

# Moral Injury in Health Care: A Unified Definition and its Relationship to Burnout

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**Background:** Moral injury had been discussed by health care professionals as a cause of occupational distress prior to COVID-19, but the pandemic expanded the appeal and investigation of the term. Moral injury incorporates more than the transdiagnostic symptoms of exhaustion and cynicism and goes beyond operational, demand-resource mismatches of corporatized systems.

**Observations:** Moral injury describes the frustration, anger, and helplessness associated with existential threats to a clinician's professional identity as business interests erode their ability to put patients' needs ahead of corporate and health system obligations. We propose a framework that combines 2 moral injury definitions. An individual who experiences a betrayal by a legitimate authority has an opportunity to choose their response. Moral injury arises when a superior's actions or a system's policies and practices

undermine one's professional obligations to prioritize the patient's best interest. Perceived as inescapable, the resignation or helplessness of moral injury may present with emotional exhaustion, ineffectiveness, and depersonalization, all hallmarks of burnout. Both moral injury and burnout can mediate and moderate the relationship between triggers for workplace distress and the resulting psychological, existential, and physical harm.

**Conclusions:** Moral injury is increasingly recognized as a source of distress among health care professionals. It emerges from structural constraints on the ability of health care professionals to deliver optimal care and stand up for patients, their oaths, and their professions. A unified definition of moral injury must be integrated into the framing of clinician distress alongside burnout, recentering health care on ethical decision making rather than profit.

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Moral injury was identified by health care professionals (HCPs) as a driver of occupational distress prior to the COVID-19 pandemic, but the crisis expanded the appeal and investigation of the term.<sup>1</sup> HCPs now consider moral injury an essential component of the framework to describe their distress, because using the term burnout alone fails to capture their full experience and has proven resistant to interventions.<sup>2</sup> Moral injury goes beyond the transdiagnostic symptoms of exhaustion and cynicism and beyond operational, demand-resource mismatches that characterize burnout. It describes the frustration, anger, and helplessness associated with relational ruptures and the existential threats to a clinician's professional identity as business interests erode their ability to put their patients' needs ahead of corporate and health care system obligations.<sup>3</sup>

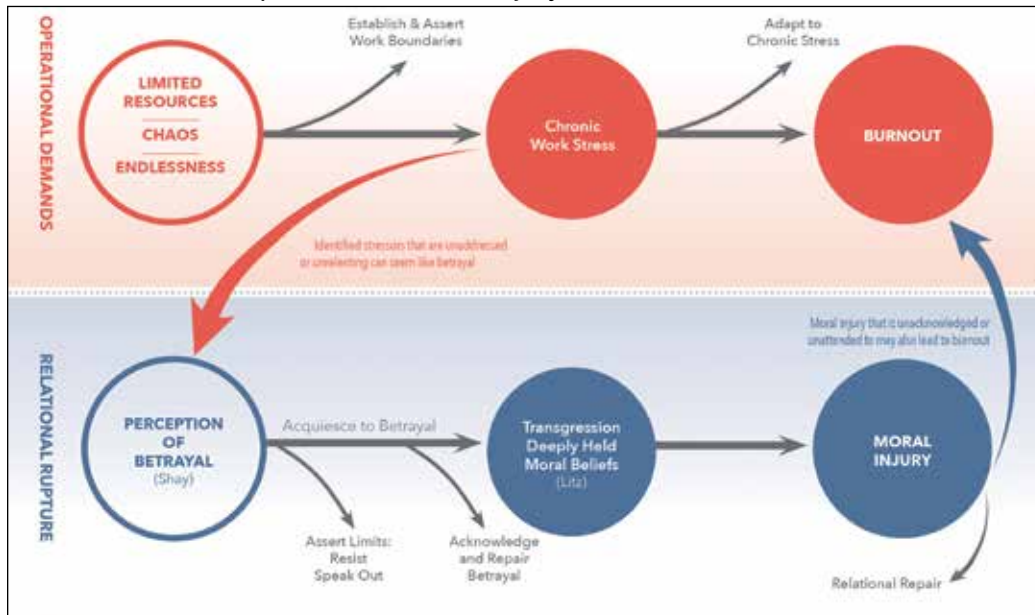
Proper characterization of moral injury in health care—separate from the military environments where it originated—is stymied by an ill-defined relationship between 2 definitions of the term and by an unclear relationship between moral injury and the long-standing body of scholarship in burnout. To clarify the concept, in-

form research agendas, and open avenues for more effective solutions to the crisis of HCP distress, we propose a unified conceptualization of moral injury and its association with burnout in health care.

