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Conference ***1*** ***Dr Penelope CAMPLING (UK)***
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Anger, Shame and Moral Injury: any way out?

I've been reflecting on the title of this conference. There seems a lot at the present time for healthcare workers to reconcile. I am a psychiatrist from the UK where mental health services are generally seen as failing, with up to 50% staff vacancy rates, a huge shortage of beds and waiting lists of over a year for adults and children. At the same time, patients have high expectations, and often come wanting a particular diagnosis confirmed – something that would not have happened 20 years ago. In this talk I'm going to take a bifocal view of the issue, moving between my work with individual patients to the wider system of healthcare and the political values that drive it.

Supporting front-line staff

When the Covid pandemic hit, I was semi-retired, so offered my services to the local hospital. Like most of you, I had watched the scenes from China and then Italy with horror, feeling not just for the stricken patients, but the doctors and nurses putting themselves in physical, and, indeed, psychological danger. I had recently retired from my role as an NHS psychiatrist but continued to work as a psychotherapist, so offering supportive therapy to frontline staff seemed a good use of my skills and I ended up with a role supporting clinicians on the two Intensive Care Units in the city where I live.

Like most countries, the UK had to struggle through various phases of the pandemic and the excess mortality figures were high. I appreciated the chance to be engaged in a useful way but was shocked at the toll the pandemic was having on these hard-working clinicians, many of whom seemed laid bare by the horrors they were witnessing, and at times despairing at their impotence in the face of this novel virus. Perhaps worst of all was the moral distress they were feeling, having to work in a way that conflicted profoundly with their professional and personal ethical values, most obviously having to keep families away from their dying loved ones. The term moral injury – first described in veterans from the Vietnam war - became widely used during the pandemic to describe this phenomenon. Moral injury is understood to be a major contributor towards stress and can lead to impaired function, suicidal thoughts and longer-term psychological harm. The levels of anguish and the sense of alienation people experience distinguish it from other mental health diagnoses such as PTSD.

I have written extensively about my experience doing this work[1] but today I want to focus on one particularly uncomfortable dynamic that arose in the later stages of the pandemic when most of the patients on the Intensive Care Unit were people who had not been vaccinated (about 10% of the population in the UK). Some of these people had just not got round to it; others had their minds set against the vaccine and were mistrustful of doctors and nurses trying to care for them. I was told of a minister of religion who had warned his congregation against vaccination and ended up on end-of-life care; of a hospital porter who refused the vaccination and died of Covid; of a close-knit extended family where a brother was a victim of the virus but still the rest of the family refused to be vaccinated, and a few weeks later two more siblings were critically ill in the Unit. "Surely, that must count as delusional?" one of the consultants asked rhetorically. (Psychiatry is very clear that labelling someone as 'deluded' or 'psychotic' should take cultural norms into account – in the case of the vaccine, the beliefs shared by one's immediate community) But I got his point and sympathised with his exasperation.

It's not easy when you find yourself feeling furious with the people you are caring for. Or the people you care about. Different attitudes to the vaccine or social restrictions during the pandemic tore some families apart. The ambivalence when we feel both anger and tender protectiveness towards the same person can be confusing and is often at the root of a presentation of depression. More generally anger can feel horribly consuming and has a way of spreading into relationships where it doesn't belong. It can drive impulsivity such as road-rage and push towards addictive behaviours - I saw a few clinicians, for example, who'd drifted into an eating disorder, become reliant on alcohol, or were misusing other drugs.

Moving on to 2023, the anger in the UK's clinical community continues to grow, most obviously expressed in the damaging ongoing strikes that include nurses, doctors and ambulance staff. In most part, this is not anger with the behaviour and attitudes of patients as in the antivax example above, but anger *on behalf of* patients that the NHS cannot be relied on to adequately meet their needs. The superficial demand is for more money - salaries have dropped about 20% in real terms over the last 5 years and there are many examples of nurses having to use foodbanks to feed their children.

