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From the burden of disease to the disease of burden

Significance:

The burden of care that healthcare workers in South Africa shoulder as a result of the failings in service delivery in the public healthcare sector is having devastating effects on the healthcare workers themselves. Moral distress is increasingly being recognised as the primary occupational hazard for clinicians working in South Africa. But recognising the problem is not enough; we need to talk openly about it. Moral suffering needs to be discussed in medical curricula, professional development environments, and in our hospitals and clinics. We need to change the culture of 'suffering in silence' to one of 'supporting in community'.

In 2009, Mayosi et al.[1] described South Africa as being "in the midst of a profound health transition that is characterised by a quadruple burden of communicable, non-communicable, perinatal and maternal, and injury-related disorders". The so-called 'colliding epidemics' of HIV and tuberculosis, chronic illness and mental health, injury and violence, and maternal, neonatal, and child mortality, have been recognised to have "had substantial effects on health and well-being"[2]. In this Commentary, we draw attention, not to the patients who are burdened with these diseases, but to the (public) healthcare workers who attend to them. We argue that the burden they shoulder as a result of the failings in service delivery in the healthcare sector is similarly a disease, one which is reaching epidemic proportions and having devastating effects on healthcare workers and on the healthcare system in which they work.

Background

South Africa has a "fragmented, two-tiered and inequitable health system"[3]. A decade ago, approximately 30% of the doctors in the country served around 84% of the population who were dependent on the public healthcare system.[3] More recent estimates suggest that "less than 20% of our medical workforce is employed to serve approximately 75–80% of our population"[4]. In 2022, South Africa's doctor to patient ratio was 0.31 per 1000 – a decrease from 0.79 per 1000 in 2019. There is also a critical lack of nurses in the country: over 5000 nursing posts remain unfilled[5]; with only 22 090 nurses, a ratio of 1 nurse for every 2300 people, or 1 per 224 patients, and a significant number set to retire in the next 10 years, it is estimated that there will be a shortage of between 131 000 and 166 000 nurses by 2030.[6]

The infrastructure is no better off: a decade ago, Mayosi and Benatar pointed to the "state of crisis" that many of the state hospitals were in, "with much of the public healthcare infrastructure run down and dysfunctional as a result of underfunding, mismanagement, and neglect"[3]. If there has been a change in the physical environment of the public healthcare system, it has been for the worse: "clinics and health facilities are overcrowded and characterised by massive infrastructure backlogs"[4]. The 2024/2025 budget year of the Health Facility Infrastructure Grant saw an 11.7% cut – totalling ZAR1.2-billion – a cut which followed the previous year's 5.2% cut as a "cost containment measure."[4]

The 2024/2025 budget for the public health wage bill came in at ZAR174.6 billion, which is a 2.5% increase year-on-year, but if we take into account inflation, this figure translates to a decrease of 2.5%.[7] The total budget for health care – ZAR271.9 billion – also saw a 2.9% real cut once adjusted for inflation. What these numbers mean in practice is that while "spending per healthcare user increased nominally from R5180 in 2023/24 to R5243 in 2024/25, once adjusted for inflation the real spend per health care user was cut by R173 for each of the 51.9 million public healthcare users."[7]

These cuts, due in large part to many years of corruption and financial mismanagement at the level of the national government, need to be understood in the context of an already struggling healthcare system.[8] In 2023, the system was described as "sick"[9]; and in 2024, as facing an "existential crisis."[4]

Moral suffering in healthcare workers

Against this backdrop, and in the context of a society characterised by poverty, deep inequality and violence, the environment in which healthcare work is performed is deeply distressing in itself. Moral distress is increasingly, albeit slowly, being recognised as the primary occupational health hazard for clinicians working in South Africa.[10]

The term 'moral distress' originated in the field of health care, specifically nursing. It was initially conceptualised and defined by American ethicists Jameton and Boss in 1984 as a psychological and emotional response experienced by healthcare professionals when they believe they know the morally right course of action but are unable to act accordingly due to various constraints such as institutional policies, hierarchical structures, legal and ethical dilemmas, or conflicting values within a healthcare setting. Jameton later refined the concept, explaining moral distress as (a) the psychological distress of (b) being in a situation in which one is constrained from acting (c) on what one knows to be right.[11] It is the experience of being seriously compromised as a moral agent in practising in accordance with accepted professional – and personal – values and standards. To put it simply, moral distress is knowing what the right thing to do is but being (or feeling) unable to do it due to circumstances beyond one's control.

