Occupational Moral Injury in Healthcare: A concept analysis

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INTRODUCTION

- This project seeks to:
  - (1) better understand the concept of occupational moral injury (MI) as it relates to moral distress (MD) and burnout (BO), and
  - (2) improve the understanding of occupational MI in healthcare settings, such that healthcare systems may better develop strategies for MI assessment, prevention, and mitigation.

METHODS

- Based on Walker and Avant's (2019) methodology, this concept analysis of occupational MI in healthcare describes the antecedents, defining attributes, and consequences of MI in relation to MD and to the oft associated phenomenon of BO.

RESULTS

- Our findings reveal a highly interconnected network of related concepts that can intensify each other and that are not mutually exclusive.
- MI, MD, and BO have shared antecedents and overlapping consequences that can render their delineation challenging.
- MI, MD, and BO in healthcare contexts all share the attribute of capturing experiences of clinician distress with varying sources, intensity, and chronicity.
- MI and MD introduce ethical tones to clinician distress and capture the effects of moral dissonance related to constrained moral agency and disempowerment.

DISCUSSION & IMPLICATIONS

- We suggest 3 necessary and sufficient conditions for defining occupational MI in healthcare (2 "moral" antecedents and 1 "injury" consequence):
  - (1) a clinician's often-appropriate commitment to the expected moral responsibilities, principles, and values of their profession, and
  - (2) a recognition of suppressed moral agency and compromised integrity from a forced violation of those principled commitments, with
  - (3) the consequence of significant and profound distress from such recognized moral violation.
- In short, MI in healthcare captures the injury of possessing professional moral responsibility while lacking commensurate moral agency.
- Shay (2012) and Litz et al. (2009) described the foundational authority-perpetrated[2] and self-perpetrated[3] definitions of MI; we integrate these definitions to suggest that MI in healthcare contexts may result from both (1) authority-perpetrated and (2) self-perpetrated moral violations that can result when clinicians experience authority-imposed pressure to act in ways inconsistent with their professional values.
- Integrating authority-perpetrated and self-perpetrated perspectives, a working definition of occupational MI in healthcare cannot be divorced from a consideration of the decision-makers and power dynamics of the contexts in which clinicians are embedded.
- Our findings invite such questions as: Are clinicians who are most committed to, or most discerning of violations to, their professional values at greater risk for MI? What actions by authorities bring about moral violations to clinicians' professional values? What values tend to be violated? Does the nature of the values violated influence whether MD or MI is experienced?

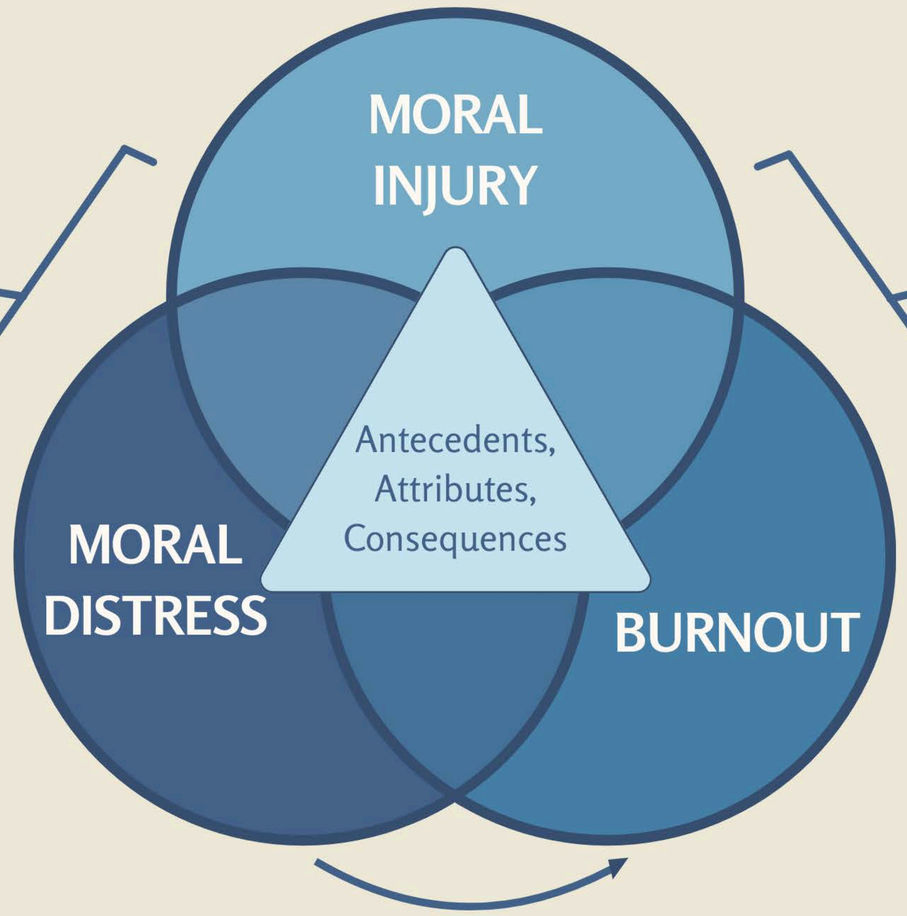
CONCLUSION

- MI, MD, and BO are defined by specific antecedents coupled with specific consequences; thus, determining whether a clinician suffers from MI, MD, BO, or some combination thereof cannot be made without assessing the full process of suffering - from antecedents to consequences.
- Framing solutions for occupational MI requires an accurate assessment of its drivers.
- We emphasize the need for preventative actions directed toward avoidable drivers of MI.
- Better understanding the avoidable antecedents that drive MI is critical for guiding targeted pre-exposure mitigation efforts and solutions for change that proactively address this problem.

Moral Injury in Relation to Moral Distress and Burnout

Moral Distress & Moral Injury

- Positively correlated but distinct phenomena with overlapping antecedents.[4]
- May capture related responses to Potentially Morally Injurious Events (PMIEs) on a continuum of severity: lower intensity consequences for MD to less prevalent but longer-lasting, higher intensity consequences for MI[4,5,6,7]; MI also shares consequences with MD.[11]
- Unmitigated, cumulative MD may also lead to MI. [4,12]



Moral Injury & Burnout

- Positively related and mutually potentiating but distinct constructs.[4,13,14,15]
- Unaddressed MI may increase the risk of BO.[16]
- Powerlessness of MI may present as emotional exhaustion, ineffectiveness, and depersonalization of BO; chronic compensation for systemic failures links MI to BO.[14,15]

Moral Distress & Burnout

- MD is positively correlated with BO and is a theorized "root cause" of BO via mechanisms of ethical disempowerment, lost moral agency, resultant moral apathy, detachment, cynicism, and exhaustion.[4,6,7,8,9,10]

RESOURCES

REFERENCES