But if you listen more closely to the strikers' concerns, or indeed look at their banners, a different story emerges. Staff feel undervalued: yes - poorly paid; but more importantly, they are working in increasingly stressful, toxic conditions, unable to provide the care for patients that they have a right to deserve in a relatively rich country in the 21st century, or even maintain the quality of care they could take for granted a few years ago.

People like me have grown-up proud to work in the NHS and support the idea of healthcare rights and equitable access as described here in these beautiful words from the NHS constitution.

The NHS belongs to the people. It is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill, and, when we cannot fully recover, to stay as well as we can to the end of our lives.
… It touches our lives at times of basic human need, when care and compassion are what matters most

[1] Campling P. (2022) *Don't Turn Away. Stories of troubled minds in fractured times,* Elliott and Thompson

…. The NHS is founded on a common set of principles and values that bind together the community and the people it serves – patients and public – and the staff who work for it.[2]

The NHS continues to attract huge support as an institution, but surveys show an increasing sense of disillusionment. Hearing the system described as 'broken' is extremely painful. Hopefully, the present situation is not the end of the story, but it can be a grim backdrop for working clinicians.

I am aware that the issues that have become so overwhelming in parts of our UK service, are issues we all face to varying degrees and I will finish this talk by trying to offer a few thoughts, not just about the bigger picture, but also about how we as individuals can manage ourselves in the face of such a stressful environment. But before I do that, I want to talk a bit about suicide.

A painful suicide

Like most psychiatrists I live in fear of my patients killing themselves. I was anxious for example that one of the ICU clinicians might kill themselves during the pandemic. It didn't happen, but many of them were tortured with intrusive thoughts of suicide which they felt ashamed about. Asking for help is not something that many doctors find easy. The incidence of suicide is higher in doctors than in the general population, and anaesthetists (including those working in Intensive Care) with so many drugs at their fingertips, are particularly at risk.

Almost every patient of mine who has killed themselves is etched in my memory. I can remember the circumstances of the death, what I was doing when I heard the news, the sense of cold horror or sometimes bone-weary resignation as the news becomes real. I often remember the last conversation we had, going over and over it in my mind, wondering if I missed something or said something insensitive. There is nothing like suicide for leaving one feeling a failure and the medico-legal system in the UK doesn't help. Our politicians talk about 'aiming for a zero percent suicide rate – absolute zero tolerance'; and psychiatrists can find themselves scrutinised in a persecutory legal process that goes on for months, or even years. Some deaths by suicide are harder to reconcile than others, sometimes because they don't make sense. I shall talk briefly about a recent suicide as I think it raises many questions pertinent to the theme of this conference.

Harry killed himself in May 2022. He was in his early thirties, working as a paramedic for the ambulance service and had a complicated history. I saw him only twice in my independent psychotherapy practice. On both occasions he had cycled 20 miles from his home to see me and arrived pleased with himself – probably enjoying the wave of endorphins - and full of joy at the beautiful spring weather. Having read some background information, which included a gender change from female to male, a recent diagnosis of Asperger's Syndrome, a past history of Anorexia nervosa, and a rather ambiguous over-dose, I was anxious about taking him on. But when I met him, I'd immediately liked him. He was extremely intelligent and seemed serious about therapy. There was also a sense of innocence about him, that I often pick up in people with a diagnosis of Asperger's Syndrome - a sense of bemusement at the world, as if they've landed in a very foreign country that is difficult to fathom. I felt we'd established a rapport. I knew he would be challenging but felt positive about being able to work with him.

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[2] Department of Health (2009) The NHS Constitution for England: The NHS Belongs To Us All. HMSO

When he didn't turn up for the third session, I immediately knew something was wrong – my first thought was that he'd had a bicycle accident. Later that day, I was informed that he'd been found dead in his flat. It later transpired that he'd been inhaling balloons of nitrous oxide and been found with a plastic bag over his head. There was no suicide letter. 15 months on, the case is still waiting to go to coroner's court, partly due to the backlog created by the pandemic. As you probably know, the internet is full of information for people thinking about ending their lives, and this method – which I hadn't previously been aware of – is described as the perfect 'blissful ending'.

