The Consequences of Moral Injury: A Capitalist Society Case Scenario

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Case:

Our patient is a very well-respected 58 year old female physician who resides in Connecticut. She knew from age seven that she wanted to be a physician and ultimately pursued a career in internal medicine, working as a hospitalist hired to care for acutely ill hospitalized patients. She thoroughly loved her work. She especially loved caring for those stigmatized by psychiatric disorders, breaking down barriers to care, doing whatever she could to support their physical health and mental welfare. Over time, however, she found herself increasingly disenchanted with her work.

She noted tremendous inconsistencies between her employer's stated mission and its actions. Patient safety and corporate transparency were touted as primary goals. Yet when she filed "mandatory" risk reports regarding several concerning medical errors, she was admonished not to do so. It caused her Medical Director "too much work;" and she was further advised that she would want to avoid being labelled "a disgruntled employee." Message received – remain silent. When she discussed this with a colleague, he mentioned a similar situation in the intensive care unit. Nurses were told not to file reports without first "checking with their manager for appropriateness."

Daily "lean" meetings led to further discomfort. These meetings were designed to align physician practices with corporate goals. In these meetings, there was jovial competition to see which physician has discharged the most patients and who had completed the most discharges before 10am. The pressure to open beds for the next paying customer was obvious. No patient satisfaction indicators were part of the meeting. Nor was there mention of any quality indicators. However, lip service was given to patient safely at the end of each of these meetings. The last *reported* serious safety event was recalled, with emphasis on the number of days since its occurrence. "Do whatever you can to keep the winning streak going," was the none-too-subtle message. *But if risk reports are being discouraged, how could this information be accurate?*

In one of these lean meetings, the physicians were told NOT to consult psychiatry for patients who voiced suicidal ideation while intoxicated, that they are "unlikely to kill themselves" and these consults "waste the psychiatrists' time." When least inhibited, a patient is voicing suicidal ideation. Isn't s/he at greater risk of suicide attempt while similarly disinhibited? How can we ignore their pleas for help when their guard is down? Just because the psychiatry staff is intentionally

understaffed (a cost containment measure) doesn't mean patient care and safety should arbitrarily suffer.

Even the electronic medical record was programmed to interrupt and pop-up constant cost reminders with hard stops for justification. She found this incessant oversite insulting. More problematic, she found these interruptions extremely disruptive, breaking her concentration, potentially causing medical errors. Worse still, she and others started largely ignoring them *even though they could contain important information*. There's a well-known term for this in the medical arena: "pop-up fatigue."

One of her colleagues ignored a pop-up that noted a patient had had more than three bowel movements in twenty-four hours. Unfortunately, the person turned out to have *C. difficile* colitis. He was reprimanded for ignoring the pop-up. Where was the system's ownership and responsibility? Why are there more and more pop-ups each week when it is well known that the more pop-ups, the more likely they are to be ignored?

On Thursday mornings, her medical director met with administration to discuss patients' length of stay. The consequent result was frequent text messages asking for justification for patients' continued hospital care. Again, she found these disruptive and insulting, especially when her medical director suggested she consult another physician to justify keeping her unstable, hypoxic patient in the hospital. After thirty years of practice, she felt quite confident in her ability to decide what was medically best for her patients. When she voiced discontent with these constant intrusions and the belittling scrutiny, she was advised that this was necessary to keep the system financially viable. Yet at a recent meeting, she and others had been "congratulated" that the hospital made more than a million dollars in profit the prior year – at whose expense?

When she once inquired about a raise, she was told "No," that her salary was in line with those throughout the State. She researched this conclusion and found otherwise. In fact, a soon-to-be graduating resident was offered her current salary. When she queried the CMO about this decision, he stated that "physicians are paid based on job description. A new graduate is doing the same thing you are, so why should you be paid more?" Her silent answer was "because we are more

efficient and knowledgeable, because we are lower risk to patients and the system as a whole, because you should want to retain those with experience and a solid track record…"

Eventually, our physician found she could no longer tolerate the touted but poorly supported mission, the constant pecking, the pressure to race patients and their families out of the hospital, the pressure to do more without adequate resources, the lack of support from other departments because they were stretched too thin as well. The final straw came from the Psychiatry Chief. He asked that she stop ordering tests for hepatitis and HIV on patients in his unit. This was "a cost-saving measure, you can understand." She could not. Our physician was selective about this testing, ordering it only for those patients with clear risk factors *and* with known paltry access to healthcare (due to mental illness, homelessness, and/or other circumstances). Just two weeks prior, she had diagnosed a patient with hepatitis C. He was referred to a gastroenterologist for treatment after being discharged from the psychiatry unit. Had she not tested him, he would not have known, likely for years, not until cirrhosis had destroyed his liver, not until he'd infected several others through sharing needles and sexual activity… Our physician sank into a severe depression for which she, herself, required hospitalization.

