cultures before individuals can take steps themselves, hence why the structural recommendations take precedent in this report.

4. Seek advice
Sometimes, when taking a decision, it can be reassuring for a doctor to check in with an expert or colleague on their thought processes if possible. In some instances, local ethics committees have been established, which doctors can find useful when facing a tough choice. The BMA is always happy to help with any queries and contact details for the organisation's first point of contact service can be found **here.**

5. Develop a self-care plan
Perhaps obvious, it is nevertheless important to reiterate the importance of medical professionals taking the time to look after themselves. Physical and mental fatigue both contribute to moral distress and injury, potentially worsening their effects, and so finding the time for nutrition, exercise, and rest can all help. The BMA's wellbeing services are available 24/7 and can be found here. For many of the wellbeing services provided, you do not have to be a BMA member to utilise them.

Appendix 1: Moral distress survey breakdown

1. Methodology
The aims of this survey were to get insight to general awareness and prevalence of moral distress and moral injury among doctors. The survey also tried to gather an understanding of what are the biggest contributors to moral distress, and if there are any clear ways to alleviate moral distress and moral injury.

Respondents to the survey were self-selecting, this means that we cannot be sure that the findings are representative of the general doctor population. An example is that 47.8% of respondents said they were a consultant, and this means that consultants were overrepresented in this survey.

The survey was distributed through a link (open to all) to the online survey. The survey was highlighted in BMA's newsletters to members as well as social media.

This survey was not aimed at medical students, and so disqualified any that tried to respond.

Analysis
A mixture of SPSS, Excel and Survey Monkey were used to analyse the quantitative data. The quantitative analysis presented below highlights where key differences were identified between sub-groups. All percentages are presented alongside the actual number of respondents.

Significant differences were identified in two ways, using the inbuilt significance tester in Survey Monkey and for ethnicity, age[31], and speciality the survey star significance testing calculator was used. For analysis of different specialities results were compared to all respondents due to sample sizes of many of the sub-groups. For the other comparisons sub-groups were compared to each other for example responses from females compared to males. In many cases the sample sizes were too small to report differences.

This report primarily focuses on the quantitative analysis. The free text comments were reviewed once, and quotes added where relevant to the report. Where an issue was raised by a sufficient numbers of respondents and was not already represented within quantitative analysis (for example respondents raised that moral distress/moral injury pre-dates the pandemic, but this is already reflected in the quantitative analysis), it was added to the relevant section.

2. The survey
BMA ran a UK-wide survey on moral distress between 18 March 2021 and 12 April 2021. We received 1933 responses to the survey[32]. Of 1901 who responded to the question on where they mainly worked, 88.7% of respondents said they mainly worked in England, 1.7% worked in Northern Ireland, 6.1% worked in Scotland and 2.7% said they worked in Wales. The remaining 0.8% of respondents said other.

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31 This is because ethnicity and age needed to be regrouped to increase the sample sizes.
32 This includes partial as well as complete responses. Many of the questions were voluntary, so the actual number of responses to each question varies.

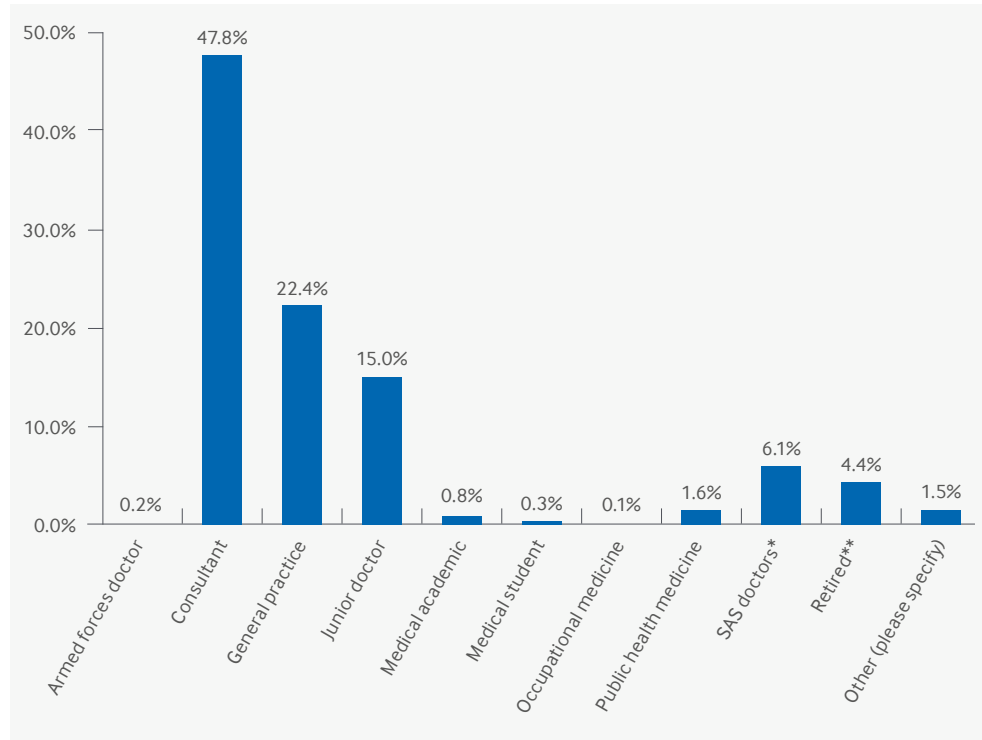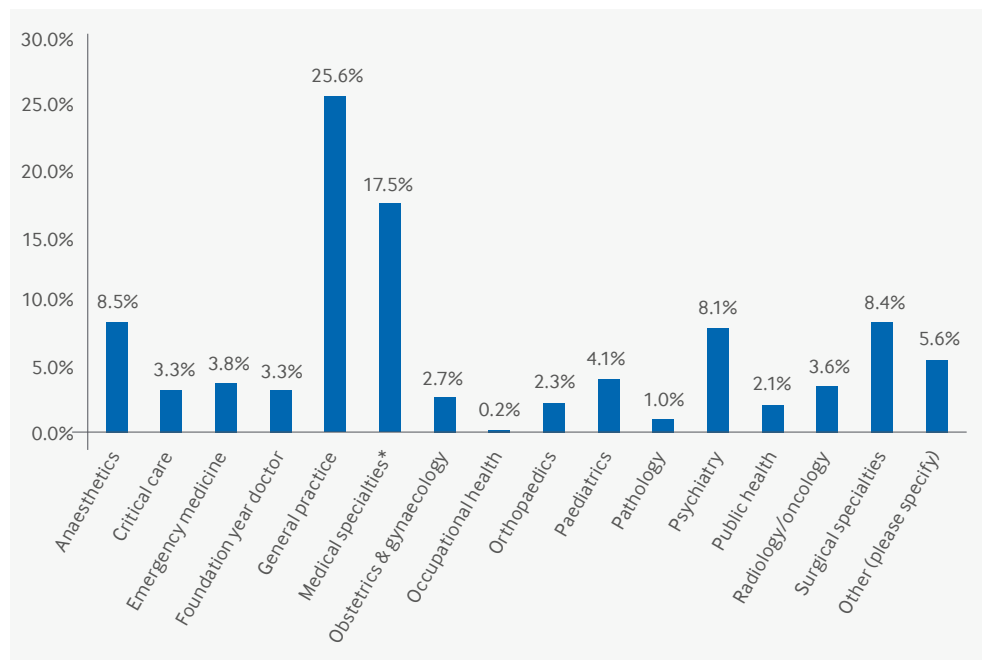**Figure 1: What is your branch of practice? (n= 1933)**