In the psychotherapeutic literature on suicide, there is the concept of a split between the self and the body: the suicidal act is seen as the 'self-killing off the body'. Interestingly, there is evidence from a research study talking to people whose suicide attempts had failed, that at the point when they intended to kill themselves, they experienced their body as a separate object. It seems many of them wanted to kill off their body, but imagined, at some level, another part of them would continue to live on in a conscious but bodiless state. These beliefs were independent of religious affiliations or formal belief in an afterlife.

I attended Harry's funeral, which was packed out and included a guard of honour made up of his colleagues from the ambulance service. He would have been surprised by their attendance, and their very obvious grief. His mother, very bravely, read Psalm 139, which she described as 'the psalm for people who see themselves as misfits.'

……For you created my inmost being; you knit me together in my mother's womb.

Harry's death has haunted me. Looking back, he had been quite resistant to talking to me about suicide. He'd told me he had a method of suicide worked out for the future if he needed it, but said he wasn't preoccupied with suicide at the present time. I'd imagined we'd have returned to talking about it later in his therapy. Remember I'd only seen him on two occasions. I've no idea if he was executing a carefully planned exit – in which case why embark on therapy? – or whether it was a spur of the moment behaviour, an autistic meltdown. I wondered if he was driven by the thrill of risky behaviour; was he playing Russian roulette with himself?

Harry's life and death raise many questions pertinent to the theme of this conference. He was born female to loving parents and named Harriet. Harriet had hated the changes to her body during puberty and particularly hated her growing breasts. She had no particular desire to be male but was told she could only have her breasts removed if she changed her name and lived as a male. This she did and underwent a double mastectomy – something she described as 'the best thing she ever did'. Harry then became conscious that his female voice didn't fit with his new male persona and made people uncomfortable, so he went to a private clinic and was prescribed Testosterone. He then ran out of money: the clinic discharged him, the GP refused to prescribe Testosterone, so he was forced to get hold of the hormone on the internet with no medical monitoring. I discovered after his death that he was struggling with severe menorrhagia and was due to attend a gynaecology clinic the day after he died. I also wondered about the effects of Testosterone on his risk taking behaviour.

I don't want to get into too much detail. But psychiatrists are increasingly aware that a triad of diagnoses often appear together – Anorexia nervosa, Gender dysphoria and Asperger's Syndrome (often now referred to as Autistic Spectrum Disorder. In Harry's case, these were all dealt with separately, and I feel strongly that a more integrated whole-person approach might have had a very different outcome. It was clear to me that Harry's approach to weight and eating, and to his body

and his gender was very fragmented and autistic in nature. The assessment for Asperger's Syndrome had been done on-line during the pandemic. It had been an alienating experience and he'd received no follow-up. I had hoped that a therapy experience of being seen as a unique and whole person would have been helpful. It felt like we had made a good start but it was not to be.

Market Values

Let's move on from this sad case and think about some of the themes it touches on more generally. We live in a market-driven society, where a market philosophy has been virtually unquestioned for decades and infiltrated all aspects of life, including healthcare. Less well understood is how living in such a society has insidiously changed our attitudes and behaviours. In an important turn of phrase, Michael Sandel, the Harvard political philosopher, described us '*drifting from having a market economy to becoming a market society'.* In other words, we have, consciously or unconsciously, internalised market values. There has been a move away from seeing ourselves as citizens with rights and responsibilities, to seeing ourselves as consumers, individuals who can have whatever they want providing they can pay for it.

This means patients can be demanding with little sense of the limits to what medicine can offer, and mistrustful of clinicians, finding it difficult to believe they will have their best interests at heart. In turn, health services and insurance companies are increasingly aware of the costs and the need to drive them down, always looking for ways of getting more out of their staff, with the ridiculous underlying belief that a 'more for less' philosophy can be applied year on year. This puts clinicians in an unenviable position as the gap between what we would like to provide and what is possible with available resources gets wider. An under-resourced system fosters an attitude of self-protectiveness in its staff. Rationing becomes the norm but is rarely named as such. Instead, certainly in psychiatry, we find reasons – usually without an evidence base - to turn patients away.

