War in Ukraine and moral distress:

experiences of a British GP

Disaster responders operating in humanitarian contexts — such as healthcare professionals deploying to and practising in active war zones, refugee camps, and the ground zero of famines, earthquakes, and devastating hurricanes — often experience a plethora of negative emotions because of perceived or actual transgressions of their core ethical principles.

Gustavsson *et al* describe this 'moral distress' as a stress reaction triggered by the responder being unable to discharge their deeply held moral values in various situations during disaster responses, such as when the individual is hindered from taking what they believe to be the morally required action because of external obstacles (including being associated with or affected by the morally questionable actions and decisions of others), contextual limitations (including the absence of the required equipment, medications, or specialist facilities to deliver the morally required outcome), and personal failings of the individual's character (akin to weakness of will or moral akrasia).[1] While moral stress is a normative response to the ethical challenges frequently experienced by disaster healthcare responders, the subsequent emergence of moral distress is dependent upon the intensity, duration, and frequency of the moral challenges giving rise to moral stress. Without successfully identifying and managing moral distress, harmful secondary consequences may subsequently emerge in affected responders including both those of a moral concern — such as moral residue, moral numbness, and moral detachment — and those of a psychological nature — such as work exhaustion, compassion fatigue, and professional burnout. These impacts may be deep, enduring, and impede the responder's ability to address future moral, professional, and personal challenges.[1]

PROVIDING HEALTH CARE DURING THE RUSSIAN INVASION

I am a British GP and have been providing care to internally displaced people in eastern Ukraine — people whose lives have been unexpectedly inverted due to the Russian invasion and subsequent occupation that began on 24 February 2022 — for the previous 7 weeks with a UK-based medical NGO. I have been working with national and international humanitarian colleagues to provide mobile primary health clinics in Poltava City, the wider Poltava Oblast, and Trostyanets' and its surrounding villages in the neighbouring Sumy Oblast. While Poltava has largely avoided significant Russian aggression, its city and wider region now accommodate tens of thousands of internally displaced people (IDP) who have fled from the neighbouring regions of Sumy, Kharkiv, Donetsk, and Luhansk Oblasts that have been heavily targeted by invasion and bombardment. This immense influx of people has placed enormous strain on the existing health system that was already over-stretched and under reform prior to the war.[2] Our work in these areas aims to relieve this additional pressure by providing primary health care to IDP with chronic diseases, acute minor illnesses, and psychological consequences of participating in, sheltering from, and finally escaping violent hostilities. Meanwhile, the medium-sized town of Trostyanets' was occupied by the invading Russian army for a 1-month period before liberation by Ukrainian forces.[3] Its sole hospital and most of its primary health clinics were destroyed, while many of its health professionals fled the hostilities, meaning residents that survived occupation, and those now returning to what remains of their homes, have enormous physical and mental health needs that the health system cannot yet satisfy. Our work in Trostyanets' and its surrounding villages is therefore to partially replace essential health care while the local system undergoes reconstruction.

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My moral predisposition leans towards a practical utilitarianism designed to maximise human flourishing and eradicate meaningless suffering while respecting human rights and avoiding repugnant conclusions. Motivated by this ethical framework, my experiences of practising in this intense humanitarian context have generated multiple episodes of substantial moral distress. This article will outline a few of them, and briefly describe the relevant situation, ethical challenges, and resulting moral distress.

BEING UNABLE TO CARE FOR THOSE IN GREATEST NEED

While I'm confident that our ongoing work adds significant value to the lives of war-affected Ukrainians, our impact could be greater if targeted elsewhere. The greatest burden of disease, and therefore the largest opportunity to maximise impact, lies in those cities subjected to severest hostility. Paradoxically, it is precisely these areas that have the least access to health care, due to infrastructure destruction and health worker evacuation, thereby creating a war zone variant of the inverse care law.[4] My conscience instructs me to push to the east — closer to the frontline where the health need is greatest — but the obvious security risk strongly prevents this. My appetite for risk must be considered alongside that of my colleagues, along with an array of other important variables including security intelligence, programming objectives, and organisational procedures. While the greatest good for the greater number could be maximally achieved via sustained interventions on a wider scale, the emotional pull to relieve the most acute suffering affecting smaller numbers — such as those in Donbas that has been largely destroyed[5] — is difficult to ignore.