Figure 2: What is (or was) your specialty?[33] (n = 1901)

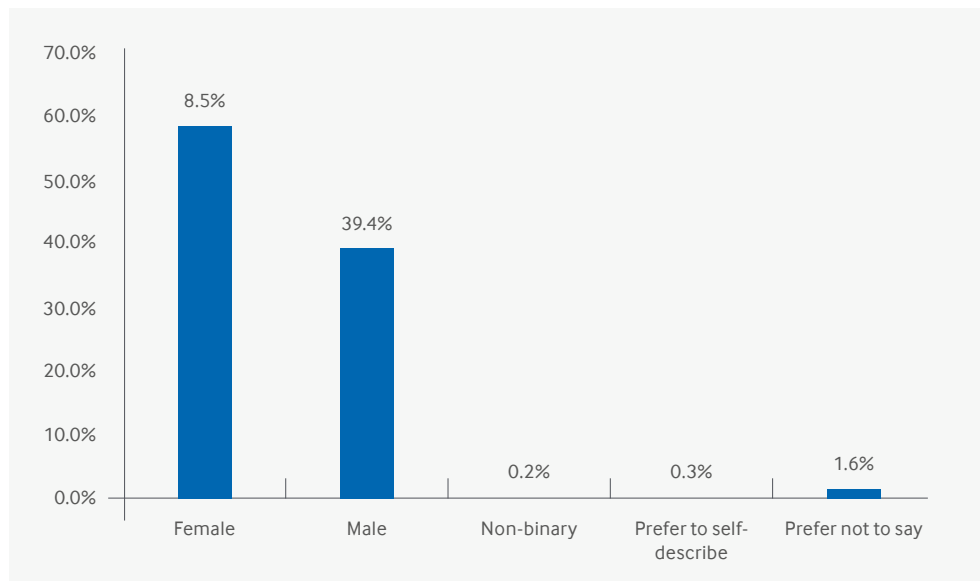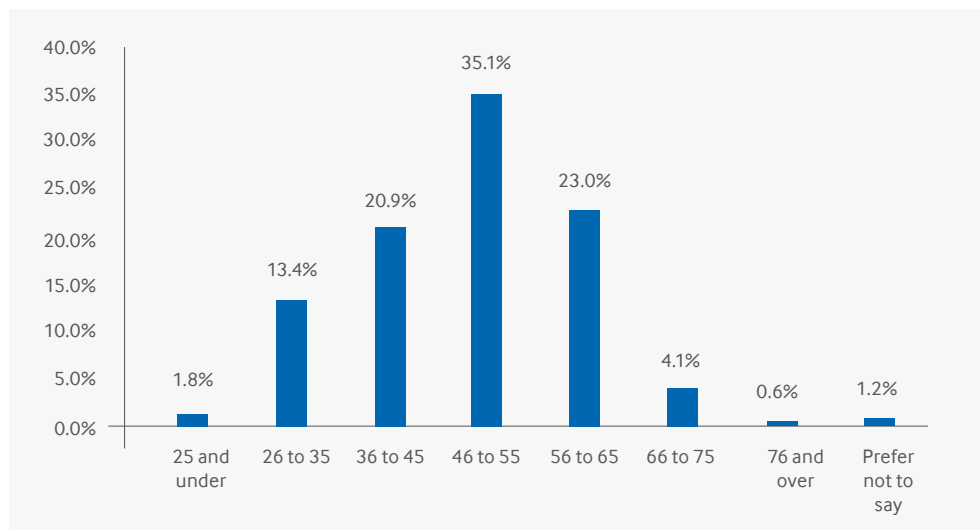33 * includes dermatology, gastroenterology, cardiology, etc

Socio-demographics questions
Figure 3: How would you describe your gender? (n=1872)

Figure 4: In which age band do you fall? (n=1872)

Figure 5: Do you have a disability, or physical or mental health condition or illness, lasting or expected to last 12 months or more? (n=1872)
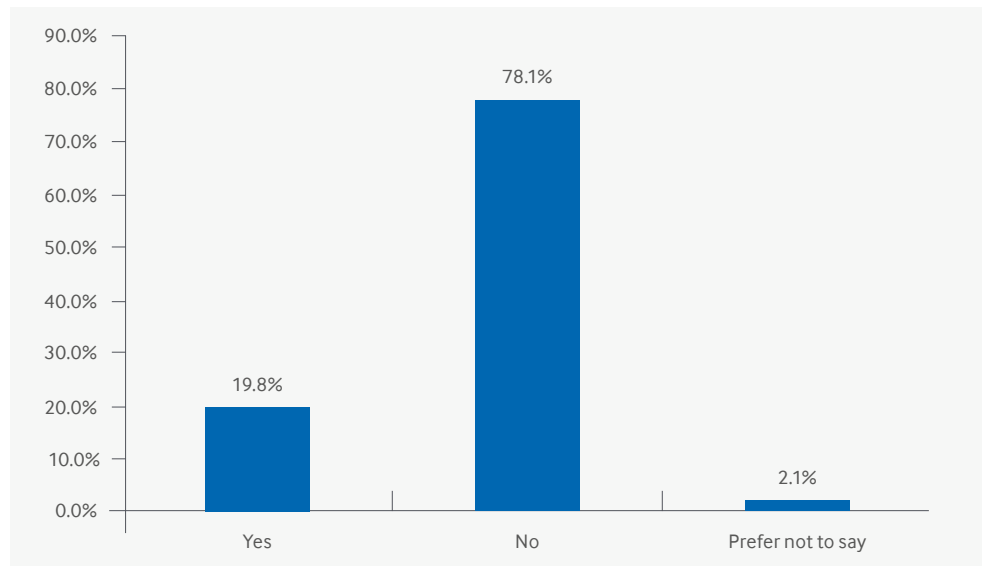