In this market economy, the system is typically mistrustful of its own employees, increasingly reliant on lawyers and an ever-increasing amount of bureaucracy, that can further undermine clinicians' impulse to give of their best.

Critics of mental health services in the UK have started to describe a 'system of exclusion' where a huge amount of energy goes into defining exclusion criteria, and a great many patients and their families feel unheard and neglected. I wish I could say that this is all down to resources but it's more complicated than that. Ultimately, it is clinical staff that deliver the negative messages and we can't completely wash our hands of responsibility in how we do so. Some struggle with the moral distress involved; others - I hope a minority – go along with it without question, self-righteously ticking off exclusion criteria and prioritising bureaucracy over patient care. I fear that some clinicians are so used to excluding people that they hardly notice the impact. The recognition of distress becomes distorted and the desire to help is undermined.

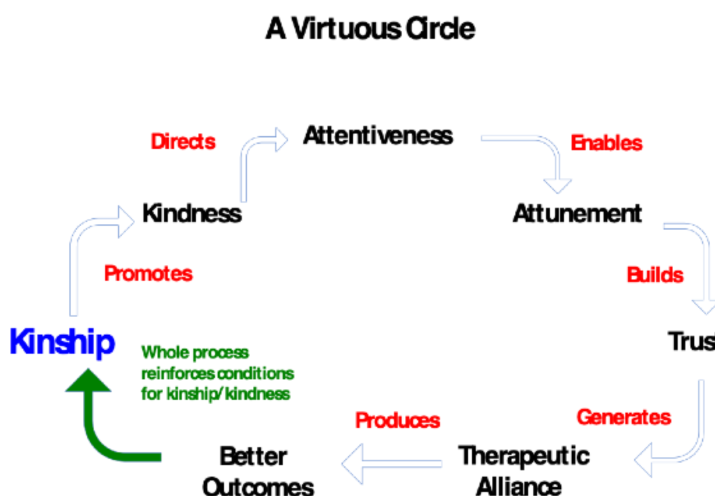
Rescuing kindness

A few years ago, I was working as a psychiatrist and director of a local NHS service. It was an era when a new funding structure meant mental health services were constantly losing out to acute physical services and I was having to make cuts and redundancies year on year. It was a sad and conflictual process. But as well as the lack of resources, it seemed to me that the culture in which

we work was deteriorating: the way we spoke about patients, the way we spoke to each other, the frenetic pace that prevented a chance meeting in the corridor leading to a friendly conversation, the lack of space to catch-up and check-up on each other, the increasingly autocratic tone of emails. I could go on….

I started to write about what I was observing happening to the culture of healthcare.[3] I wanted to think more clearly about the underlying causes rather than just blame other bits of the system, and, importantly, think of ways to help individual staff members navigate their way through, holding true to the humane values that had initially motivated them, and not allowing the increasingly anxious system to blunt their compassion. I found myself focussing on the concept of kindness. Stories from patients and their carers illustrate again and again that kindness or its absence touches them deeply, colours their experience and is what they remember years afterwards. Was it possible to nurture such kindness in the system?

The word itself has ethical and collective resonances that are helpful. So, the word 'kind' in English is not just an adjective; it is also used as a noun, where it indicates that we are 'of a kind', that we are linked together, with natural responses and responsibilities towards each other. It links with the concept of 'kin', meaning family – in this case, the whole human family. I began to imagine what it would be like if kindness was integrated in to all decisions in healthcare - not just how we interact with our patients, but the way we work together in teams and organisations, the way we manage and lead, the way we develop and implement policy, the way we plan research, the way we train and teach and support staff. What if all of this was looked at through the lens of kindness?



