ResetEthics
THE MORAL HARM PROJECT

SCENARIO 5 - F1 Doctor

Content warning

Please be aware the following scenario contains depictions of the challenges of winter pressures and poor care for a patient with a suspected stroke, and the emotional and moral harm this causes for staff. Please consider your potential emotional responses to these topics before engaging with this scenario and related discussions.

Context

This scenario is about a F1 Doctor, who had always wanted to be a doctor. They had completed a bioscience degree, and then a graduate-entry medical degree. Despite concerns of high student loans and debt, they loved medical school, throwing themselves into studies and extra-curricular opportunities. As they neared completion, the F1 Doctor decided that they were keen to specialise in elderly care as they liked the challenge of managing co-morbidities. They also had a really good relationship with their grandparents, with a lot of respect for the contributions made to family and society by older people. They felt strongly about wanting to be part of the provision of quality care to older people, that elderly people deserve the best. This desire was underpinned by a clear sense of the type of NHS doctor they wanted to be. To achieve this vision, they had decided to pursue the F1 training on a part-time basis, knowing this would enable them to cope better with the hours and demands of the job, and to offer better patient care. Whilst it sounds idealistic, it really mattered to them to undertake their F1 role properly, to really embrace it.

Scenario

The F1 training went well at first. Whilst it was scary being a doctor and having all that responsibility, the F1 Doctor did feel prepared and eased into the role in a way that was manageable. It was also noticeable how quickly their clinical skills improved, leading to increased confidence with things like taking blood, cannulating, catheterising, etc. The F1 Doctor became increasingly efficient at taking histories, identifying diagnoses, and contributing ideas to treatment management plans. It was hard, but enjoyable.

Things started to change when the F1 Doctor rotated to an acute medical assessment unit during winter. Things were really busy, new patients coming in constantly and, while there were proper beds with cubicles, a lot of patients – including some who were really sick - were on trollies in the corridors or waiting on chairs. Generally, patients had been triaged in A&E or in the community and were seen roughly in order of priority, unless they suddenly deteriorated.

One day a nurse came to the F1 Doctor to report that a patient waiting in the corridor was having a stroke. The F1 Doctor saw them immediately, but they should never have been waiting so long on the unit, they should have been sent straight to a Registrar for immediate assessment. On speaking with the patient, the F1 Doctor learned that they had already been waiting for 4 hours, well over the window from onset of symptoms for thrombolysis treatment (medically trying to break down a blood clot with drugs). The F1 Doctor ordered all the necessary scans etc. but knew that the patient had missed the chance for most effective treatment. Who knows, maybe this patient wouldn't have been a good candidate for thrombolysis treatment, but it felt like their opportunity to benefit from it had been wasted by a system error which had been further compounded by waiting times on the unit.

This situation really affected the F1 Doctor, who kept re-running the events through their mind and started to really dread coming into work. Recognising these feelings, the F1 Doctor decided to speak to their Registrar about what had happened with this patient. The Registrar made time to talk things through but, whilst they were not unkind, made it clear that the bottom-line was 'get used to it, this is normal, toughen up'. The F1 Doctor spoke to another Registrar whose reaction was similar. The F1 Doctor found these responses shocking and difficult to accept. The bottom-line was so discordant with their medical school training, and actual practice was so far removed from NICE guidelines they were taught to follow.

After this experience and the subsequent discussions, the F1 Doctor started to really notice how the system stacked up against patients due to lack of resources. The backlog on the waiting-list for surgery meant the F1 Doctor was seeing patients deteriorate to the point that they were no longer eligible for the surgery they were waiting for. This often meant they then needed more complex treatment, requiring them to join a new waiting list for a more serious procedure with greater risks. Or they would have an emergency procedure with less good outcomes because they were unstable. Or worse, they missed the boat completely and received palliative care until they died prematurely.

And then there were the ward rounds on the acute short-stay wards. As an F1 Doctor, their role was to accompany a consultant on their ward round, to pick up patient notes and write down "jobs" that were set by the consultant. There was often little time to get a sense of the patient as a whole. Sometimes the consultant would give a good explanation to the patient – especially if they were new to the ward – and from this the F1 Doctor would learn about their condition. But this was much less likely to happen if a patient had been on the ward for a few days. The F1 Doctor found that the aim was to get the job done –to complete the ward round by 1 p.m. and spend the afternoon carrying out all the "jobs" on the patients. There just wasn't enough time to do a good ward round *and* provide good patient care. The only real chance the F1 Doctor had to get to know patients was chatting with them when inserting a cannula – but even this

was a means to an end, distracting the patient from the discomfort of a cannula insertion.

In the end, this all seemed too far away from the sort of doctor the F1 Doctor wanted to be. They wanted not just to make a difference to health outcomes, but to do this whilst expressing compassion and empathy for each patient as an individual. With so little time, this was simply impossible. This was a reality the F1 Doctor was unable to accept. Whilst at school they had worked at a store warehouse where their role was to rush about collecting items for orders, with a target of 20 orders an hour. It's a role that is done by robots now. The F1 Doctor couldn't ignore the echoes of that role in what they were now being asked to do as a doctor – rushing around, not able to offer person-centred care, or really any kind of caring. Just trying to complete clinical tasks as quickly as possible, providing functional care. It was piece-rate working, but with people as the pieces. It just felt inhumane.

This sense never really left the F1 Doctor. It felt to them like winter pressures every single day. No time to offer proper explanations to patients or to co-workers. The F1 Doctor found themselves feeling almost grateful if a patient didn't ask too many questions, so they could move onto the next – a conveyer belt. Decisions and practice felt chaotic, with a constant fear that a patient may fall through the cracks and come to serious harm. Ultimately, it eroded the F1 Doctor as a person, never mind as a doctor.

In the end, the F1 Doctor completed their training to secure GMC registration but left medicine. They now work in medical tech, hoping that perhaps tech will enable doctors to become doctors again. They simply couldn't, in good conscience, continue to practice as a doctor under the conditions that were normalised in the NHS. They recognised the role that doctors were playing, and the good they were doing – patients were treated, some improved, and yes some died, but that was part of the role. What wasn't expected was the sense that, every day, the F1 Doctor was failing their patients. The NHS simply didn't have capacity for them to be a 'good enough' doctor, let alone a good doctor. Functional care in the form of clinical jobs was given but there was little in the way of "real" care, delivered with compassion and empathy, paying attention to the person beyond the procedure. This wasn't a reality, in the end, that the F1 Doctor was able to accept.