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MAINTAINING DIPLOMACY TO FACILITATE ACCESS

Establishing and nurturing local partnerships is paramount to the delivery of effective humanitarian programmes. While this rightly necessitates subordination to those with relevant local knowledge and political influence, it often requires humanitarian actors to go against their immediate moral compulsions in order to preserve the necessary relationships that facilitate access to beneficiaries. This challenge ranges from enduring mild inconveniences and apparent wastages of time through theatrical activities such as extensive introductions, facility tours, and photography obligations, to more demanding collisions of ethical priorities including decisions regarding where, when, and to whom clinical care should be provided. While I'm generally able to maintain diplomatic relations and represent my organisation in a professional manner, I must frequently remind myself that such 'elaborate nonsense' is apparently required to appease those officials who provide our organisation with access to patients, and is therefore a non-negotiable prerequisite to our humanitarian goals.

WHAT STANDARDS SHOULD BE ASPIRED TO IN PRACTICE?

Generally, access to quality health care varies inversely with distance from major cities in eastern Ukraine. Accordingly, before the war, city-based residents enjoyed a developed health system containing knowledgeable professionals and innovative technologies, while those residing in remote villages endured relatively undeveloped health care akin to those of lower-income countries. These geographical disparities have been exacerbated by the war, as the destruction of infrastructure, interruption of public transport, and reduced health coverage in hard-to-reach areas renders access to health professionals and high-quality health care exceptionally challenging beyond pre-conflict levels. Practising in such contexts, particularly the rural areas receiving effectively no health care, raises many ethical issues of a deeply challenging nature. For example, what standard of care should I aim to deliver in a context where no care would exist had I not shown up for clinic? Should I aspire to NHS gold standards, an utterly impossible feat because of absence of infrastructure?

Should I hold myself to Ukrainian standards, which vary substantially according to geographical location? Or is 'any care better than no care' in this seemingly deprived context? What principles should I turn to for guidance in my practice? Acceptability? Sustainability? Genuine human compassion? Without reliable access to medications, investigations, and routine, emergency, or palliative care services, how should I deal with the obviously advanced malignancy palpitated in the breast of a 60-year-old lady? Should I even alert her to the presence of this life-ending disease? Her son has just died while fighting off the Russians, she lives only with her husband who's dependent on alcohol, and she's already poorly mobile after a stroke numerous years ago. Is there efficacy in her home remedy for which no evidence base exists, yet she reliably concocts and applies twice daily, or should I humbly defer to local tradition, a respect for autonomy, and a desperate appeal to the placebo effect by agreeing that such herbs are likely to be of benefit? I mutter strings of English sentences unheard in the NHS. *'Yes, chalk will help, honey will soothe, tree bark will heal.'* I realise that compassion must remain when all else is lost.

GOING HOME

After spending 7 weeks with a collection of people — my international colleagues but primarily our Ukrainian friends, partners, and patients — who display the virtues of stoicism that I strive to cultivate within myself, I both do not want to, and feel like I cannot, return home. Had my passport been issued in Ukraine, the imposition of martial law would prevent me along with all other men aged 18–60 years from leaving the country in preparation for conscription.[6] Only for an accident of birth that I did not personally author am I able to return to a safe, stable, and prosperous society, and for this I feel a deep, uneasy guilt. Ukrainians are a proud, caring, resilient people who have shown warm and genuine gratitude for my efforts in their country. The work I do here is more impactful than that at home, and the prospect of returning to an advanced healthcare system with frequent exposure to often demanding, entitled, and ungrateful patients is not one I relish. The aforementioned definitional work and conceptual development by Gustavsson and colleagues has helped me recognise and understand the uncomfortable feelings I have experienced in Ukraine derived from collisions between deeply held principles and practical reality. The outlined examples of moral distress seem typical of healthcare workers that practise in such settings,[7] and necessitate careful attention to prevent the emergence of harmful secondary consequences.

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