A related concept to moral distress is moral injury, defined in 1995 by Shay as "being present when i) there has been a betrayal of what is morally right, ii) by someone who holds the legitimate authority, and iii) in a high stakes

situation"[12]. While moral injury was originally studied in the context of Vietnam soldiers' experiences of PTSD, it has more recently been applied to the healthcare setting, specifically in the context of the COVID-19 pandemic, with its significant impacts on healthcare systems and providers. As Cartolovni et al.[13] argue, moral injury is "unique to those who bear witness to intense human suffering."

Individuals experiencing either moral distress or moral injury are generally at a higher risk of developing chronic physical and emotional exhaustion, as well as a sense of reduced accomplishment and autonomy, typically resulting from prolonged exposure to high levels of stress and impossible workloads that make excessive demands on energy, strength, or resources in the workplace. Work-related psychological distress in health workers may be associated with burnout and long-term adverse effects such as decreased quality of patient care, conflict with colleagues, cognitive impairment, substance use, suicide, poorer physical health, and leaving the healthcare profession.[14]

A host of studies have shown the physical and mental effects of moral distress and injury. They do not only negatively affect the healthcare provider, but directly and indirectly affect the efficiency and quality of healthcare delivery. Studies have found a causal relationship between moral distress and job performance, burnout and workplace attrition and ultimately, and most concerningly, patient care. In societies characterised by deep inequality and violence, such as ours in South Africa, the environment in which clinicians work is distressing in itself. This compounds the experience of moral distress in healthcare workers as resource shortages in the system combined with patients' very difficult personal circumstances leads to frequent exposure to distressing ethical situations.[15]

According to the Medical Protection Society survey released in October 2023, more than a third (35%) of healthcare practitioners in South Africa say their mental well-being is worse now than it was during the COVID-19 pandemic, and 39% of those surveyed said that the impact of burnout and exhaustion on patient safety was impacting their mental well-being. A quarter of the participants considered leaving the medical profession or retiring early due to mental well-being concerns and 22% said they planned to or considered leaving South Africa for those same reasons.[16] Other studies have "indicated that over 70% of young doctors working in primary care have burnout [from the] cumulative effects of mental and emotional stress, high workload in substandard facilities, and job instability."[4]

Care for the carers – what needs to be done?

How do we heal the healthcare system and its people?

First, we – all of us – need to hold our leaders to account: in May 2023, President Cyril Ramaphosa addressed participants at the Second Presidential Health Summit and acknowledged the need for "Government [to] invest more in training programmes for healthcare professionals and increase staffing levels to meet the population's needs"[7]. Yet there are now fewer healthcare workers than there were, as posts have been frozen in an attempt to deal with the budget cuts. All of us need to advocate for a halt to and reversal of austerity measures – because all of us are affected by them. To end the current crisis caused by national government, we need a reinvestment in public health urgently.

Second, we need leaders to listen to those on the ground such as the more than 16 academic heads of departments and nearly 1000 senior clinicians, nursing leaders and healthcare workers in the Western Cape, who voiced their concerns in an open letter[17] addressed to (then) Minister of Finance Enoch Godongwana, Western Cape Premier Alan Winde and the province's MEC for Finance Mireille Wenger. Penned by Ntobeko Ntusi and Lydia Cairncross, the letter highlighted the "devastating" impact that the severe budget cuts are having on the province's healthcare system.

While systemic change takes time and money, we can and must, in the interim and as a matter of urgency, recognise that the problem of moral suffering exists, is real, and, most importantly, is not shameful. This last point is critical: what exacerbates the experience of moral distress or poor mental well-being in healthcare workers is that there is a tendency for them to feel isolated and lonely in their suffering.[10] One contributing factor may be that, in the medical profession, vulnerability and uncertainty are seen as a sign of weakness, and this perception is reinforced by a culture of silence which convinces clinicians that their colleagues are successfully managing these stresses. A high rate of loneliness in medical settings has been correlated with poor work organisation, less managerial support, worse atmosphere in the team, and more irresponsible attitudes of colleagues. Loneliness in clinicians can be used to predict occupational burnout which in turn is correlated with high rates of attrition.[10] The connection and sense of belonging within the clinical team can provide the strongest protection against despair and loneliness. Each clinician needs to take responsibility for a change in medical culture. We as clinicians must create time for attending weekly peer support sessions, where we can, as clinical teams, explore parts of ourselves together, think and connect together within our unit/division/department, in a way that encourages and maintains psychological safety, social connections and a sense of belonging.[10]

But recognising the problem is not enough: we need to talk openly about it. Moral suffering needs to be discussed in medical and allied healthcare curricula, in professional development environments, and in our hospitals and clinics. We need to change the culture of health care from one of 'suffering in silence' to one of 'supporting in community'. Fawcett and Mullan argue that "fostering a practice culture where ethical issues and situations that give rise to moral distress can be openly discussed is important for mental health and wellbeing."[18]