## CONTEXTUAL DISTINCTIONS

It is important to properly distinguish between the original use of moral injury in the military and its expanded use in civilian circumstances. Health care and the military are both professions whereupon donning the “uniform” of a physician—or soldier, sailor, airman, or marine—members must comport with strict expectations of behavior, including the refusal to engage in illegal actions or those contrary to professional ethics. Individuals in both professions acquire a highly specialized body of knowledge and enter an implied contract to provide critical services to society, specifically healing and protection, respectively. Members of both professions are trained to make complex judgments with integrity under conditions of technical and ethical uncertainty, upon which they take highly skilled action. Medical and military professionals must be free to act on their ethical principles, without confounding demands.<sup>4</sup> However, the context of each profession's

**FIGURE** Relationship Between Moral Injury and Burnout



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commitment to society carries different moral implications.

The risk of moral injury is inherent in military service. The military promises protection with an implicit acknowledgment of the need to use lethal force to uphold the agreement. In contrast, HCPs promise healing and care. The military promises to protect our society, with an implicit acknowledgment of the need to use lethal force to uphold the agreement. Some military actions may inflict harm without the hope of benefitting an individual, and are therefore potentially morally injurious. The health care contract with society, promising healing and care, is devoid of inherent moral injury due to harm without potential individual benefit. Therefore, the presence of moral injury in health care settings are warning signs of a dysfunctional environment.

One complex example of the dysfunctional environments is illustrative. The military and health care are among the few industries where supply creates demand. For example, the more bad state actors there are, the more demand for the military. As we have seen since the 1950s, the more technology and therapeutics we create in health care, coupled with a larger share paid for by third parties, the greater the demand for and use of them.<sup>5</sup> In a fee for service environment, corporate greed

feeds on this reality. In most other environments, more technological and therapeutic options inevitably pit clinicians against multiple other factions: payers, who do not want to underwrite them; patients, who sometimes demand them without justification or later rail against spiraling health care costs; and administrators, especially in capitated systems, who watch their bottom lines erode. The moral injury risk in this instance demands a collective conversation among stakeholders regarding the structural determinants of health—how we choose to distribute limited resources. The intermediary of moral injury is a useful measure of the harm that results from ignoring or avoiding such challenges.

### HARMONIZING DEFINITIONS

Moral injury is inherently nuanced. The 2 dominant definitions arise from work with combat veterans and create additional and perhaps unnecessary complexity. Unifying these 2 definitions eliminates inadvertent confusion, preventing the risk of unbridled interdisciplinary investigation which leads to a lack of precision in the meaning of moral injury and other related concepts, such as burnout.<sup>6</sup>

The first definition was developed by Jonathan Shay in 1994 and outlines 3 necessary

### **BOX Defending Moral Beliefs: The Ray Brovont Story**

Ray Brovont, MD, was an emergency department physician designated to handle all inpatient resuscitations in the department but staffed only 1 emergency physician at a time. Brovont declared this unsafe. He knew eventually a trauma or critically ill patient would arrive in the emergency department while the lone physician was occupied. Brovont's supervisor, a physician-turned-administrator, refused requests to always staff at least 1 additional emergency physician to assist in such situations due to cost. Brovont felt betrayed,

believing physicians in this role could not guarantee safe care because of constraints in the system outside of their control. Instead of defending his superior's position to his staff, explaining the reality of his institution's tight finances and their need to do more with less, Brovont spoke up. He defended his deeply held moral belief of prioritizing the needs of the patient to avoid moral injury.<sup>9</sup> In court, he successfully defended his deeply held moral belief of prioritizing patient needs to avoid moral injury.

components, viewing the violator as a powerholder: (1) betrayal of what is right, (2) by someone who holds legitimate authority, (3) in a high stakes situation.<sup>7</sup> Litz and colleagues describe moral injury another way: "Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations."<sup>8</sup> The violator is posited to be either the self or others.

