Healing/Resolution of Moral Injury

HeaR-MI:

How reframing distress can support your workforce and heal your organization

Moral Injury of Healthcare
info@moralinjury.healthcare

Contents

Executive Summary

Maybe we have been "treating" the wrong thing…

The healthcare workforce was in an epidemic of distress for years before the pandemic. COVID-19 stressors have made matters worse. Burnout surveys reveal numbers that, for years and despite myriad interventions, stubbornly refused to budge.

What if burnout is not an accurate diagnosis?

The healthcare workforce recognizes **moral injury** as a better descriptor of their experience. It affects their ability to deliver care, and it hinders hospitals and health systems from achieving their mission and purpose while maintaining their values. Moral injury stems from a conflict between the principles of good medicine and the principles of good business that is too often unrecognized and is rarely addressed. It does not mean organizations are acting unethically or immorally. It means that the natural divide between the business and clinical sides of medicine has not been intentionally, explicitly bridged to the detriment of clinicians, patients, and administrators alike.

We offer an approach to clinician distress that:

- Diagnoses the root cause of moral injury
- Offers workable solutions to reduce it
- Allows healthcare leaders to improve their organization's:
  - Quality of care
  - Patient safety
  - Operational efficiency and
  - Professional wellbeing

The interventions are designed for low impact on operations and early results to build momentum.

The Crisis

The pandemic hit a healthcare system already caught in an epidemic of clinician distress. Measures to address burnout have been underway for decades, but have not made a meaningful impact. It is time to take a different approach.

2X

Doctors and nurses die by suicide at twice the rate of age-matched peers

2/3

Of doctors and nurses express feeling more distressed during the pandemic

2/3

Of nurses say they may leave patient care earlier than expected. ½ of doctors say the same

What is Moral Injury?

When groups of clinicians are given the definitions of both burnout and moral injury, 3 out of 4 choose moral injury as a better representation of their experience. Why does moral injury resonate so deeply? Because it encapsulates the helplessness many feel when confronted with a multitude of constraints imposed by the financial framework of medicine.

Moral injury results from knowing the right thing to do but lacking the autonomy, latitude, or authority to do it. It may also arise from a sense of betrayal by legitimate authorities in a high-stakes situation (i.e., COVID-19).

Suffering moral injury requires two separate insults—a troubling incident, and a moral trespass. Witnessing a difficult situation is unquestionably distressing, but by itself, it does not lead to moral injury. Moral injury requires an element of insult that erodes one's deepest sense of oneself as a moral being—a loss of calibration of one's moral compass, so to speak.

The deeply held moral beliefs that are transgressed are the tenets espoused in the oaths practitioners took, whether explicit or implied, to put those they serve first, above all else. Those promises define the covenant of care between a clinician and a patient, a lawyer and a client, or educator and a student, and they are the foundation of shared professional identity, shaped and nurtured as such throughout one's education and training. Hindering those commitments undermines trust, practitioner self-concept, and the very integrity, the moral and ethical underpinnings, of the field itself.

When practitioners are no longer able to always act in the best interest of those they serve, two major consequences ensue:

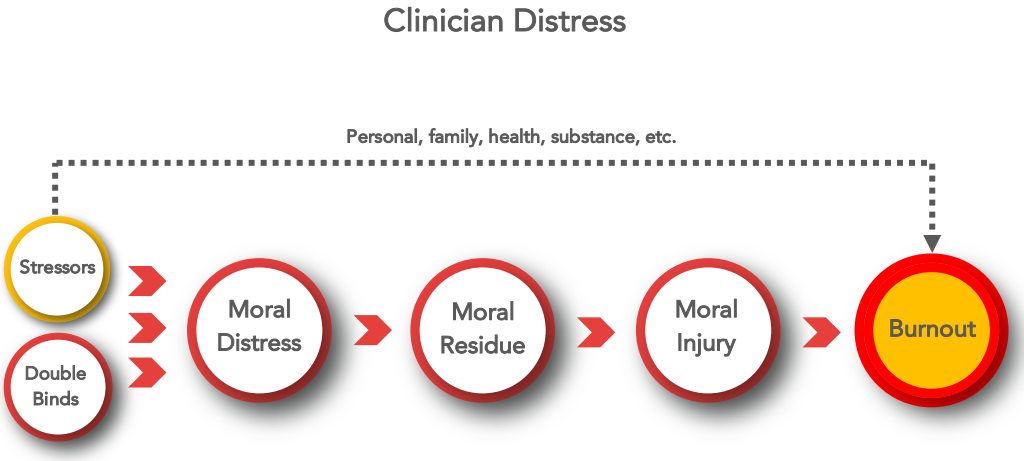
1. They suffer distress and, too often, moral injury.
2. Their positions as fiduciaries are compromised. Such compromise puts the trusted authority of the whole enterprise at risk.

