Moral distress and professional freedom of speech among doctors

BACKGROUND Previous studies indicate that Norwegian doctors experience distress in their encounter with differing and partly contradictory ideals, such as the obligation to criticise unethical and inappropriate practices. The objective of this study was to investigate the perception of moral distress and professional freedom of speech among Norwegian doctors as of today, as well as identify changes that have occurred since the previous study undertaken in 2004.

MATERIAL AND METHODS A total of 1 522 economically active doctors received a questionnaire listing various statements describing the perception of moral distress and professional freedom of speech. The responses were compared to responses to the 2004 study.

RESULTS Altogether 67 % of the doctors responded to the questionnaire. The proportion who reported «fairly strong» or «strong» moral distress varied from 24 % to 70 % among the different statements. On the whole, the «rank and file» hospital doctors reported the highest degree of moral distress. Nevertheless, a decrease in the scores for moral distress could be observed from 2004 to 2010. During the same period, the perception of professional freedom of speech increased slightly.

INTERPRETATION A reduced level of distress associated with ethical conflicts in working life may be due to improved methods for handling distressing situations, or because the consequences of the health services reorganisations are perceived as less threatening now than in 2004, immediately after the introduction of the hospital reform. However, the perceived lower distress level may also be due to professional and ethical resignation. These findings should be followed up by a qualitative study.

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MAIN POINTS

The perception of moral distress is common among Norwegian doctors, particularly among hospital doctors in specialist training and senior consultants.

The perception of moral distress decreased slightly from 2004 to 2010.

The perception of professional freedom of speech is more positive in 2010 than it was in 2004.

Modern health services make several, and sometimes conflicting, demands on doctors. Ethical problems and moral distress come to the fore when a person has a clear perception of what it is morally correct to do but is prevented from acting in line with this ideal (1, 2). Moral distress can also occur when two values compete, and when doubt or disagreement arise on which course of action is best. The health services should be professionally justifiable, caring and safe, and the rights of patients and their families must be safeguarded. Other significant ideals are that the health service must be fair, and that it must in particular protect the interests of the weakest and the most seriously ill. In addition, tight budgets must be adhered to. The Norwegian health service has become more strongly regulated, and doctors must pay attention to both legislation and administrative guidelines. The latter include comprehensive and time-consuming requirements regarding documentation. Research among nurses and other health personnel shows that many such employees experience moral stress in their work (3–5). For example, research from home-based nursing care in Norway indicates that scarce resources result in nurses being faced with dilemmas that threaten their professional ethics (6).

Less research has been conducted into moral distress among doctors compared with that carried out among nurses (2, 7). A study from 2004 based on the Norwegian medical panel under the auspices of the Institute for Studies of the Medical Profession showed that 50 % of doctors experienced distress if they had to act against their personal convictions (8). The doctors also felt distressed if they had too little time for their patients, and if the patients had to wait too long for examination and treatment. In 2004 almost half of them said they experienced distress when the most insistent patients were treated first (9).

When professional and ethical standards are threatened and conflicts of conscience arise, it is important to be able to report this to a higher level of authority. Restricted financial frameworks or the suboptimal organisation of the health service may threaten professional quality and patient safety. In this event, section 17 of the Norwegian Health Personnel Act provides a statutory obligation to report the matter (10). This obligation creates a conflict of conscience among health personnel if they perceive that they can be exposed to reprisals and accusations of disloyalty by whistleblowing or by submitting serious criticism of their superiors.