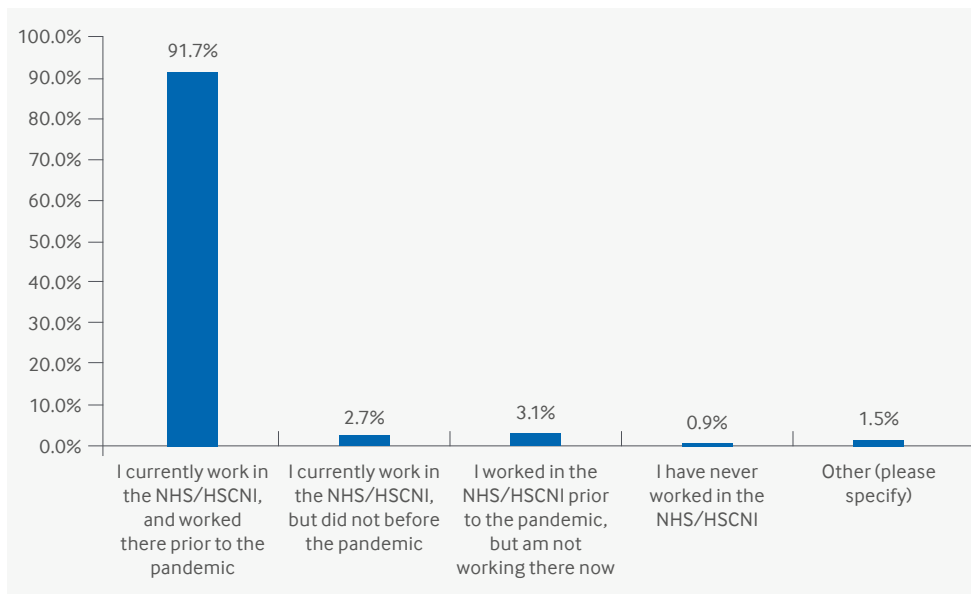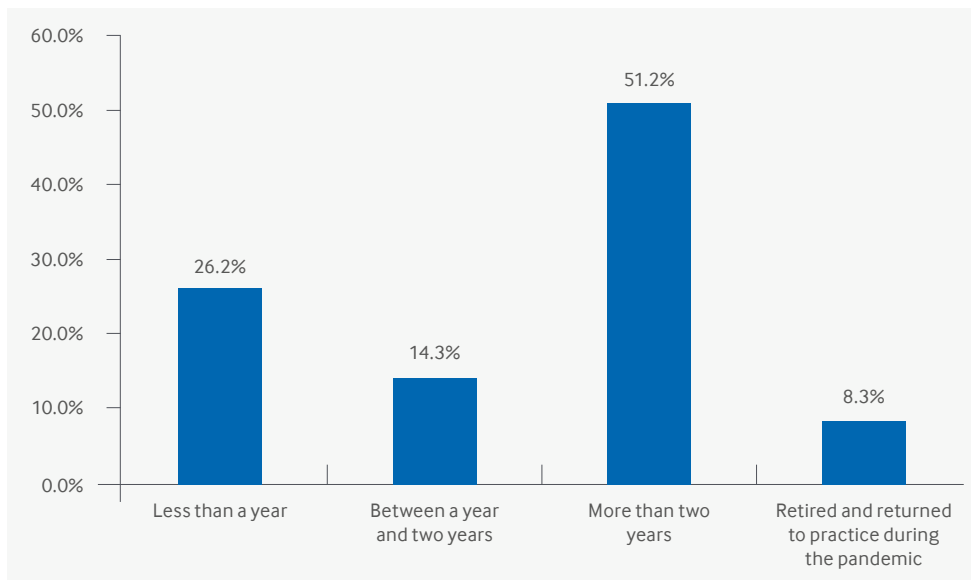**Figure 6: Which of the following best describes your ethnicity? (n=1872)**

Figure 7: Which of the following best describes your experience working in the NHS/ HSCNI (or equivalent employer for public health/medical academia/armed forces)? (n=1817)
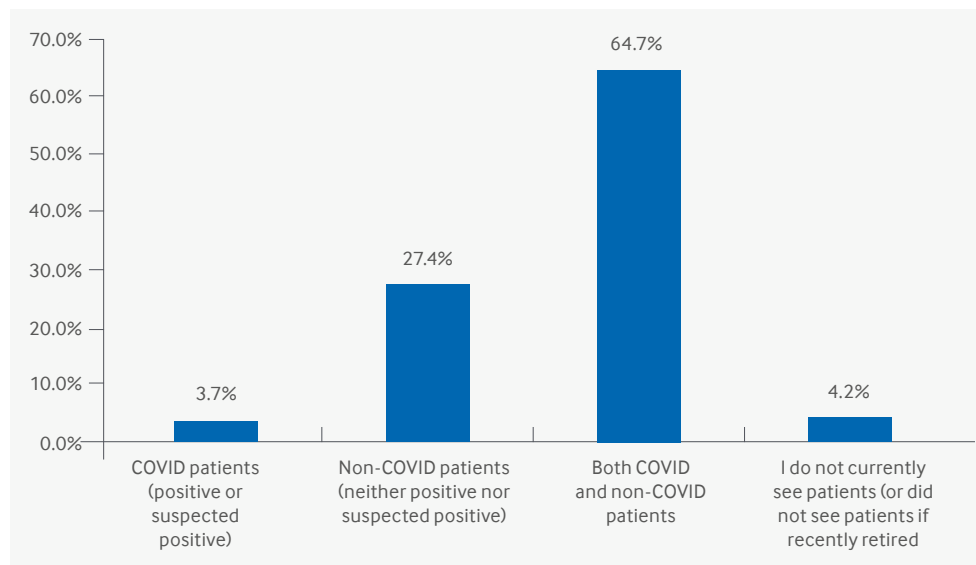

Most non-retired respondents to the survey reported currently working in the NHS (or equivalent employer for public health/medical academia/armed forces) and had done so prior to the pandemic (91.7%, 1667).