When she was ready to return to work, she was unexpectedly prevented from doing so. Administration was concerned that she was now "impaired." They mandated that she report herself to the State organization (Haven) for such physicians. Only with this organization's clearance could she return. They cited hospital risk as their rationale, based upon an extremely broad and vague Connecticut law stating, "if there is a possibility of impairment due to mental illness," the hospital is mandated to report her to this agency. *Everyone meets this definition*, so how exactly did her employer weigh this risk – compared with and apparently more concerning than all the other risks she watched left either unspoken or unaddressed? The consequences of this action were myriad, including invasion of her privacy, stigma, and full financial cost of three years of obligatory monitoring. If she wanted to work at another facility, she would have to inform them that she was being monitored. But what value was this agency providing, other than appeasing the hospital's suddenly re-awakened risk aversion? She had been cleared to return to work by her physician, as would happen after any medical illness. If a diabetic physician were hospitalized with ketoacidosis, would he be reported to the State organization for three years of supervised glucose monitoring? The answer is "No."

Adding insult to injury, the website of Haven states that it offers a "confidential alternative to public disciplinary action for professionals suffering from chemical dependency, emotional or behavioral disorder, or physical or mental illness." *When is public disciplinary action ever and appropriate response to illness?* The statement itself perpetuates the stigma that mental illness is a weakness rather than a disorder requiring medical attention.

This was the final insult, the final betrayal. Our physician seriously weighed her options. Not only was the system preventing safe and appropriate care – It had no turned on her directly. She seriously considered retiring from medicine…

Discussion:

In 1984, Andrew Jameton published the first article to define "moral distress," which he described as "knowing what to do in an ethical situation, but not being allowed to do it."[1] One step further, the term "moral injury" was codified by Dr. Jonathan Shay, a Veterans Affairs psychiatrist, who noted that soldiers were suffering from something more complicated than PTSD. They weren't just traumatized by what they saw and experienced during active duty. They were also plagued by internal conflict. Shay defined moral injury as psychological trauma resulting from (1) a betrayal of what is morally correct, (2) by someone who holds legitimate authority, and (3) in a high-stakes situation.[2]

In 2009, Brett Litz broadened the definition, describing it as "the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations."[3] Others have additionally added that being the recipient of morally dissonant acts from those in authority may also lead to moral injury.

The International Centre for Moral Injury now summarizes moral injury as involving "a profound sense of broken trust in ourselves, our leaders, governments and institutions to act in just and morally good ways" and the experience of "sustained and enduring negative moral emotions – guilt, shame, contempt and anger – that results from the betrayal, violation or suppression of deeply held or shared moral values."[4]

Moral injury, in turn may result in depression, anxiety, PTSD, substance abuse, emotional detachment, and difficulty with interpersonal relationships. Granted, the impact varies widely in the context of prior and current experiences, personality type, future goals, and support systems. Left unacknowledged and untreated, however, moral injury may lead to suicide.

In their 2018 seminal paper, Drs. Wendy Dean and Simon Talbot made the connection between moral injury and physicians.[5] We are increasingly forced to follow corporate protocols and policies which violate our Hippocratic Oath. Patient care and safety are no longer the drivers of medicine. Moral injury occurs when we are forced to provide sub-standard care and to remain quiet when we witness it. Moral injury occurs when we are repeatedly treated like unfeeling cogs in a machine. The days of a well-educated, responsible, and autonomous physician running a private practice and being in control of patient care goals and expectations are almost entirely over in the United States. Profit margins, executive bonuses, risk aversion, and insurance company regulations now rule. Physicians are assessed (and often incentivized) based on productivity metrics. We are pushed to do more and more for our patients, complete more and more metric-driven paperwork, with fewer allocated resources, in order to maximize the corporate bottom line. In his book *The Moral Distress Syndrome Affecting Physicians,* Dr. Eldo Frezza states:

> "The major problem… is that physicians have no significant recognition or rewards, neither monetary, as we are not making the same salary as 20 years ago, nor emotional, as legislation has relegated us to the role of secretaries doing administrative work, and we are made to spend more time on paperwork than on patient care. But we are more than that, much more!"[6]

No longer primarily medical practitioners, we have been molded into multi-functional cogs in a complex morass, easily interchanged regardless of our years of experience or reputations.