Two Elements of Moral Injury

It is important to note that suffering moral injury has two elements: an event that causes distress and which transgresses of deeply held beliefs. This may be the result of a single egregious event or, as is more often the case in healthcare, an accumulation of smaller events over time.

How is Moral Injury Different Than Burnout?

Burnout has been used for decades to describe a challenging relationship with work. It describes a constellation of nonspecific symptoms without linking them to causal drivers. The condition has been quantified, analyzed and addressed with innumerable interventions for nearly two decades. Yet the number of distressed clinicians has not changed appreciably.



The anti-burnout industry has focused on improving individual vulnerabilities. Mindfulness, meditation, yoga, coaching[1], nutrition advice, sleep apps, colored armbands[2], and reset rooms[3] promise to relieve one's individual distress. Some medical schools have implemented programs encouraging students to hold each other accountable[4] for healthy habits, or to choose a healthy behavior[5] and track their progress towards it.

Unfortunately, those activities most often offer only fleeting symptomatic relief. They distract from the fundamental issue of concern without actually addressing it, and clinicians are aware of that. No amount of yoga practice, healthy eating, or good sleep will make up for constant battles with barriers to good patient care.

When anti-burnout programs focus on optimizing individuals, rather than focusing on creating strong interdependent, adaptable communities, they fail to account for the current weakness of the collaborative care dynamic. In other words, making the individual walls of the House of Medicine extremely strong overlooks the fact that a sturdy house has strong walls securely connected to each other, and tied tightly to a solid roof with good integrity that provides top cover during storms.

Why Address Moral Injury?

There are many studies linking the wellbeing of clinicians with the quality and outcomes of patient care. The more proactive institutions can be in addressing moral injury, the lower the risks of major medical errors[6], patient mortality[7], hospital-acquired infections[8], and the likelihood of incurring a malpractice suit[9].

Moreover, reducing moral injury may improve patient satisfaction scores[10], reduce staff turnover[11,12], and recapture productivity equivalent to seven medical school graduating classes[13].

Clinicians are a healthcare organization's **most valuable asset**, **most expensive resource**, and one of its **greatest liabilities**.

They are the **repository** of its culture and the **ambassadors** of its brand.

Minimizing the risk of clinician moral injury is a key to **optimizing the performance, satisfaction, and retention** of exceptional clinicians.

It is also a key factor in **attracting potential candidates** for open positions.

Getting at the Roots of Distress

Discussions about what clinician distress is and what we can do to address it have been around for a long time. The problem with these discussions is that, in spite of the volumes written and billions in resources invested in mitigating burnout over the last two decades, there is not meaningful change in the incidence or intensity of the problem. Although there has been work to discover the drivers of distress—those factors that contribute—there has been less discussion about the root cause. Instead, we have focused on symptomatic relief with individual burnout solutions. But clinicians are wearing out. They have been saying, for years, that *burnout* is not an accurate descriptor.

In 2018, we introduced the concept of MORAL INJURY[14] to healthcare.

Doctors, nurses, physical therapists, social workers, and others across the spectrum of healthcare say this language describes their experience more accurately than *burnout*. We have taken the first step toward solving an epidemic in healthcare: accurately defining the problem. We have established the framework for how moral injury happens and how an integrated culture shift can make a meaningful difference in clinician wellbeing. It is time to take the next steps to make the environment more sustainable for clinicians.

The Language Clinicians Use

Clinician distress has been discussed as *burnout* for decades, but the term is increasingly problematic for clinicians. It implies an inability to cope with a high intensity environment—a personal failure to manage reasonable challenges. Few clinicians entered healthcare believing it would be an easy career. They knew they would work long hours and see some impossibly difficult things. They made it through rigorous, competitive education experiences, and grueling training. Suggesting they wilt in the face of adversity defies logic.

The term *burnout* **does not describe the problem** accurately. Therefore, it **does not lend itself to a workable solution**.

What *burnout* does not encompass is the more apparent conflict between the core tenets of medicine and the business ethics of corporate healthcare. Clinicians increasingly identify with the concept of ***moral injury***, as opposed to *burnout*.

