

Reframing Clinician Distress: Moral Injury Not Burnout

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For more than a decade, the term *burnout* has been used to describe clinician distress.^{1,2} Although some clinicians in federal health care systems may be protected from some of the drivers of burnout, other federal practitioners suffer from rule-driven health care practices and distant, top-down administration. The demand for health care is expanding, driven by the aging of the US population.³ Massive information technology investments, which promised efficiency for health care providers,⁴ have instead delivered a triple blow: They have diverted capital resources that might have been used to hire additional caregivers,⁵ diverted the time and attention of those already engaged in patient care,⁶ and done little to improve patient outcomes.⁷ Reimbursements are falling, and the only way for health systems to maintain their revenue is to increase the number of patients each clinician sees per day.⁸ As the resources of time and attention shrink, and as spending continues with no improvement in patient outcomes, clinician distress is on the rise.⁹ It will be important to understand exactly what the drivers of the problem are for federal clinicians so that solutions can be appropriately targeted. The first step in addressing the epidemic of physician distress is using the most accurate terminology to describe it.

Freudenberger defined burnout in 1975 as a constellation of symptoms—malaise, fatigue, frustration, cynicism, and inefficacy—that arise from “making excessive demands on energy, strength, or resources” in the workplace.¹⁰ The term was borrowed from other fields and applied to health care in the hopes of readily transferring the solutions that had worked in other industries to address a growing crisis among physicians. Unfortunately, the crisis in health care has proven resistant to solutions that have worked elsewhere, and many clinicians have resisted being characterized as burned out, citing a subtle, elusive disconnect between what they have experienced and what burnout encapsulates.

In July 2018, the conversation about clinician distress shifted with an article we wrote in *STAT* that described the moral injury of health care.¹¹ The concept of moral injury was first described in service members who returned from the Vietnam War with symptoms that loosely fit a diagnosis of posttraumatic stress disorder (PTSD), but which did not respond to standard PTSD treatment and contained symptoms outside the PTSD constellation.¹² On closer assessment, what these service members were experiencing had a different driver. Whereas those with PTSD experienced a real and imminent threat to their *mortality* and had come back deeply concerned for their individual, physical safety, those with this different presentation experienced repeated insults to their *morality* and had returned questioning whether they were still, at their core, moral beings. They had been forced, in some way, to act contrary to what their beliefs dictated was right by killing civilians on orders from their superiors, for example. This was a different category of psychological injury that required different treatment.

Moral injury occurs when we perpetrate, bear witness to, or fail to prevent an act that transgresses our deeply held moral beliefs. In the health care context, that deeply held moral belief is the oath each of us took when embarking on our paths as health care providers: Put the needs of patients first. That oath is the lynchpin of our working lives and our guiding principle when searching for the right course of action. But as clinicians, we are increasingly forced to consider the demands of other stakeholders—the electronic medical record (EMR), the insurers, the hospital, the health care system, even our own financial security—before the needs of our patients. Every time we are forced to make a decision that contravenes our patients' best interests, we feel a sting of moral injustice. Over time, these repetitive insults amass into moral injury.

The difference between burnout and moral injury is important because using different

terminology reframes the problem and the solutions. Burnout suggests that the problem resides within the individual, who is in some way deficient. It implies that the individual lacks the resources or resilience to withstand the work environment. Since the problem is in the individual, the solutions to burnout must be in the individual, too, and therefore, it is the individual's responsibility to find and implement them. Many of the solutions to physician distress posited to date revolve around this conception; hence, the focus on yoga, mindfulness, wellness retreats, and meditation.¹³ While there is nothing inherently wrong with any of those practices, it is absurd to believe that yoga will solve the problems of treating a cancer patient with a declined preauthorization for chemotherapy, having no time to discuss a complex diagnosis, or relying on a computer system that places metrics ahead of communication. These problems are not the result of some failing on the part of the individual clinician.

Moral injury, on the other hand, describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control. Moral injury is the consequence of the ever-present double binds in health care: Do we take care of our patient, the hospital, the insurer, the EMR, the health care system, or our productivity metrics first? There should be only 1 answer to that question, but the current business framework of medicine pressures us to serve all these masters at once. Moral injury locates the source of distress in a broken system, not a broken individual, and allows us to direct solutions at the causes of distress. And in the end, addressing the drivers of moral injury on a large scale may be the most effective preventive treatment for its cumulative effects among health care providers.

The long-term solutions to moral injury demand changes in the business framework of health care. The solutions reside not in promoting mindfulness or resilience among individual physicians, but in creating a health care envi-

ronment that finally acknowledges the value of the time clinicians and patients spend together developing the trust, understanding, and compassion that accompany a true relationship. The long-term solutions to moral injury include a health care system that prioritizes healing over profit and that trusts its clinicians to always put their patients' best interests first.

Treating moral injury will not be simple. It cannot happen quickly, and it will not happen without widespread clinician engagement. Change can begin when clinicians identify the double binds they face every day and convey those challenges to their administrators. If administrators and clinicians are willing to work together to resolve these double binds, health care will improve for everyone.

The following are our recommendations for how you can bring change both locally and on a broader scale.

Bring together the 2 sides of the health care house: administrators and clinicians. Invite administrators to join you on rounds, in clinic, or in the operating room. Ask them to follow you during a night of call or to spend an overnight shift with you in the emergency department. The majority of people, including health care administrators, have had only glancing encounters with the medical system. They see their primary care doctor, have regular screening procedures, and maybe get treated for a routine illness or injury. None of those encounters expose them to the depth of challenge in the system.

It takes exposure over a longer duration, or with greater intensity, to appreciate the tensions and double binds that patients and clinicians face regularly.^{14,15} Whether or not the administrators accept your invitation, you must also ask to see the challenges from their side. Block out an afternoon, a day, or a week to follow them and learn where they struggle in their work. Only when we understand the other party's perspective can we truly begin to empathize and

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communicate meaningfully. That profound understanding is the place where commonality and compromises are found.

Make clinician satisfaction a financial priority. Although care team well-being is now part of the quadruple aim (patient experience, population health, reducing costs, and provider experience), organizations must be held accountable to ensure it is a priority. If we choose to link patient satisfaction with clinician compensation, why not link clinician satisfaction with executive compensation?

Make sure every physician leader has and uses the cell phone number of his or her legislators. Hospitals and big pharma have nearly bottomless lobbying budgets, which makes competing with them for lawmakers' attention a formidable prospect. Despite this, physician leaders (ie, chief wellness officer, department chairperson, medical society president, etc) have a responsibility to communicate with legislators about the needs of patients (their constituents) and what role our legislators can play in fulfilling those needs. We must understand how policy, regulation, and legislation work, and we need to find seats at every table where the decisions that impact clinical care are made. The first step is opening lines of communication with those who have the power to enact large-scale change.

Reestablish a sense of community among clinicians. Too often clinicians are pitted against one another as resources shrink. Doctors compete with each other for referrals, advanced practitioners and nurses compete with doctors, and everyone feels overstressed. What we tend to forget is that we are all working toward the same goal: To give patients the best care possible. It's time to view each other with the presumption of charity and to have each other's backs. Uniting for support, camaraderie, mentorship, and activism is a necessary step in making change.

Author disclosures

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care, a nonprofit organization; they report no other actual or potential conflicts of interest with regard to this article.

Disclaimer

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