Figure 8: How long have you been retired? (n=84)

Most retired respondents reported being retired for more than two years (51.2%). Retired respondents that has been retired for less than a year were asked the same questions that respondents who were currently working in NHS (or equivalent employer for public health/ medical academia/armed forces) and had done so prior to the pandemic.

Figure 9: Which of the following best describes the patient groups you mostly see/ treat (or if recently retired did see/treat)? (n=1730)
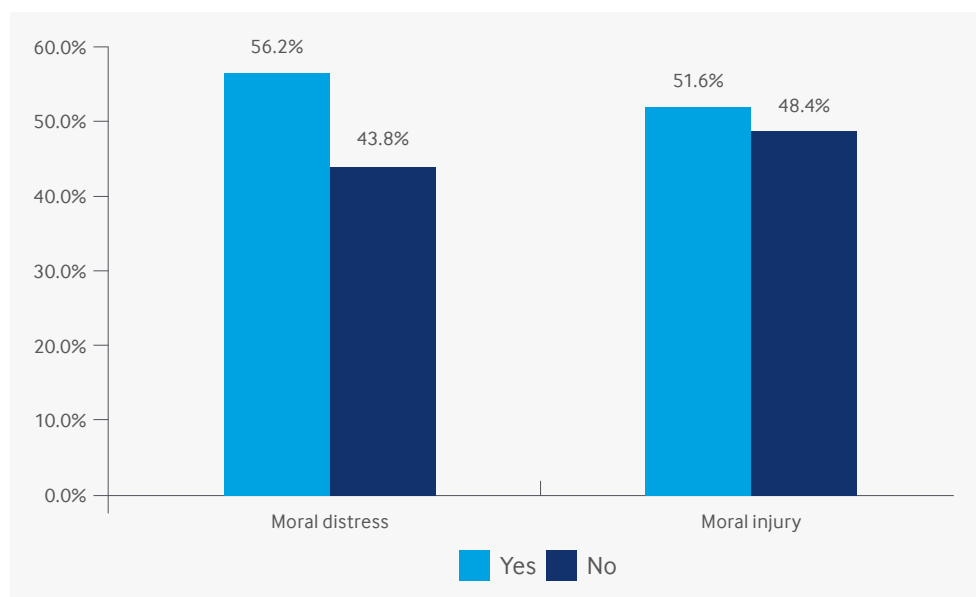

Those respondents currently working in the NHS (or equivalent employer for public health/ medical academia/armed forces) were asked what best described the patient groups they mostly see/treat, and the majority reported working with both COVID and non-COVID patients (64.7%, 1119).

— Within this survey, this varied with doctors from ethnic minority backgrounds more likely to be working with both COVID and non-COVID patients (70.5%, 270) compared to white doctors (63.2%, 807)[34].

— Junior doctors are also more likely to work with both COVID and non-COVID patients (82.9%, 223) than consultants (65.2%, 569) or GPs (58.7%, 236).

Awareness

Figure 10: Have you heard of the term 'moral distress' before? / Have you heard of the term 'moral injury' before? (n=1864)
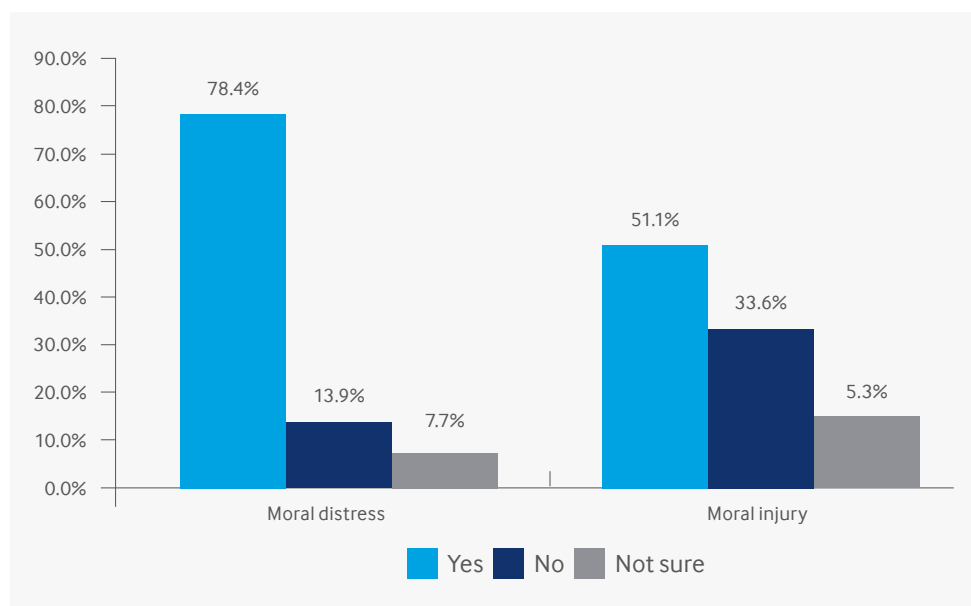

34 The other two groups (working with COVID patients/not currently seeing patients) are too small to report on here.

56.2% (1048) of respondents said they had heard of moral distress and 43.8% (816) saying they had not heard of it. Respondents were slightly less familiar with moral injury, with 51.6% (962) saying they had heard of it, compared to 48.4% (902) they had not.
- Females more likely to have heard of both terms than males:
  - With 58.8% (641) females saying they had heard of moral distress compared to 52.9% (389) of males.
  - Similarly, 53.8% (587) reported having heard of moral injury compared to just 48.8% (359) of males.
- Respondents who said they have a disability, or physical or mental health condition or illness, lasting or expected to last 12 months or more, were more likely to heard of both moral distress (61.6%, 228) and moral injury (60.0%, 222) than those that said they didn't (54.9%, 799 and 49.7%, 723 respectively).
- Looking at consultants, junior doctors, and GPs:
  - Consultants are more likely to have heard of moral distress (60.9%, 548) than junior doctors (48.2%, 131) and GPs (50.0%, 210).
  - Consultants (56.7%, 510) were also more likely to have heard of moral injury than junior doctors (49.6%, 135) and GPs (41.8%, 176).
- Doctors working in critical care and psychiatry were much more likely to have heard of moral distress 87.3% (55) and 69.1% (103) than all respondents (56.2%, 1048). For moral injury, 71.4% (45) of critical care doctors had heard of it and 70.9% (105) of doctors working psychiatry compared to all respondents (51.6%, 962).