Moral injury ***describes the situation which results in distress****: the double bind of knowing how to care for patients but being unable to do it because of the constraints built into our systems of care. Of particular importance is that moral injury, as we frame it, does not refer to personal moral conflict, but to the conflict of being unable to uphold the professional standards of medicine.*

Using the language that resonates with clinicians is the first, easiest way to develop better alignment, trust and rapport between the organization and the clinicians. It is the most basic form of verbal mirroring[15]. Failing to use language that speaks to clinicians' experience may exacerbate the alienation clinicians already feel.

We have taken the first step toward solving an epidemic in healthcare: accurately defining the problem. We are ready to guide the next steps toward making the healthcare environment more sustainable for clinicians.

How Moral Injury Impacts Patients

At a small hospital, before the COVID-19 crisis, a physician patient was critically ill with an acute exacerbation of a long-standing condition. The specialists treating him seemed to have little sense of urgency in escalating his care. They had recently transitioned from private practice to being employees of a health system. The system had bound the physicians so tightly with scheduling control, data and metrics, policies and punishments that they, too, could barely breathe. They had almost no control over their patient interactions or their referral options.

They were bound so tightly, in fact, that they stopped struggling because they felt it was futile. It was partly about being too busy; it was also about feeling their hands were tied. They knew what patients needed but did not think they had the latitude or the autonomy to get it. They looked beaten, distant, as if they had given up, disengaged, stopped empathizing, depersonalized, as if they felt that they couldn't accomplish much, so they thought, "Why even bother to try?"

That critically ill physician had a narrow miss. His care team had little sense of urgency about his condition or about transferring him to a higher level of care. Without the advocacy of his family and partners, he might not have had the same outcome.

This is but one stark example of the hazards that moral injury represents for patients.

Distress in a Pandemic

The pandemic caused a convergence of two cataclysms:

1. **Suboptimal preparedness rooted in the fiscal necessities of paring staff, supplies and space to bare minimums in pre-pandemic times.**

2. **The catastrophic failure at the highest levels of leadership in the U.S. to adequately address and control the pandemic.**

Health care workers were left to manage the ensuing chaos—many of whose warnings been dismissed or ignored—feeling disposable, devalued, and demoralized.

Solutions

The National Academy of Medicine (NAM) report from October 2019 was an attempt to review the available information about the problem of burnout for healthcare clinicians and to make recommendations for future interventions. The report identified no program or systemic intervention that has made a meaningful difference in clinician distress. NAM could not recommend any approach to reduce clinician burnout. This is a powerful statement, and a call to action regarding approaches to the crisis.

As clinicians, when our patients do not get better with the treatment we recommend, we take one of two approaches: try a different treatment or reconsider the diagnosis. As noted above, programs to treat burnout have taken myriad approaches, all targeting the individual, and all assuming individual gaps in coping or self-care. None of those approaches has made lasting impact or meaningfully changed the level of the crisis.

Therefore, we reexamined the diagnosis.

Perhaps the source of distress was not an individual frailty, but system dysfunction impinging on individual sensibilities. Individuals have been left feeling they are accountable for decisions and actions over which they have little control. Then, perhaps, the solution is not simply improving individual resilience, but building community resilience and systemic change.

The framework for transforming moral injury is based on those principles.

Healing/Resolution of Moral Injury (HeaR-MI)

Moral injury arises when employees know what is right to do, but for various reasons—cultural, structural, or practical—they are unable to follow through. We have a variety of approaches to address moral injury recognizing the unique goals and constraints of each organization:

- Consultation—remote or on-site
- Diagnostics—qualitative and quantitative
- Coaching—executives or clinicians
- Training—awareness and skills-building
- Comprehensive programs for lasting change

The following steps are modified according to the scope and goals identified in initial conversations.

Phase 1: Needs Assessment

Targeted to gauge the environment in the organization and areas of attention.

Phase 2: Solutions

Based on the results in Phase 1, recommendations for change will include elements from the approaches below. The solutions will be targeted and aimed to cause little disruption and deliver early results.

Solution Elements

Leadership

Change does not happen without leadership champions. Training and coaching for individuals or leadership groups is crucial to successfully addressing moral injury because so much is about operations impinging on clinicians. Engagement with leadership continues throughout the transformation, not only at the outset. The goals are to improve the following:

- More complete understanding of moral injury and why change is critical
- Persuading for and managing change
- Reframing priorities to focus on those at the coalface of care
- Building partnerships within the organization
- Building community resilience
- Supporting—and developing—clinician-centered, care-focused leaders

Workforce

Training for how to advocate for professional values alignment in the work environment. Without such training, the likelihood of developing a learning organization that can accept feedback and apply it, is limited.