Dealing with the problem requires skill – a particular kind of skill. We need to provide training for healthcare workers to develop ethical reasoning and critical thinking skills which are needed to have the confidence to discuss and make complex ethical decisions. Peer argues that "The skill to ethically reason is as important as technical and research-based skills and transcends all aspects of a profession. Just as technical and clinical skills mature with practice, so do ethical skills."[19] Schafer and Vieira suggest that ethics education "can help to promote the workers' ethical competence. Ethically competent professionals have greater skill in coping with the ethical questions posed by practice and, as a result of this, are better able to deal with the moral distress and its consequences."[20]

At the same time, we need to create spaces for healthcare providers to work together to find solutions. Khaghanizadeh et al.[21] have reported positive effects on moral reasoning, moral distress and moral sensitivity in nurses through group discussions. Clinical Ethics Forums offer healthcare workers the space to practise their reasoning skills in non-emergency settings and provide a psychologically safe environment where healthcare providers, particularly those from minority or underrepresented groups, feel valued and included, and where the climate encourages recognition of and support for each other's distress in making morally injurious clinical decisions in resource constrained healthcare facilities. Staff should have protected time to attend such forums which are a resource for developing ethical resilience in themselves, and in their clinical teams. This has been done before – at the height of the COVID-19 pandemic.[10] It is imperative that the system allows – and promotes – time for this again.

Lewis[22] claims that the most important way to prevent moral distress is to design an environment aimed at encouraging moral decision-making and empowering decision-makers to act. We also need to focus on creating support structures for complex clinical ethics decisions to be made in real time. Clinical Ethics Committees should be constituted; for smaller settings, these can be inter-institutional. Such committees function to promote, uphold, and respect the dignity and rights of patients and healthcare workers and can provide support and advice for navigating complicated ethical dilemmas. Moreover, they provide opportunities to build and strengthen a culture of collaboration in which the emphasis is on 'doing right' rather than 'being right'.

In addition, we need to find funding for the establishment of clinical ethics consultation services and/or clinical ethics posts embedded within hospitals.

Conclusion

Our proposed solutions signal a fundamental shift away from the idea of individualised support where the pathology is placed on the healthcare providers themselves who need to seek out, find time, and often pay for interventions. Stigma, shame, and isolation are substantial barriers to the success of individual-focused well-being efforts. In addition, individual-level interventions can produce toxic side effects of causing feelings of stress by implying it is an individual problem and self-imposed.

The individualised support approach discounts the role that the healthcare environment plays in causing distress. Sharma and Cotton have suggested at least one of the challenges of dealing with moral distress for healthcare workers in low- and middle-income countries is the absence of support mechanisms.[23] In such instances, the healthcare worker becomes the "second victim."

We have proposed a multi-pronged approach to dealing with the moral suffering experienced by healthcare workers, that includes: training for healthcare workers to develop critical thinking and ethical reasoning skills, Clinical Ethics Forums for promoting collaboration in problem-solving, and Clinical Ethics Committees for sharing decision-making responsibilities. These are not offered as an alternative to addressing the systemic problem – corruption, inefficiency, and maladministration – but as complements. We reiterate our concern that urgent attention to all these measures is needed. As with any disease, the longer you wait to intervene, the more difficult it is to cure. Unless we provide real support for healthcare workers whose moral suffering is already reaching epidemic proportions, the disease of burden will be fatal.

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Declarations

We have no competing interests to declare. We have no AI or LLM use to declare. Both authors read and approved the final manuscript.

