How to Mitigate Moral Injury Distress for Physicians and Care Teams

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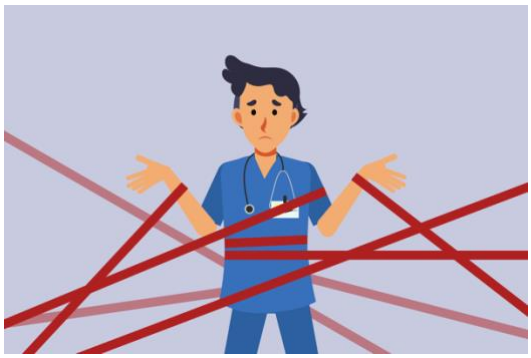

Mary had been diagnosed with a 16 cm tumor and needed surgery. She found a surgeon she liked, Dr. Gregory, who worked in a large clinic. The initial appointment went well and surgery was recommended. Dr. Gregory said that his office assistant would make the arrangements for scheduling and pre-op. Mary stopped by the desk and the assistant said she couldn't schedule anything but would reach back out. Several days went by, there was no contact, so Mary reached out to the clinic herself. She called several times and was on hold each time without an answer. She was unable to reach anyone in the clinic, including the manager. After some time, the surgery was scheduled and went well.

Dr. Gregory had asked for a follow up appointment with Mary in the next few weeks. Again, when Mary reached out to the clinic she was put on hold and never got an answer. She also left a message on the patient portal for Dr. Gregory. She was so frustrated she went to another surgical clinic for her follow up. Six months later, Dr. Gregory reached out and was inquiring about what happened.

This is an example of moral injury; the surgeon was stuck in a system that prevented him from doing what he knew was the right thing. He had no control or input into the system. When reflecting on moral injury in recent years, many people think of less everyday experiences, such as having to choose which patient to provide a ventilator to.

What is Moral Injury?

According to Wendy Dean, "Moral injury occurs when we perpetrate, bear witness to, or fail to prevent, an act that transgresses our deeply held moral beliefs. In the healthcare context, that deeply held moral belief is the Hippocratic oath each of us took when embarking on our paths as healthcare providers: Put the needs of patients first."[1]

How often have we, as practitioners, felt like our core values and core morality has been challenged in healthcare? In systems, this can be difficult to correct and can contribute to the constellation of symptoms we call "burnout". Burnout is not only caused by moral injury, but many factors also contribute that we might have some control over, including relationship conflict, judgment, shame, fatigue and exhaustion.

In her study of healthcare worker distress during COVID, Hines notes, "Moral injury severity was less than that reported in Army National Guardsmen, but similar to scores in military service members exposed to 7-month war zone deployments, particularly in the reporting of betrayals by others."[2] The authors do not go into detail about the betrayals, but others have described the lack of support for materials, staff, education and other factors as betrayals they have felt. Despite the initial injury that happens there is also a component of "moral residue" that also contributes to ongoing distress.

Roycroft states the "build-up of 'moral residue', those niggling doubts about the finely balanced decisions made, can result in moral injury."[3] Less complex cases in line with common practice are likely

to require the level of support as more clinically and ethically complex cases. If we go back to the original situation, there are several sources of moral injury to address:

- The lack of telephonic support from front-office staff
- Poor follow-through
- Lack of reminders
- Poor use of patient portal
- Distress on not being able to follow through as desired with Dr. Gregory
- Identification of system failures that led to loss of patient to another system

So, what are we to do?

How do we help ourselves? Our patients? And the systems we work in? There are many studies that discuss the idea of mental distress, moral injury, PTSD and "burnout" in healthcare, not only during the pandemic but prior as well.

Giving voice and recognition to moral distress is the first step[4]. Epstein & Hamric suggested three key preventative strategies:

- Enhanced decision-making support with complex decisions shared,
- The provision of time and space for clinicians to 'decompress' and
- Staff working consistently within the same team[5].

Enhanced decision-making support with increasing complexity requires a more enhanced clinician support. As we have more Physician Assistants and Nurse Practitioners working hard to provide support to patients, clients and residents, physicians and experienced PA's and NP's need to be available to support practitioners as they manage the increasing complexity of care. No one should feel that they are on their own. Providing intermittent touch backs with your clinical team and discussing complex cases can help provide increased levels of support. Sharing moral responsibility with other clinicians will help to reduce the intensity of dilemmas and the build-up of moral residue.

Impact of Schedule

Developing space for clinicians to decompress is critical. We believe that a lack of time to process events is key to the build-up of moral residue and the development of moral injury. Thus, time to 'decompress' can reduce the risk. It should be recognized that repeated, long, intense shifts and making decisions overnight, whilst being expected to work the next day, are not conducive to this. Rostering approaches need to better balance, and vary, the intensity of working environments for individuals[6]. Acceptance and Commitment Therapy (ACT) has been applied to clinicians with significant positive effect, especially the components of mindfulness. Mindfulness seems to moderate the factors that lead to the contribution of complex decision making to moral injury. The more we can create this space the more psychological flexibility is possible for clinicians[7].

Impact of the Team

Having the ability to work and share breaks with a team can help build comradery, support and loyalty to each other that can help mitigate moral injury distress by knowing there is a team that can work. We can provide teams with tools to build trust and support for each other that can give an increased sense of wellness, minimize isolation of complex decision-making process and pool resources to diffuse the

burden of the moral injury. The ability to create healthy teams is an essential component of minimizing the long- and short-term effects of moral injury.

We Can Help

VITAL WorkLife is here to support you or your team to build trust and support to positively impact patient care. From physician peer coaching to group facilitation, our resources can minimize the effects of moral injury. For counseling, coaching and other resources contact us at **952.230.5109**, through the **VITAL WorkLife App** or contact us online.

Sources:

[1] Dean W, Talbot S, Dean A. "Reframing Clinician Distress: Moral Injury Not Burnout." *Federal Practitioner* September 2019: 400-402.

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[7] Tziana Ramaci, Diego Bellini, Giovambattista Presti, Giuseppe Santisi. "Psychological Flexibility and Mindfulness as Predictors of Individual Outcomes in Hospital Health Workers." *Frontiers In Psychology* 12 June 2019: 1302.