In 2004 we asked doctors about their perception of professional freedom of speech at their specific workplace. The same questions were asked in 2000, before the health

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Table 1 Number (%) of doctors in the different groups who in 2010 responded «Somewhat distressing» or «Very distressing» to ten statements on moral distress. Those who did not respond or who responded «Not relevant for me» have been excluded in each statement. The number of respondents (that the percentage proportion is based on) therefore varies from question to question in each category of doctors

	Hospital managers (n = 6–46)	Senior Consultants (n = 39–210)	Doctors in specialist training (n = 11–84)	Specialists in private practice (n = 3–31)	GPs (n = 31–129)	Others (n = 21–64)	**All (n = 122–607)**
Elderly patients are not prioritised	6 (19)	39 (23)	11 (16)	4 (22)	41 (26)	21 (32)	**122 (24)**
Treatment not likely to be effective is given	10 (26)	73 (34)	33 (40)	3 (18)	41 (24)	30 (39)	**190 (32)**
The patient who «cries loudest» gets more or quicker treatment	14 (24)	88 (29)	40 (40)	11 (19)	101 (44)	29 (29)	**283 (34)**
Patients who should be hospitalised in other institutions take up place for others	15 (37)	83 (36)	37 (44)	5 (24)	31 (24)	25 (37)	**196 (34)**
Patients are not treated adequately due to economic limitations	11 (29)	96 (45)	31 (43)	10 (48)	39 (27)	24 (33)	**211 (38)**
I must sometimes act against my conscience	17 (44)	90 (47)	42 (53)	7 (50)	56 (35)	38 (48)	**250 (44)**
A great deal of the working day is spent on administration and documentation	35 (56)	182 (58)	57 (53)	18 (41)	113 (53)	40 (37)	**145 (52)**
Patients must wait long for treatment	28 (48)	171 (57)	52 (51)	29 (50)	122 (54)	53 (53)	**455 (54)**
The care for patients suffers due to time constraints	32 (60)	210 (70)	77 (74)	26 (46)	101 (47)	64 (67)	**510 (62)**
Constant reorganisations in the national health service	46 (70)	158 (78)	84 (76)	31 (67)	129 (62)	59 (56)	**607 (70)**

authority reform. We found that in 2004 more doctors perceived it as risky to report professional and unacceptable practice at their workplace (11).

Since 2004 it has been suggested several times in the media that doctors employed in Norwegian hospitals may be subject to sanctions from the management when they criticise superiors who hold responsibility (12, 13). This is in spite of the fact that the Working Environment Act protects whistleblowers and makes it compulsory for employers to facilitate such notifications (14). Since 2007 the health authorities have drawn up their own guidelines for such notifications and for the protection of whistleblowers (15, 16). Nonetheless, it can be claimed that laws and guidelines are of little value if it is *perceived* as hazardous to express criticism at a workplace. Since criticism and whistleblowing are a key component of the work on quality, it is important to examine whether this fear is widespread in the Norwegian health service.

This study thus had a dual objective: firstly to investigate the perception of moral distress and professional freedom of speech among Norwegian doctors as of today, and secondly to identify changes that have occurred since the previous study was undertaken in 2004.

Material and method

The data have been retrieved from the reference panel of the Institute for Studies of the Medical Profession. They constitute an almost representative sample of approximately 1 600 economically active doctors who have received questionnaires in the post every other year since 1994 with questions concerning health, working conditions and current health policy issues. The sample represents a so-called unbalanced cohort since the participants who gradually retire are replaced with younger doctors, while at the same time attempts are made to retain the representativeness of the sample. This article utilises data from 2004 (N = 997) and 2010 (N = 1 005). Some of the analyses exclusively use data from doctors who responded on both occasions.

The doctors are grouped as follows:

- Doctors who are managers in the specialist health service
- Senior consultants (heads of sections, senior consultants and acting senior consultants)
- Doctors in specialist training (who are not working as acting senior consultants)
- Specialists in private practice
- General practitioners (GPs)
- Other doctors (mainly attached to administration or research)

Moral distress

The degree of moral distress was evaluated using the following ten statements:

- The patient who «cries loudest» gets more or quicker treatment
- Patients must wait long for treatment
- The care for patients suffers due to time constraints
- Patients who should be hospitalised in other institutions take up place for others
- A great deal of the working day is spent on administration and documentation
- Patients are not treated adequately due to economic limitations
- Treatment that is not likely to be effective is given
- Elderly patients are not prioritised
- I must sometimes act against my conscience
- Constant reorganisations in the national health service (only in 2010)