References

1. Mayosi BM, Flisher AJ, Lalloo UG, Sitas F, Tollman SM, Bradshaw D. The burden of non-communicable diseases in South Africa. Lancet. 2009;374(9693):934–947. https://doi.org/10.1016/S0140-6736(09)61087-4
2. Achoki T, Sartorius B, Watkins D, Glenn SD, Kengne AP, Oni T, et al. Health trends, inequalities and opportunities in South Africa's provinces, 1990–2019: Findings from the Global Burden of Disease 2019 study. J Epidemiol Community Health. 2022;76(5):471–481. https://doi.org/10.1136/jech-2021-217480
3. Mayosi BM, Benatar SR. Health and health care in South Africa – 20 years after Mandela. N Engl J Med. 2014;371:1344–1353. https://doi.org/10.1056/NEJMsr1405012
4. Nash J, Ross AJ, Naidoo M, Ras T, Brits H, Mathew S. Health budget cuts will be paid for by the most vulnerable. S Afr Fam Pract. 2024;66(1), Art. #5934. https://doi.org/10.4102/safp.v66i1.5934
5. Lencoasa M, Brown D. Opinion: More austerity is the wrong medicine for our public health crisis. Spotlight. 2023 October 27 [cited 2024 Jun 26]. Available from: https://www.spotlightnsp.co.za/2023/10/27/opinion-more-austerity-is-the-wrong-medicine-for-our-public-health-crisis/
6. Businesstech. South Africa desperately needs more nurses [webpage on the Internet]. c2023 [cited 2024 Jun 26]. Available from: https://businesstech.co.za/news/business-opinion/687459/south-africa-desperately-needs-more-nurses/
7. Aneesa. South Africa will spend nearly R320 less per learner and R200 less per health service user in the coming year. Section 27. 2024 February 22 [cited 2024 Jun 24]. Available from: https://section27.org.za/2024/02/south-africa-will-spend-up-to-r320-less-per-learner-and-r200-less-per-health-service-user-in-the-coming-year/
8. Maphumulo WT, Bhengu BR. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. Curationis. 2019;42(1), Art. #a1901. https://doi.org/10.4102/curationis.v42i1.1901
9. Huisman B. Women in health: "No one taught me how to treat a sick system," says leading young Professor. Spotlight. 2023 August 11 [cited 2024 Jun 27]. Available from: https://www.spotlightnsp.co.za/2023/08/11/women-in-health-no-one-taught-me-how-to-treat-a-sick-system-says-leading-young-professor/
10. Hoare J. Provision of mental health care to healthcare workers during COVID-19: A call for the practice of vulnerability. S Afr J Sci. 2022;118(5/6), Art. #13904. https://doi.org/10.17159/sajs.2022/13904
11. Jameton A. What moral distress in nursing history could suggest about the future of health care. AMA J Ethics. 2017;19(6):617–628. https://doi.org/10.1001/journalofethics.2017.19.6.mhst1-1706
12. Shay J. The birth of tragedy – out of the needs of democracy. Didaskalia. 1995;2(2).
13. Cartolovini A, Stolt M, Scott PA, Suhonen R. Moral injury in healthcare professionals: A scoping review and discussion. Nurs Ethics. 2021;28(5):590–602. https://doi.org/10.1177/0969733020966776
14. Hoare J. The power of connected clinical teams: From loneliness to belonging. Philos Ethics Humanit Med. 2023;18(1):16. https://doi.org/10.1186/s13010-023-00143-7
15. Matisonn H, De Vries J, Hoare J. Capturing moral distress as a global phenomenon in healthcare. Am J Bioethics. 2023;23(4):82–84. https://doi.org/10.1080/15265161.2023.2186520
16. Medical Protection. Survey shines a light on mental wellbeing of doctors in South Africa [webpage on the Internet]. c2023 [cited 2024 Jun 26]. Available from: https://www.medicalprotection.org/southafrica/casebook-and-resources/medicolegal-articles-and-features/view/survey-shines-a-light-on-mental-wellbeing-of-doctors-in-south-africa
17. Metelerkamp T. Western Cape health professionals make united appeal for 'catastrophic budget cuts' to be halted. Daily Maverick. 2024 February 06 [cited 2024 Jun 27]. Available from: https://www.dailymaverick.co.za/article/2024-02-06-western-cape-health-professionals-make-united-appeal-for-catastrophic-budget-cuts-to-be-halted/
18. Fawcett A, Mullan S. Managing moral distress in practice. In Practice. 2018;40(1):34–36. https://doi.org/10.1136/inp.j5124
19. Peer K. Ethics education: Preventing moral distress and empathy decline in sports medicine practice. Int J Athl Ther Train. 2016;22(1):47–52. https://doi.org/10.1123/ijatt.2016-0024
20. Schafer R, Vieiera M. Ethical competence as a coping resource for moral distress in nursing text context nursing. Florianópolis. 2015;24(2):563–573. https://doi.org/10.1590/0104-07072015001032014
21. Khaghanizadeh M, Koohi A, Ebadi A, Azimin AE. The effect and comparison of training in ethical decision-making through lectures and group discussions on moral reasoning, moral distress and moral sensitivity in nurses: A clinical randomized controlled trial. BMC Med Ethics. 2023;24:58. https://doi.org/10.1186/s12910-023-00938-5
22. James Madison University. Meeting the challenge of moral distress [webpage on the Internet]. c2015 [cited 2024 Jun 26]. Available from: https://www.jmu.edu/news/2015/09/lewis-erica-discusses-moral-distress.shtml
23. Sharma D, Cotton M. We care for patients, but who cares for us? Trop Doct. 2021;51(2):141. https://doi.org/10.1177/00494755211007280