- Teaching employees how to voice their values for both relief of current moral injury and prevention of future moral injury
- Teaching those in the organization, at every level, to value feedback from within
- Supporting implementation and scaling to optimize adoption and persistence of these skills throughout the organization

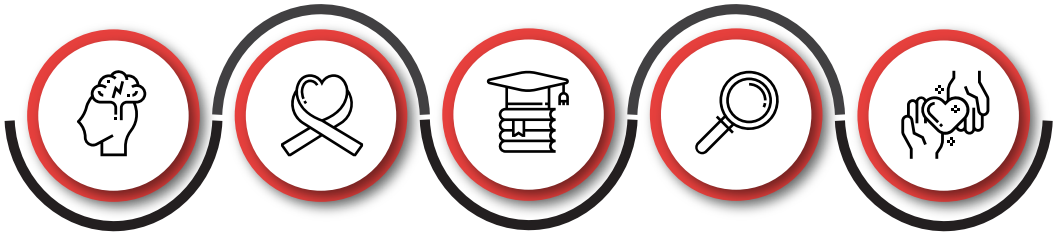
Organization

Moral injury stems from a fundamental disconnect between hospital and individual expectations, and the implementation of those expectations. We can guide the organization through minimizing that disconnect, through policy change, cultural transformation, or both. These suggestions will mitigate the prevalence of moral injury, while also increasing patient safety and professional integrity/compliance.

Our Organization

Moral Injury of Healthcare, LLC is a 501(c)3 founded by two physicians driven to make medicine better.

What We Do



Awareness
Writing
Speaking
Media
Podcast
Documentary

Advocacy
Local Government
State Government
Professional Societies

Education
Workshops
Transition Programs
Courses

Research
Quantify Problem
Identity Drivers
Assess Interventions

Consulting
Health Systems
Hospitals
Private Practices
Executive Teams
Clinical Teams
Individuals

What We Bring…

- Subject matter expertise—we established the current framework of clinician distress as moral injury
- Lived experience—of distress, front line care, and executive roles
- Credibility with the clinician community
- Executive perspective
- Broad expertise within our organization and through collaborating partners

Leadership

Wendy Dean, MD

Dr. Dean is the President/CEO, and co-founder of The Moral Injury of Healthcare, a nonprofit organization addressing the crisis of clinician distress.

A psychiatrist by training, Dr. Dean left clinical medicine to focus on finding innovative ways to make medicine better for both patients and physicians--technologically, ethically, and systemically. She has worked in research funding oversight for the Department of Defense, and as an executive for a large non-profit supporting military medical research. Dr. Dean has worked on various initiatives with the White House Office of Science and Technology Policy, the Biomedical Advanced Research Development Agency, DARPA, NASA, and the National Institutes of Health.

Dr. Dean graduated from the University of Massachusetts Medical School. She completed her residency training at Dartmouth Hitchcock Medical Center in Hanover, NH.

Simon G. Talbot, MD

Dr. Talbot is co-founder of The Moral Injury of Healthcare. He is a practicing hand surgeon and microsurgeon who is Associate Professor of Surgery at Harvard Medical School and Attending Surgeon in the Division of Plastic Surgery at the Brigham and Women's Hospital (BWH) in Boston, Massachusetts. He is Director of the Upper Extremity Transplant Program at BWH.

In addition to his work in Boston, Dr. Talbot regularly volunteers his time to perform surgery and to train local physicians. This work has taken him to Rwanda, Vietnam, Malawi, The Cook Islands, and Kenya.

Dr. Talbot is widely published and is active in several professional societies. He is a Board member of the American Society for Reconstructive Transplantation and is the physician representative to several committees at BWH.
He graduated from the University of Auckland School of Medicine in New Zealand. He completed his residency in the Harvard Plastic Surgery Residency Program followed by a fellowship in hand and microsurgery at Beth Israel Deaconess Medical Center.

Collaborating Partners

Ira Bedzow, PhD

Dr. Bedzow is an associate professor of medicine and UNESCO Chair in Bioethics at New York Medical College. He is also Senior Scholar of the Aspen Center for Social Values, a contributor at the MirYam Institute, and a regular contributor in Forbes for their Leadership, Diversity and Inclusion section. Bedzow received his PhD from Emory University.