Rather than representing "self" or "other" imposed moral injury, we propose the 2 definitions are related as exposure (ie, the perceived betrayal) and response (ie, the resulting transgression). An individual who experiences a betrayal by a legitimate authority has an opportunity to choose their response. They may acquiesce and transgress their moral beliefs (eg, their oath to provide ethical health care), or they could refuse, by speaking out, or in some way resisting the authority's betrayal. The case of Ray Brovont is a useful illustration of reconciling the definitions (Box).<sup>9</sup>

Myriad factors—known as potentially morally injurious events—drive moral injury, such as resource-constrained decision making, witnessing the behaviors of colleagues that violate deeply held moral beliefs, questionable billing practices, and more. Each begins with a betrayal. Spot-lighting the betrayal, refusing to perpetuate it, or taking actions toward change, may reduce the risk of experiencing moral injury.<sup>9</sup> Conversely, acquiescing and transgressing one's oath, the profession's covenant with society, increases the risk of experiencing moral injury.<sup>8</sup>

Many HCPs believe they are not always free to resist betrayal, fearing retaliation, job loss, blacklisting, or worse. They feel constrained by debt accrued while receiving their education, being their household's primary earner, community ties, practicing a niche specialty that requires working for a tertiary referral center, or perhaps believing the situation will be the same elsewhere. To not stand up or speak out is to choose complicity with corporate greed that uses HCPs to undermine their professional duties, which significantly increases the risk of experiencing moral injury.

### **MORAL INJURY AND BURNOUT**

In addition to reconciling the definitions of moral injury, the relationship between moral injury and burnout are still being elucidated. We suggest that moral injury and burnout represent independent and potentially interrelated pathways to distress (Figure). Exposure to chronic, inconsonant, and transactional demands, which things like shorter work hours, better self-care, or improved health system operations might mitigate, manifests as burnout. In contrast, moral injury arises when a superior's actions or a system's policies and practices—such as justifiable but unnecessary testing, or referral restrictions to prevent revenue leakage—undermine one's professional obligations to prioritize the patient's best interest.

If concerns from HCPs about transactional demands are persistently dismissed, such inaction may be perceived as a betrayal, raising the risk of moral

injury. Additionally, the resignation or helplessness of moral injury perceived as inescapable may present with emotional exhaustion, ineffectiveness, and depersonalization, all hallmarks of burnout. Both conditions can mediate and moderate the relationship between triggers for workplace distress and resulting psychological, physical, and existential harm.

## CONCLUSIONS

Moral injury is increasingly recognized as a source of distress among HCPs, resulting from structural constraints on their ability to deliver optimal care and their own unwillingness to stand up for their patients, their oaths, and their professions.<sup>1</sup> Unlike the military, where moral injury is inherent in the contract with society, moral injury in health care (and the relational rupture it connotes) is a signal of systemic dysfunction, fractured trust, and the need for relational repair.

Health care is at a crossroads, experiencing a workforce retention crisis while simultaneously predicting a significant increase in care needs by Baby Boomers over the next 3 decades. The pandemic served as a stress test for our health care system and most institutions failed. Instead, the system was held together by staff, which is not a plan for sustained organizational resilience.

Health care does not have the luxury of experimenting another 30 years with interventions that have limited impact. We must design a new generation of approaches, shaped by lessons learned from the pandemic while acknowledging that prepandemic standards were already failing the workforce. A unified definition of moral injury must be integrated to frame clinician distress alongside burnout, recentering ethical decision making, rather than profit, at the heart of health care. Harmonizing the definitions of moral injury and clarifying the relationship of moral injury with burnout reduces the need for further reinterpretations, allowing for more robust,

easily comparable studies focused on identifying risk factors, as well as rapidly implementing effective mitigation strategies.

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## Author disclosures

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## Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

## Ethics and consent

The Veterans Affairs Greater Los Angeles Healthcare System institutional review board determined that this study was exempt. The datasets generated and/or analyzed during the current study are not publicly available but may be available from the corresponding author on reasonable request.

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