Definition
Figure 11: Does the term moral distress resonate with your experiences at work (or when you were working)? (n=1797) / Does the term moral injury resonate with your experiences at work (or when you were working)? (n=1793)

When presented with a definition, the majority of doctors responding to the question felt that the term moral distress resonated with their experiences at work (78.4%, 1409) and just over half (51.1%, 917) felt that the term moral injury resonated with their experiences at work.
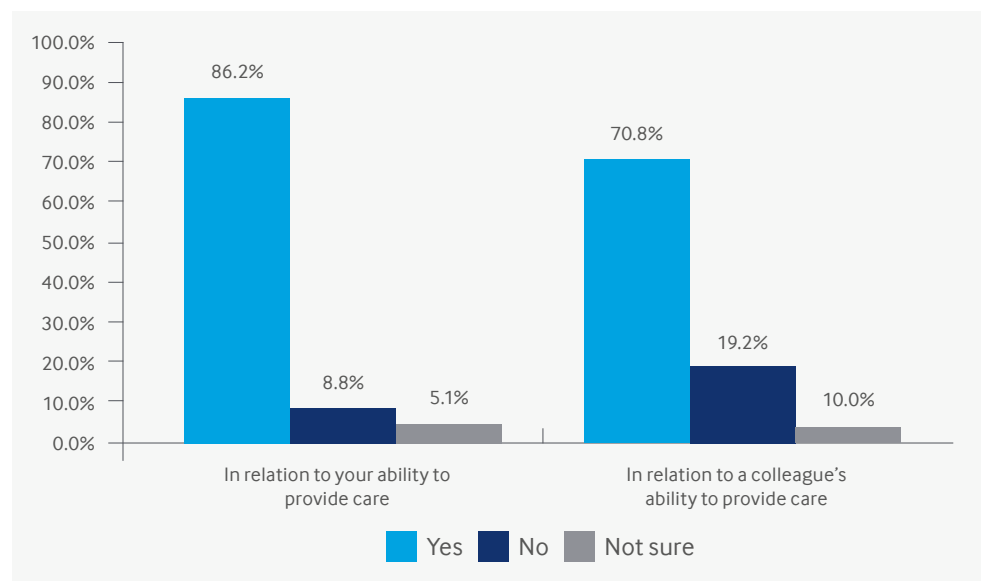- Doctors who are working with only COVID patients are more likely to say that moral distress (88.9%, 56) and moral injury (68.3%, 43) resonate with their experience compared to doctors working with non-COVID patients (73.3%, 332 and 45.4%, 205) and doctors working with both COVID and non-COVID patients (80.9%, 861 and 52.4%, 556)[35].

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35 Doctors working with non-COVID patients (73.3%, 332 and 45.4%, 205) are also significantly less lower than for doctors working with both COVID and non-COVID patients (80.9%, 861 and 52.4%, 556) for how much moral distress and moral injury resonate with their work.

— Respondents who said they have a disability, or physical or mental health condition or illness, lasting or expected to last 12 months or more, were more likely to say that moral injury resonate with their experiences at work (58.9%, 215) compared to those that said they didn't (48.4%, 673).
— Respondents who were 55 or under were more likely to say that the terms moral distress and moral injury resonated with their experience at work 82.6% (1054) and 54.4% (693) respectively compared to doctors above 55 (67.7%, 340 and 42.1%, 245).
— 88.4% (343) of doctors from ethnic minority backgrounds reported that moral distress resonated with their experiences at work compared with 75.6% (1017) of white doctors. 64.6% (250) of doctors from ethnic minority backgrounds felt that the term moral injury with their experiences at work compared with just 47.0% (631) of white doctors.
— 84.5% (218) of junior doctors reported that moral distress resonated with their experiences at work compared to 78.3% (684) of consultants and 75.3% (302) of GPs[36]. However, a slightly different pattern emerged when looking at moral injury, where it resonated more with junior doctors (52.1%, 134) and consultants (53.7%, 468) than GPs (44.1%, 177).
— 88.9% (56) and 88.5% (54) of critical care and foundation year doctors reported that moral distress resonated with their experiences at work compared to all respondents (78.4%, 1409).

Experience during the pandemic

Figure 12: During the pandemic, have you experienced moral distress in relation to your ability to provide care?/During the pandemic, have you experienced moral distress in relation to a colleague's ability to provide care? (n=1405)