This diagram of a virtuous circle tries to capture this vision and the potential for the continuous reinforcement of attentive kindness. Such a dynamic has the potential to improve communication, understanding, assessment and diagnosis; it can promote co-operation with treatment, intervention or advice; it should reduce anxiety (for staff and patients), minimise defensiveness, improve outcomes, well-being, and satisfaction. We – I wrote the book Intelligent Kindness with my husband - have used this virtuous circle as a focus to bring staff and patients together to review services and

[3] Ballatt J, Campling P, Maloney C, (2020) *Intelligent Kindness, Rehabilitating the Welfare State* (Second Edition) Cambridge University Press. First published in 2011 as *Intelligent Kindness, Reforming the Culture of Healthcare.*

to improve them. And it can be seen as a driver for improving staff morale, lowering stress levels and sickness rates, contributing to productivity and efficiency.

I'm assuming that people who've chosen to come to a Christian conference inspired by the work of Paul Tournier don't need persuading about the importance of all this. But I wonder if some of you, like me, worry that the values we feel are fundamental to good healthcare are being squeezed out? Is it getting harder to be kind? Let's look at some of the challenges that make this so difficult in our present era.

Kindness Disparaged

Kindness can be seen as a primary virtue. But that does not mean it should simply be regarded as a 'good thing'. A virtue has to be worked at, because achieving it is difficult. All major religions and the cultures they have influenced, promote compassion, hospitality to the stranger, treating other people as one would wish to be treated oneself, whilst crucially recognising that much of human nature pushes against it.

Many thinkers have criticised the way, as human beings in the modern world, we are increasingly short-termist in our thinking. We are encouraged to assume that solving the problem immediately in front of us is what matters. We forget that patterns of sociability and ethical standards have evolved over millennia. The problem with this is that it is easy to lose sight of the larger questions about, for example, the meaning and purpose of our healthcare institutions in the long-term. Rowan Williams, the ex-Archbishop of Canterbury, wrote the following in response to evidence of the 'thinning out' of historical knowledge.

But if we don't know how we got here, we will tend to assume that where we are is obvious. If we assume that where we are is obvious, we are less likely to ask critical questions about it. The less likely we are to ask critical questions about it, the more resistant we will be to other people's challenge to it. In other words, not understanding how we learned to be the people we now are has an immediate and highly dangerous effect on the society we are and might seek to be…[4]

We live at a time when the concept of virtue itself is attacked, with, for example, assertions of values being written off as 'virtue signalling'. Perhaps this is not a new thing. The warping and obscuring of what kindness is about has been extensively discussed by two British authors, psychoanalyst, Adam Phillips, and historian, Barbara Taylor. They explore the way in which a philosophy and culture of competitive individualism and the pursuance of self-interest have challenged and negatively influenced the meaning of kindness. They describe a process in which what had been a core moral value, with a subversive edge, at centre stage in the political values of the Enlightenment, became something sentimentalised, marginalised and denigrated through the nineteenth and early twentieth century. This movement was closely associated with the Industrial Revolution, mass production and the associated market, and a shift in emphasis in people's lives to being consumers rather than sharers. They are very clear that an individualistic, competitive society, is, whatever its achievements, prone to breed unkindness.

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[4] Williams R. (2018) *Being Human* SPCK Publishing

A culture of 'hardness' and cynicism grows, fed by envious admiration of those who seem to thrive – the rich and famous: our modern priesthood – in this tooth and claw environment.[5]

I sometimes hit cynicism when I talk to groups of healthcare staff about intelligent kindness. What has kindness got to do with the important scientific, technological task of medicine?

Or, harder to challenge - tokenistic approval of the importance of kindness, but it is clearly seen as a side issue, and a low priority – something that will be squeezed out as soon as things get stressful and difficult.

Particularly irritating, are the people who want to take it up and commodify it, incorporate it into the bureaucracy, use it to tick boxes, but are uninterested in the real challenge and its power to shift the culture.

Understanding the roots of kindness in kinship can help us grasp some of the challenges. There is, and always has been, a drive to define ourselves *against others,* to narrow down our sense of kinship to immediate family, social group, race or nation. On the other hand, much of what is civilised about humanity has grown through extending kinship to *include* others, to share, co-operate, and to develop a wider sense of common identity and common interest. The challenge is ever present. This makes kindness difficult, involving overcoming narrow self-interest, anxiety, conflict, distaste, and limited resources. It involves cost and the risk of getting things wrong, maybe of getting hurt in the process.