Although several papers and books have been written on the topic, attention to the dangers of moral injury on physicians has not yet gained significant attention from the media, the public, or even physicians themselves. The media and society view physicians as a privileged elite who should have little or no reason to complain about their circumstances. Physicians, as a group, tend to ignore and/or dismiss our dis-ease. We are the caretakers; our needs are secondary. To admit that we are in distress is to admit to lack of strength, resiliency, and stamina which we worked so hard to develop and polish during years and years of strenuous training. To admit that we are in

distress is to risk being seen as "impaired"... Additional reasons include: severe time and resource constraints requiring prioritization of patient care above all else; fear of being labeled "difficult;" fear of retaliation, including loss of license; and perhaps most poignant, difficulty acknowledging complicity with practices we would ordinarily challenge. In their book *If I Betray These Words*, Drs. Dean and Talbot note that "unless someone is in a position of power or has nothing to lose, speaking out is often too dangerous."[7] As cogs, we are especially vulnerable if we "squeak," even though *we provide the primary service upon which healthcare systems rely and exist*.

In 2018, Harvard University and the Massachusetts Medical Society announced that physician burn-out was a "public health crisis."[8] Burn-out occurs in the context of increasingly onerous workloads, declining recognition/rewards, unfair treatment by superiors, and communication breakdowns with administration.[5] The result is emotional exhaustion, physical fatigue, cynicism, decreased productivity, decreased concentration, and less attention to detail – a set-up for patient errors. The pressure on physicians is constant to do more and more with fewer resources, to practice medicine with "one hand tied behind our backs." Efficiency and speed are paramount. There is rarely time to gather complete medical data, let alone build a rapport with patients and their loved ones. Patients and physicians alike are increasingly disenchanted by the current healthcare system. Productivity and profitability are more important than patient care and safety. Burnout rates amongst physicians are greater than 50%, according to a 2016 Mayo Clinic survey.[9]

Combine burn-out with moral injury and we create the perfect storm. Those most severely affected are at grave risk of suicide. It is estimated that the United States loses 300-400 physicians per year to suicide – at least one per day. Women physician rates of suicide are 400% higher than that of women in other professions. Male physician rates are 50-70% higher.[6] Other physicians are leaving the field at increasing rates. A 2022 survey found that 13% of physicians planned to leave medicine within the following year.[10] This number was likely augmented by the impact of COVID, as other studies have demonstrated rates of 6-7%.[11] Currently, there are just over a million actively practicing physicians in the United states. If we round to 10% opting to leave medicine, this equates to 100,000 physicians annually. Our medical schools are equipped to train and graduate ~30,000 new physicians each year. Foreign medical school graduates bring another ~7,500 physicians to the Unites States annually. That leaves an annual net loss of ~62,500 physicians along with the suicide of 300-400 others. *At this mathematical attrition rate, there will be no*

physicians in the United States in just 16 years. **THIS is a national health crisis.** So how do we stem this tide? How do we prevent physicians from leaving medicine? How do we prevent and mitigate further moral injury? How do we repair the damage already done?

Our employers suggest that physicians engage in "wellness" awareness and activities. We are advised to practice yoga, exercise more, follow healthier diets, and seek out (employer-run) Employee Assistance Programs for psychological concerns. While perhaps well-intentioned, this places the onus of the problem on physicians, not on the causative system.

What are some potential systems solutions? The two arenas to target are profit and risk. If society values safe, high quality medical care, it must start making necessary changes. These changes must be top-down, and broad-sweeping – not just small and local. Possibilities include:

- Legislating that insurance and healthcare companies must be not-for-profit.
- Capping insurance and healthcare company executive bonuses.
- Outlawing financial incentives in the healthcare setting. Use quality metrics instead.
- Revising "impaired physician" laws such that they are applicable to physicians who are *truly* impaired rather than *may be*.
- Capping medical lawsuit winnings.
- Unionizing

We cannot remain an ostrich with our collective head in the sand and pretend that our healthcare system will meaningfully survive. Physicians, society, and the media need to act now and advocate for change. Moral injury is eroding our medical care. We need to convene local and national think tanks to come up with creative ideas to redress the current situation and stall the exodus. We need to pay physicians not only based on their expertise, but also on their experience, efficiency, and record of quality care. We need to create legislation which protects physicians as much as *if not more than* the corporations which hire them. Physicians do not necessarily need accolades, but we do require respect. We've poured our hearts, souls, and millions of personal educational dollars into caring for our fellow citizens. It is time to shift gears and re-imagine medicine. It is time to reclaim the primacy of physician-determined safe and expert patient care. It is time to treat physicians as professionals, *at the very least as sentient beings,* not as dispensable pawns in an impersonal corporate maze.

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