Respondents who said they were currently working in the NHS (or who have recently retired, but worked during the pandemic), and said that moral distress resonated with their experience at work, were asked if they had experienced moral distress during the pandemic in relation to their own care and the care of their careers. 86.2% (1211) of those that responded to the question felt that they had experienced moral distress in relation to their ability to provide care. 70.8% (995) felt that during the pandemic they have experienced moral distress in relation to a colleague's ability to provide care.
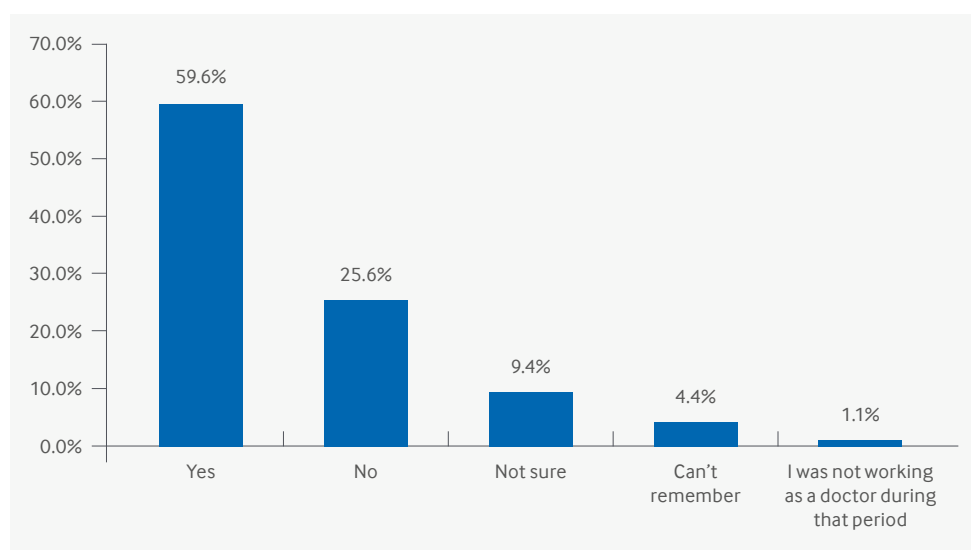— Looking at the data by patient groups doctors are working with:
    — 96.6% (57) of respondents working with only COVID patients reported felt that they had experienced moral distress in relation to their ability to provide care compared to 84.7% (305) of those working with non-COVID patients, and 87.7% (788) of those working with both COVID and non-COVID patients.

36 Unfortunately, the number of respondents we received from other branches of practice were too low to breakdown the data to this level of detail.

— 88.1% (52) of those working with COVID patients felt to the that during the pandemic they have experienced moral distress in relation to a colleague's ability to provide care compared to 62.7% (225) of those working with non-COVID patients, and 73.9% (665) of those working with both COVID and non-COVID patients[37].
— Females (87.9%, 472) were more likely to report having experienced moral distress in relation to their ability to provide care during the pandemic compared to males (83.7%, 446).
— Doctors who are 55 or under were more likely to report:
  — Moral distress in relation to their ability to provide care (87.8%, 936) compared to doctors who are 56 or above (80.9%, 262).
  — Moral distress in relation to a colleague's ability to provide care (73.2%, 781) compared to doctors who are 56 or above (63.3%, 205).
— When we looked at these questions by ethnicity:
  — 68.5% (699) of white doctors saying they have experienced moral distress in relation to colleague's ability to provide care with to this compared 78.6%, (246) of doctors from ethnic minority backgrounds.
  — This rises to 83.2% (163) of doctors from an Asian (Indian/Pakistani/Bangladeshi) / Asian British background.
— 91.6% (197) of junior doctors reported that they had experienced moral distress in relation to their ability to provide care compared to 86.3% (613) of consultants.

Experience prior to the pandemic
Figure 13: Now thinking specifically about the 12 months before the COVID-19 pandemic (ie year prior to March 2020), did you have experience of moral distress at work? (n=1424)

Respondents who said they worked in the NHS before the pandemic, and those that had retired but where working in this period were asked about their experience of moral distress in the 12 months prior to the COVID-19 pandemic (i.e. year prior to March 2020).
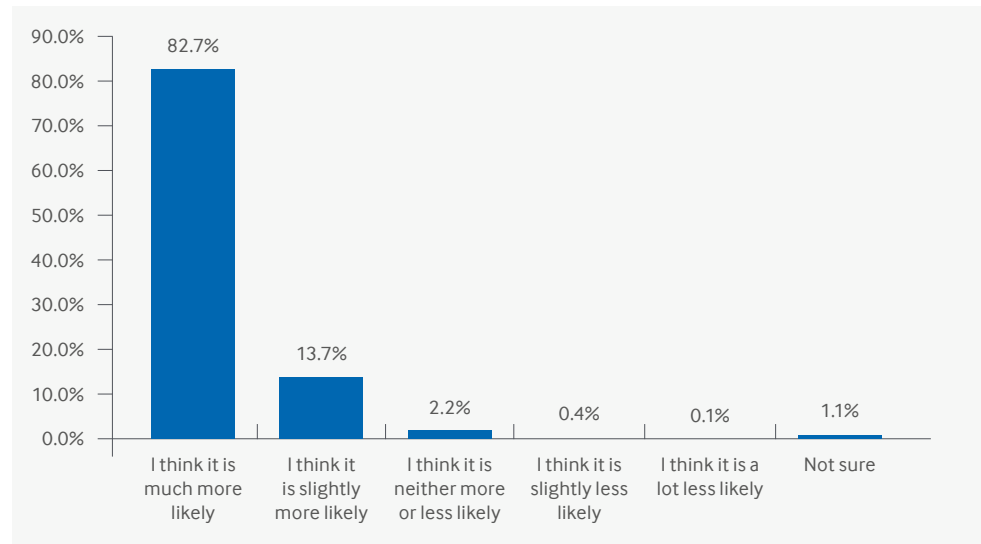— 59.6% (848) of those that responded to the question said that they experienced moral distress at work in the 12 months before the COVID-19 pandemic (ie year prior to March 2020).
  — Respondents who said they have a disability, or physical or mental health condition or illness, lasting or expected to last 12 months or more, were more likely they experienced moral distress at work in the 12 months before the pandemic (67.4%, 196) compared to (57.2%, 629) who said they didn't.
  — GPs were more likely to report having experienced moral distress prior to the pandemic (67.0%, 215) compared to consultants (57.2%, 413) and junior doctors (57.1%, 113).

37 73.9% (665) of those working with both COVID and non-COVID patients was also significantly higher than the 62.7% (225) of those working with non-COVID patients.

— Doctors in emergency medicine (81.0%, 47) are more likely to report having experienced moral distress prior to the pandemic than all respondents (59.6%, 848).

Impact of the pandemic

Figure 14: Do you think the risk of doctors experiencing moral distress has changed during the COVID-19 pandemic? (n=1568)

We also asked those that had been working both prior and during the pandemic if they felt that the risk of experiencing moral distress had changed during the pandemic. 82.7% (1296) said they thought it was much more likely. More than 96.3% (1510) of respondents thought that it was slightly more likely, or much more likely.

— 98.2% (55) of those working with COVID patients thought that it was much more likely compared to 83.1% (350) of those working with non-COVID patients, and 81.3% (805) of those working with both COVID and non-COVID patients.
— Female respondents (84.7%, 802) said 'I think it is much more likely' compared to 79.6% (471) of males.