Intelligent Kindness

I always emphasize that kindness must be intelligent if it is to make a positive difference. I'm sure as healthcare professionals you can think of examples where kindness can miss its target or even make things worse.

One trap is to over-identify another person's needs with our own. Thinking back to Harry's death, I should tell you my eldest daughter also has a diagnosis of Asperger's Syndrome and is roughly the same age. I have wondered if this made it more difficult for me to engage with the despairing, suicidal part of him. It has certainly made his death particularly painful.

More systemic threats to the expression of kindness are the increasing move towards specialisation and the tendency for healthcare systems to standardise interventions as if everyone's needs are the same. In mental health services, this is made worse by the increasing focus on short-term risk. These can undermine the need to listen properly and tailor our conversations to the individual patient. In Harry's case, it was clear that as a 19 years old, Harriet's dramatic weight loss had led to a diagnosis of Anorexia, but a more in-depth conversation might have led to a better understanding of her underlying autistic thinking that was making life so difficult for her but wasn't picked up for another 15 years.

Sometimes in medicine, we simply don't have the knowledge at the time to get to the nub of the problem. When Harriet was a child, professionals tended not to think of autism in relation to girls who we now know tend to present in a very different way from boys. Doctors tend to be bad at

[5] Phillips A and Taylor B (2009) *On Kindness.* Penguin pg108

recognising and admitting the limits to our knowledge. Our struggle with humility can sometimes lead us to be unkind. I can think of many examples in psychiatry: for example, the way we used to dismiss patients' descriptions of child sexual abuse as fantasy, or the way early 'refrigerated mothering' of autistic children was seen as the cause of the child's disability.

I imagine that everyone here would sign up to a virtuous circle with kindness at its centre. But most of us would agree that this doesn't reflect the predominant values that drive healthcare services at the present time. Of course, there are millions of very kind staff members, and indeed, teams and organisations that have found a way to cultivate kindness in their practice. But this is not the predominant discourse and many clinicians are working in situations that force them to act or tolerate circumstances that are contrary to their professional and ethical values and leave them feeling morally distressed, inadequate, shameful and angry.

The fact that moral injury is a *normal* response to *abnormal* circumstances is emphasised in the academic literature and was an obvious feature of clinicians' struggle during the pandemic. It is perhaps even worse when the circumstances have been deteriorating over many years and become normalised rather than out-of-ordinary events. In these situations, moral injury becomes not just an individual syndrome, but a dangerously toxic characteristic of the system.

A friend of mine recently retired early at the age of fifty. The final event that precipitated her resignation was having to send a fourteen-year-old patient, a child in the care of the local authority, over a hundred miles away to a secure unit run by the private sector. She felt it was no longer safe to keep her in the local child and adolescent unit; there were simply not enough staff to contain her difficult behaviour. My friend was under no illusions. She knew that being isolated from family and friends would make the girl worse, amplifying her already deeply rooted sense of rejection; and she had little faith that the private hospital would make her better (many privately-run mental health units in the UK are notorious) What's more, she knew that her NHS unit would have been able to manage such behaviour a few years previously.

She felt terrible about resigning but explained it like this: 'I just couldn't do my job properly anymore. It wasn't safe. Constantly making decisions that I couldn't really defend. I'd stopped sleeping. Couldn't look patients in the eyes. Just all the time waiting for something awful to happen'.

There are too many people working in healthcare at the present time feeling like my friend. How can we change this? The first step is to support people at every level, to acknowledge, and engage in an ongoing dialogue about the problems. Everyone working in healthcare should be encouraged to reflect on their experience and question the way things are done. This is not just to share and process their feelings, but to work towards an understanding of the basic values that need to underpin healthcare and create a culture that will cultivate and sustain intelligent kindness.

Somehow we have to find a new language, or perhaps rediscover an old language that will give us hope.