Table 2 Changes in the perception of moral distress from 2004 to 2010. The figures represent differences in average values (confidence interval) on a scale from 1 («Not distressing at all» to 4 («Very distressing»), arranged according to rising value. The table comprises only those who evaluated the statement in both 2004 and 2010. Those who did not respond, or who responded «Not relevant for me», have been excluded in each statement. The number of respondents therefore varies from one question to another

	Difference 2010–2004 (95 % CI)	
Elderly patients are not prioritised	–0.17	(–0.70 to –0.07)
A great deal of the working day is spent on administration and documentation	–0.19	(–0.28 to –0.10)
Patients who should be hospitalised in other institutions take up place for others	–0.21	(–0.31 to –0.11)
Patients are not treated adequately due to economic limitations	–0.21	(–0.33 to –0.10)
Patients must wait long for treatment	–0.22	(–0.29 to –0.14)
The care for patients suffers due to time constraints	–0.24	(–0.32 to –0.16)
Treatment not likely to be effective is given	–0.25	(–0.35 to –0.14)
I must sometimes act against my conscience	–0.31	(–0.42 to –0.20)
The patient who «cries loudest» gets more or quicker treatment	–0.32	(–0.40 to –0.25)

Table 3 Changes in perception of freedom of speech from 2004 to 2010. The figures represent differences in average values (confidence interval) on a scale from 1 («Very appropriate») to 4 («Inappropriate»), arranged according to rising value. The table comprises only those who evaluated the statement in both 2004 and 2010. Those who did not respond, or who responded «Not relevant for me», have been excluded in each statement. The total number varies from one question to another

	Difference 2010–2004 (95 % CI)	
Those who criticise risk sanctions from the department management	0.03	(–0.10 to 0.16)
Those who criticise may risk having to change their workplace	0.32	(0.20 to 0.43)
Those who criticise the hospital risk sanctions from the administrative management	0.47	(0.33 to 0.60)
Those who criticise are at risk of considerable personal stress	0.67	(0.56 to 0.79)

The participants scored each statement on a four-point Likert scale («Not distressing at all», «A little distressing», «Somewhat distressing», and «Very distressing»). In addition there was a response alternative «Don't know» (2004)/«Not relevant for me» (2010).

Professional freedom of speech
The perception of professional freedom of speech was evaluated using the following four statements:

- Those who criticise risk sanctions from the department management
- Those who criticise the hospital risk sanctions from the administrative management
- Those who criticise are at risk of considerable personal stress
- Those who criticise may risk having to change their workplace

These statements were also scored on a four-point Likert scale («Very appropriate», «Quite appropriate», «Slightly appropriate», «Inappropriate») as well as «Not relevant for me».

Statistics
The responses to the questions on moral distress were dichotomised. Here we report the proportion who responded with «Somewhat distressing» or «Very distressing» within each group of doctors, in some cases with a 95 % confidence interval (CI). To analyse changes in the period from 2004 to 2010, we calculated the difference between the responses from 2004 and those from 2010 for each doctor. These differences were almost normally distributed for all variables, and are given here with a 95 % CI. If this confidence interval does not include the value 0, the change is statistically significant and corresponds to $p \leq 0.05$. The statistical program SPSS, version 19 (SPSS Inc, Chicago, Illinois), was used.

Results

In autumn 2010 a total of 1 025 out of 1 522 dispatched questionnaires were returned completed, i.e. a response rate of 67 % (the same response percentage as that of 2004). The distribution of age, gender, work situation and professional field in the panel is not materially different from the corresponding distribution in the register of doctors (data not shown).