Bedzow's interests relate to understanding the ethical implications of biotechnology and healthcare policy as well as how organizations can create an ethical culture through values-driven leadership. When it comes to ethical leadership, he tries to show that making a values-driven decision and implementing it effectively consist of different skills and face different challenges. Understanding the difference between asking "what to do" and "how can I act on my values successfully" is key to leadership and organizational success, as well as personal-professional wellbeing.

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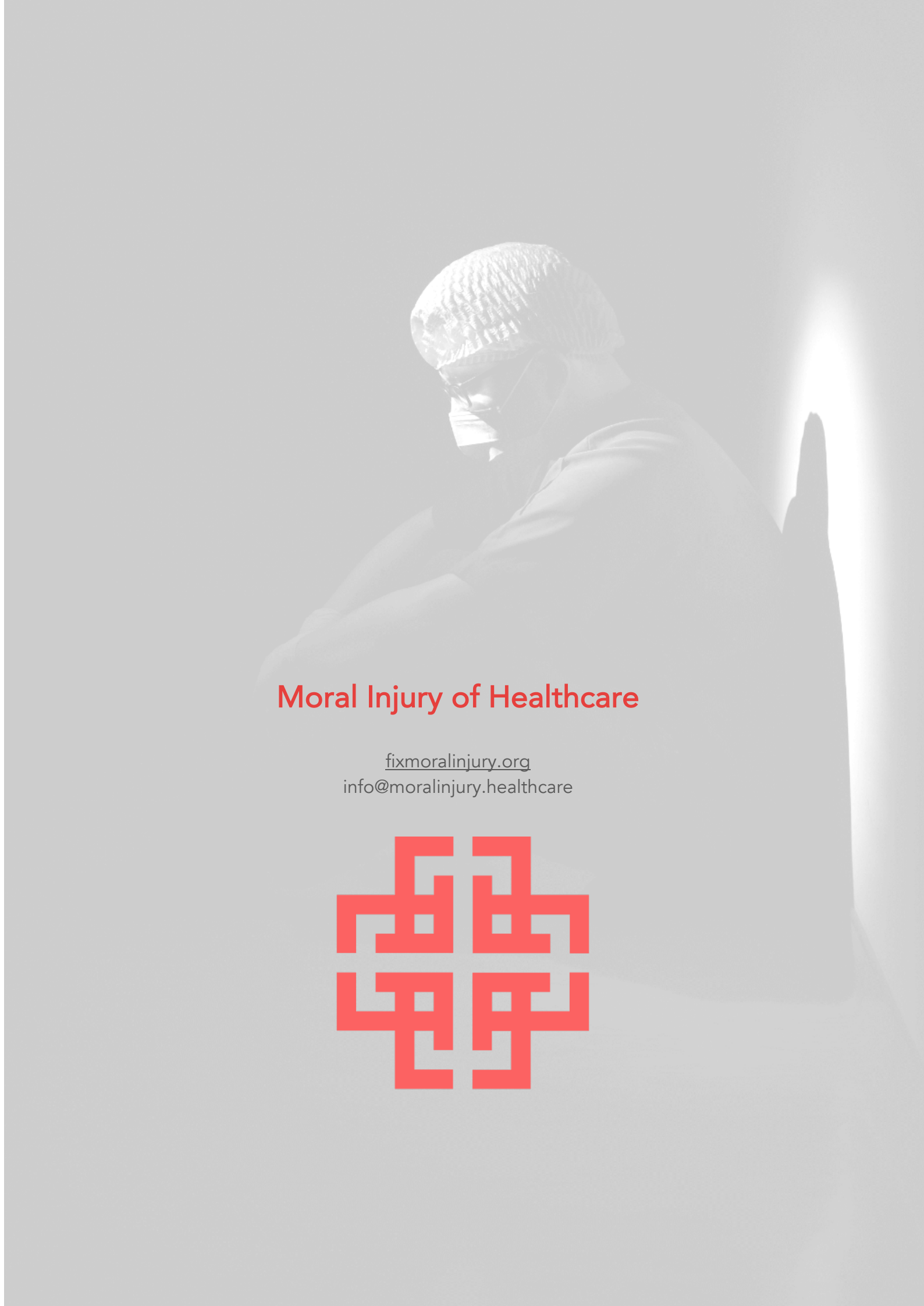

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info@moralinjury.healthcare