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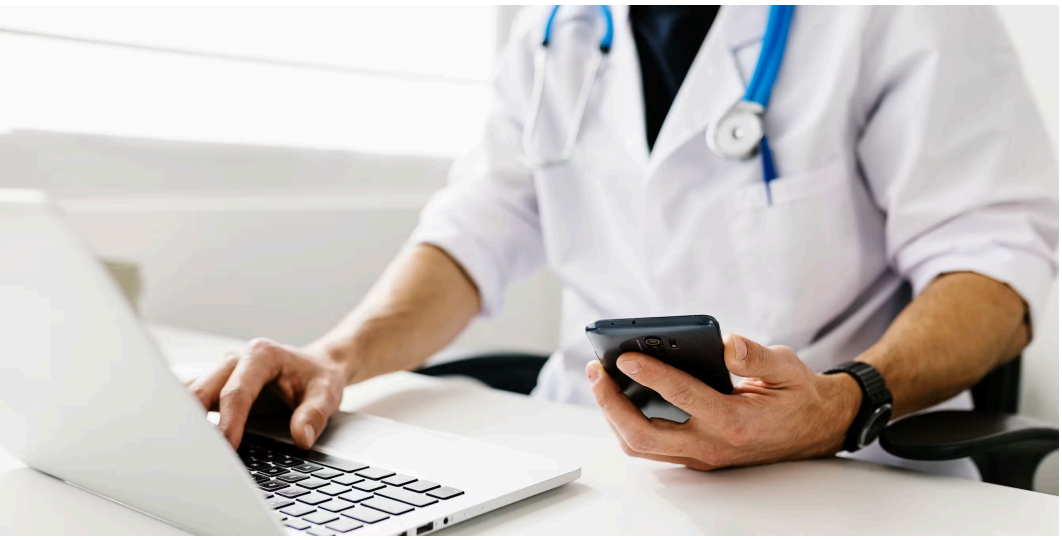

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Moral distress: for primary care doctors, ‘doing the right thing’ can feel impossible

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Modern healthcare systems ask much of primary care doctors. They are expected to diagnose, reassure, coordinate care, manage chronic illness and increasingly fill the gaps when other parts of the system come under strain.

In New Zealand, general practitioners (GPs) deal with around 90% of all medical problems. Research consistently shows that strong relationships with a GP improve patient health outcomes while saving money, with every $1 invested in primary care returning up to $13 elsewhere in the health system.

Yet primary care is facing a mounting workforce crisis. New Zealand is already short by almost 500 full-time GPs, with that deficit expected to grow in the coming years.

Our newly published research sheds new light on a psychological factor adding to this pressure – and one that tells us much about the taxing environment doctors work in today.

The everyday burden of moral distress

As part of our study, we interviewed 26 GPs in New Zealand and 24 family physicians in the United States about the joys and challenges of their work.

Beneath many of the structural pressures doctors face each day – from heavy caseloads to underpaid administrative work – we found widespread instances of what is known as “moral distress”.

This arises when people know the right thing to do but are unable to do it because of circumstances beyond their control. As one doctor told us: “A lot of my work felt harmful and in conflict with what I knew to be best for my patients.”

It typically leads to feelings of guilt, inadequacy and a deep emotional fatigue that can be confused with burnout]. The most common source was cost barriers preventing patients from receiving the care they needed.

In the United States, these barriers largely stem from the profit-driven, insurance-based health system. In New Zealand, they more often reflect under-resourced services and difficulties accessing specialist hospital care.

For example, when patients are declined operations such as hip or knee replacements, they return to their GP, who must continue managing their pain despite having few treatment options. GPs are left carrying the moral burden of decisions over which they have no control.

Doctors described how such scenarios left them in an impossible position that was harmful for both parties. Patients continued to live with severe pain and a reduced quality of life, while GPs could do little to help after hospitals had declined treatment.

Strategies and symptoms

Our interviews pointed to three common ways doctors respond to moral distress. One is "moral self-differentiation", or going above and beyond for patients despite the health system's constraints.

For example, doctors described frequently working beyond paid hours because, as they put it, doing so felt like "the right thing to do".

Over time, however, these efforts can become self-sacrificing. Because doctors cannot overcome systemic barriers on their own, continually going above and beyond leaves many physically and emotionally exhausted, contributes to burnout and depression, and may ultimately drive them out of medicine.

Another strategy is moral dissociation, or emotionally distancing oneself. As one doctor put it: "I've mentally told myself it's the system's fault, not my fault. So I've disconnected."

A third strategy is what we call "extra-role moral engagement". Rather than trying to push back against the system from inside the consulting room, doctors sought to address underlying issues outside the clinic by advocating for wider reforms.

This also highlights the central role primary care doctors play in healthcare systems. When they experience moral distress, it is a sign the system is asking them to shoulder responsibility for problems they cannot fix on their own.

Just how widespread moral distress is among primary care doctors remains uncertain, and larger studies are needed to understand its prevalence.

But our research made one point clear. Moral distress is much more than a symptom of doctors' "bleeding hearts".

The purpose of any healthcare system is, ultimately, to care for patients. That responsibility must, of course, be balanced against financial constraints.

But if those constraints leave doctors unable to provide the care they believe patients need – and drive experienced clinicians from the profession – moral distress becomes more than a subjective wellbeing issue.

It becomes a warning sign that the system is operating at odds with its own fundamental purpose.

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