Moral distress
Table 1 shows the proportion of doctors who in 2010 responded «Somewhat distressing» or «Very distressing» to each of the ten statements on moral distress. The proportion varies from 70.1 %, who perceive the constant reorganisations in the health service as rather distressing or very distressing, to 23.8 % who experience distress due to elderly patients being assigned low priority. A total of 44.1 % (95 % CI 37.7–50.5) of general doctors perceived «The most insistent patient is given faster treatment than others» as distressing, compared with 29.6 % (95 % CI 26.0–33.2) of the other doctors – a statistically significant difference assessed according to the confidence intervals. In general it is the «rank and file» hospital doctors (Senior Consultants and doctors in specialist training) who felt most distress, particularly in relation to reorganisations and to time constraints imposed on patient care. Many hospital doctors and GPs perceive moral distress because a large portion of their working hours is spent on administration and documentation.

Altogether 44.2 % of all the respondents perceive having to act against their own convictions as rather distressful or very distressful. More doctors in specialist training and specialists in private practice than managers and Senior Consultants perceive distress through having to act against what their conscience dictates.

In general there was less perceived moral distress in 2010 than in 2004. Table 2, which only includes the doctors who evaluated the statements in both 2004 and 2010, shows that for these doctors the importance of all nine stressors (the statement on reorganisation was not used in 2004) was reduced. The largest reduction applied to the statement that «The patient who «cries loudest» gets more or quicker treatment» where 33.5 % still perceive this as distressing.

Perceptions of the consequences of criticism

Table 3 shows the change from 2004 to 2010 for the four statements on professional freedom of speech. In 2010 the doctors describe a working environment that is regarded as more open for criticism than that of 2004. However, the statement «Those who criticise risk sanctions from the department management» shows no significant change. Here the proportion who responded «Quite appropriate» or «Very appropriate» in 2010 was highest among Senior Consultants, with 29.8 % (n = 325), closely followed by the 112 hospital doctors in specialist training with 26.8 % (n = 112).

Discussion

Between 50 % and 70 % of all the doctors reported that they perceive distress because of constant reorganisations in the national health service, and also because patient care is inadequate due to time constraints, because patients have to wait a long time for treatment and because working hours are spent on administration and documentation. These responses can be viewed in correlation with the organisation of work, and they are therefore relevant for health service managers. It is also worth noting that it is the rank and file hospital doctors who report most distress regarding time constraints and constant reorganisations. New legislation can be the source of ethical dilemmas if it sets guidelines that have negative consequences for other key values. It is likely that individuals who work closest to the patients are those who experience ethical conflicts most strongly (17). Improved patient rights may be implemented at the expense of fairness and care for the weakest patients who cannot fight for their rights. This corresponds with the results of the study conducted by Tønnessen and her colleagues on home-based nursing care: the nurses reported that to avoid tiresome conflicts they gave most attention and time to the patients who were able to set demands – either themselves or through voluble family members (6). The prioritised patients were not given more than they were entitled to, but when strict resource limits are imposed the requirements of those who need most help are not met or they must wait longer for help. This puts conscientious professionals under impossible conflicting pressures. Similarly it is not surprising that it is primary healthcare doctors who in this study reported most distress when the most insistent patients are given more or faster treatment. Perhaps such «side-effects» of good political intentions should be brought to light to a far greater extent than is the case today. This is a task for researchers, ethicists and professionals – and not least for politicians. The fact that GPs perceived more distress than hospital doctors regarding prioritisation problems in 2010 can also be explained by the fact that the prioritisation guidelines for the specialist health service have made prioritisation simpler and placed it more in line with contemporary political and bureaucratic signals. It is worth noting that GPs are those who are most affected by the fact that elderly patients are assigned low priority. In addition, the amount of time spent on administration and documentation is a source of frustration for both GPs and hospital doctors.