Factors contributing to moral distress

Figure 15: In your experience, what factors do you think contribute to moral distress? Please select the five you think are most important (n=1717)

Respondents were asked to select the five most important factors contributing to moral distress in their experience. Insufficient staff to suitably treat all patients (52.5%) and individual's mental fatigue (40.8%) were the two factors most likely to be selected.[38]

— Looking at the data by ethnicity, there are some differences, doctors from ethnic minority backgrounds were more likely to say:
  — 'A workplace culture that does not encourage 'speaking up'' (39.5%, 148) compared to white doctors (25.2%, 323)
  — 'Guilt over risk of infecting family or friends with COVID-19 or other infectious diseases' (36.8%, 138) compared to white doctors (25.6%, 328)
  — 'Lack of personal protective equipment (PPE)' (32.0%, 120) compared to white doctors (19.7%, 253)
  — 'Individual's physical fatigue' (30.4%, 114) compared to white doctors (18.7%, 240)
— There were some differences between male and female respondents, with males more likely than females to say:
  — 'A workplace culture that does not encourage 'speaking up'' (30.9%, 207 compared to 27.0%, 274)
  — 'Lack of beds' (27.1%, 182 compared to 20.1%, 204)
— Females were more likely than males to say:
  — 'Lack of time to give sufficient emotional support to patients' (41.9%, 425 compared to 30.9%, 207)
  — 'Denying the families of dying patients access to see them' (39.0%, 396 compared to 31.5%, 211)
— Junior doctors were more likely to select 'insufficient staff to suitably treat all patients' (61.9%, 148) compared to GPs (48.2%, 174).

38 Respondents were asked to select the five most important factors that contribute to moral distress in their experience.

- GPs were more likely to select:
  - 'Lack of time to give sufficient emotional support to patients' (50.7%, 195) compared to consultants (29.8%, 249)
  - Lack of medicine tests (15.8%, 61) compared to consultants (4.90%, 41).
- Critical care doctors were much more likely to say:
  - 'denying the families of dying patients access to see them' (70.5%, 43) compared to all respondents (35.9%, 616).
  - 77.1% (47) of critical care doctors also said 'insufficient staff to suitably treat all patients' compared to all respondents (52.5%, 902).
- 65.7% (44) of doctors working in emergency medicine said a lack of beds compared to 22.8% (391) of all respondents.
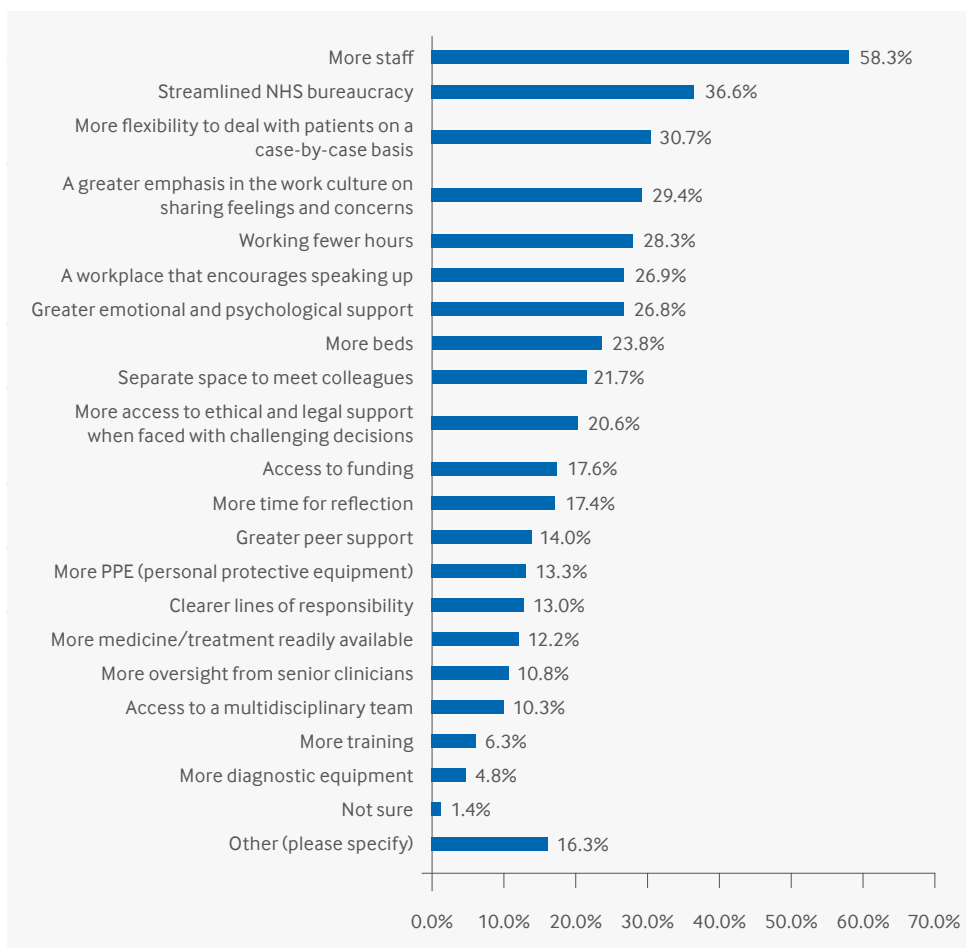
Respondents were asked rate each of their selected factors on a five-point scale (Much more of a problem than before the pandemic to much less of a problem than before the pandemic[39]), the data is presented below.