Nonetheless the results from this study indicate that Norwegian doctors experienced fewer work situations that evoke moral distress in 2010 compared with six years previously. This applies to both conflicts concerning patient treatment and those concerning professional freedom of speech. These findings are surprising. Constant reports on increased time constraints, more emphasis on financial control and more requirements regarding loyalty within the health authorities led us to presume that doctors would describe more distress related to moral dilemmas in 2010 compared with 2004. One possible explanation for our finding could be that the statements in the questionnaires have poor validity. Even though many of the statements have been used in other studies on moral distress (1), they can be criticised for being superficial and not sufficiently specific. If these topics were to be studied in more detail, a qualitative study would be more suitable (2). Another explanation may be that the hospital reform was relatively new in 2004, and it was implemented in order to improve financial control and impose tighter management. This may have evoked a fear of conflicts between professionals and the management, a fear that may have decreased now we have lived with the reform for eight years. An explanation of this type is reinforced by the fact that the results from 2000 are somewhat similar to those from 2010. It is also worth noting that most of the respondents have moved to new positions during the period of the study – for example from doctors in specialist training to consultant or managers. However, a separate analysis of this group shows that such transitions did not change these doctors' perceptions to any great extent (data not shown).

Even though there is a reduction in reported distress from 2004 to 2010, 44.2 % of the doctors still perceive having to act against their conscience as quite or very distressing. This finding must be taken seriously by municipalities and other employers. Being obliged to act against one's personal convictions can result in burn-out and professional nihilism, which poses a threat to the quality of the work (2). The municipalities and health authorities are responsible for the frameworks within which professionals work, and for creating the conditions to resolve appropriately any ethical dilemmas that arise. An extremely poor coping strategy for moral distress is to ignore conflicts, with the result that compromises made regarding standards of professional ethics are ultimately not noticed. The result may be emotional detachment and conscious avoidance of value conflicts, leading to easier acceptance of suboptimal solutions. This may also explain the decrease in the perception of moral distress during this six-year period, in which case this represents a cause for concern as well as a threat to the quality of the health service. Moral sensitivity – the perception that values are threatened – is a necessary prerequisite for being moral subjects (18). If the changes we can see are due to resignation, the figures are not necessarily reassuring (19). To enable problematic practice to be identified and the necessary change created, the problems must first be defined. These findings will therefore be followed up by a qualitative study that has already been started.

The question of professional freedom of speech has attracted considerable attention in the media, in particular in connection with reorganisations in the health authorities (12). It is therefore surprising that this study indicates that doctors have become less afraid of criticism rebounding on themselves as employees and as individuals. There is an exception to this – namely regarding sanctions from department management. This particularly applies to rank and file doctors in hospitals/Senior Consultants and to doctors in specialist training. One explanation may be that while the top management of the hospitals may claim that whistleblowing and criticism are necessary, department heads find themselves pressed between requirements from the management and frustration on the part of the department employees. It is also important to underline that dissatisfaction with local reorganisation processes – for example the merger at Oslo University Hospital – will not be reflected to any great extent in our nationwide data. In addition, considerable criticism has surfaced during the past two years, i.e. after 2010. Another possible explanation for the fact that there appears to be less insecurity in the medical profession concerning criticism is the positive effect of the statutory provision from 2007 which granted whistleblowers better legal protection.

Reprisals can also be informal and therefore difficult to identify. Not least can an aversion to open disagreement in the medical culture make criticism emotionally difficult. In 2000 the reference panel was also

asked two questions on the extent to which the workplace allowed criticism of colleagues on professional and ethically unacceptable conduct. Approximately 40 % of the doctors were of the view that this was problematic (20). Thus it is not only the management that is regarded as difficult to criticise. Greater acceptance is necessary for the fact that disagreement is an important and legitimate part of medical practice.

Strengths and weaknesses

The study has a response rate of 67 % in both 2004 and 2010, which is relatively high compared with other questionnaire-based studies of doctors (21, 22). Furthermore the respondents are representative of Norwegian economically-active doctors with regard to age, gender and place of work (data not shown). There are therefore grounds to assume that the results from this study are also representative. One weakness is that it is not always possible to completely identify questions on experiences or attitudes through questionnaires: the way in which each respondent perceives the term «moral distress» will vary. On the other hand our data are considerably strengthened by the fact that the same individuals are asked the same questions over a period of time. It must also be mentioned that our data do not allow analyses on several levels. Due to the requirement concerning anonymity we do not know which doctors may be working in the same department in the same health authority.

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