Figure 16: Factors that contribute to moral distress

	Factor (n=1717)	% of respondents that said this factor has become much more of a problem than before the pandemic (n=1521)
Insufficient staff to suitably treat all patients	52.5%	62.6%
Individual's mental fatigue	40.8%	78.0%
Inability to provide timely treatment	37.2%	78.2%
Lack of time to give sufficient emotional support to patients	37.2%	58.5%
De-prioritising certain patients	36.3%	72.8%
Denying the families of dying patients access to see them	35.9%	94.0%
A workplace culture that does not encourage 'speaking up'	28.7%	39.0%
Guilt over risk of infecting family or friends with COVID-19 or other infectious diseases	28.1%	88.2%
Lack of agency/power to make correct decisions for patients	25.2%	45.3%
Lack of beds	22.8%	62.4%
Lack of personal protective equipment (PPE)	22.5%	82.0%
Individual's physical fatigue	21.6%	72.1%
Public health decisions affecting communities or populations	19.5%	79.1%
Putting your own and colleagues' safety before that of the patient	17.2%	81.1%

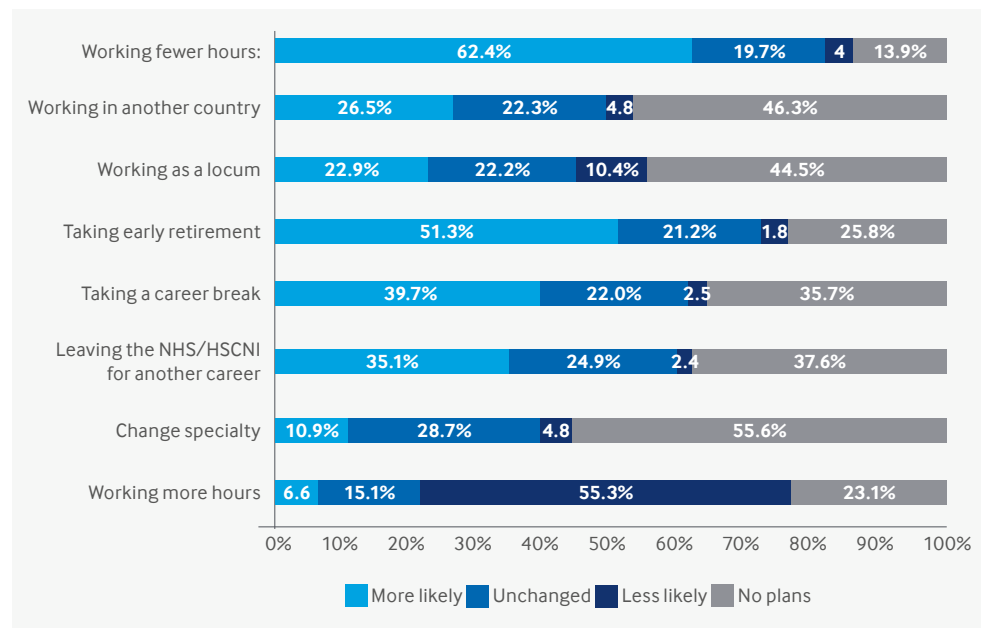- The government's handling of the pandemic and support for doctors was highlighted in the comments.
- Bullying/workplace culture were also mentioned.
- Leadership/Management was also raised by respondents in the comments.

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39 The exact question was: Thinking about the factors you think might contribute to moral distress, which ones have become more or less of a problem during the pandemic compared to before the pandemic?

What could help alleviate moral distress?
Figure 17: What would help alleviate the risks of moral distress in your current (or most recent) workplace? Please select the five you think are most important (n=1653)

Option	%
More staff	58.3%
Streamlined NHS bureaucracy	36.6%
More flexibility to deal with patients on a case-by-case basis	30.7%
A greater emphasis in the work culture on sharing feelings and concerns	29.4%
Working fewer hours	28.3%
A workplace that encourages speaking up	26.9%
Greater emotional and psychological support	26.8%
More beds	23.8%
Separate space to meet colleagues	21.7%
More access to ethical and legal support when faced with challenging decisions	20.6%
Access to funding	17.6%
More time for reflection	17.4%
Greater peer support	14.0%
More PPE (personal protective equipment)	13.3%
Clearer lines of responsibility	13.0%
More medicine/treatment readily available	12.2%
More oversight from senior clinicians	10.8%
Access to a multidisciplinary team	10.3%
More training	6.3%
More diagnostic equipment	4.8%
Not sure	1.4%
Other (please specify)	16.3%

Career plans for the next year

Figure 18: How, if at all, have you changed your career plans for the next year? (n=1570)

62.4% (964) of respondents reported planning to working fewer hours and 51.3% (790) said they were more likely to take early retirement.

— Looking at the data by ethnicity, we compared doctors from ethnic minority backgrounds to white doctors:
  — 45.5% (155) of doctors from ethnic minority backgrounds said they were 'more likely to leave the NHS/HSCNI for another career' compared to 31.5% (363) of white doctors.
  — 49.3% (169) of doctors from ethnic minority backgrounds said they were 'more likely to take a career break' compared to 36.6% (418) of white doctors.
  — Nealy 60% of doctors from ethnic minority backgrounds said they were 'more likely to take early retirement' (59.0%, 201) compared to 48.8% (561) of white doctors.
  — The same pattern was seen for 'more likely to work as a locum' (32.2%, 109 doctors from ethnic minority backgrounds compared to 19.5%, 223 of white doctors) and more likely to 'work in another country' (41.1%, 139 of doctors from ethnic minority backgrounds compared to 21.3%, 243 of white doctors).
— Looking at Branch of Practice, comparing junior doctors to GPs and consultants demonstrated some significant differences in how their career plans have changed, looking at what they said they are more likely to do:
  — Junior doctors said they are 'more likely to leave the NHS/HSCNI for another career' (43.3%, 97) compared to both consultants (34.3%, 271) and GPs (31.7%, 114).
  — Junior doctors (59.6%, 133) said they are 'more likely to take a career break 'compared to 33.3% (118) of GPs or 39.4% (312) of consultants.
  — Consultants (54.8%, 434) and GPs (55.7%, 200) said they are 'more likely to take early retirement' compared to just 35.6% (79) of junior doctors.
  — Junior doctors said they are 'more likely to work as a locum' (43.5%, 97), with 24.9% (89) of GPs saying the same and only 16.5% (130) of consultants saying they are more likely to work as a locum.
  — 45.5% (101) of junior doctors reported that they are 'more likely to work in another country', compared to 26.6% (209) of consultants and 15.5% (55) of GPs.
  — 28.4% (63) of junior doctors said they were 'more likely to change speciality compared to 10.5% (37) of GPs, and 5.9% (26) of consultants.
  — Consultants reported significance differences with GPs with in relation to 'more likely to take a career break' (39.4%, 312 compared to 33.3%, 118), 'more likely to work as a locum' (16.5%, 130 compared to 24.9%, 89), 'more likely to work in another country' (26.6%, 209 compared to 15.5%, 55) and 'more likely to change speciality (5.9%, 46 compared to 10.5%, 37).