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LETTERS

Reframing Clinician Distress: Moral Injury Not Burnout

To the Editor: In the September 2019 guest editorial "Reframing Clinician Distress: Moral Injury Not Burnout," the authors have advanced a thoughtful and provocative hypothesis addressing a salient issue.[1] Their argument is that burnout does not accurately capture physician distress. Furthermore, they posit the term *burnout* focuses remediation strategies at the individual provider level, thereby discounting the contribution of the larger health care system. This is not the first effort to argue that burnout is not a syndrome of mental illness (eg, depression) located within the person but rather a disrupted physician-work relationship.[2]

As the authors cite, population and practice changes have contributed significantly to physician distress and dissatisfaction. Indeed, recent findings indicate that female physicians may suffer increased prevalence of burnout, which represents a challenge given the growing numbers of women in medicine.[3] Unfortunately, by shifting focus almost exclusively to the system level to address burnout, the authors discount a large body of literature examining associations and contributors at the individual and clinic level.

Burnout is conceptualized as consisting of 3 domains: depersonalization, emotional exhaustion, and personal accomplishment.[4] While this conceptualization may not capture the totality of physician distress, it has provided a body of literature focused on decreasing symptoms of burnout. Successful interventions have been targeted at the individual provider level (ie, stress management, small group discussion, mindfulness) as well as the organizational level (ie, reduction in duty hours, scribes).[5,6] Recent studies have also suggested that increasing the occurrence of social encounters that are civil and respectful decreases reported physician burnout.[7]

Frustration, the annoyance or anger at being unable to change or achieve something, also can be a leading cause of burnout and moral injury. The inability to deal with unresolvable issues due to a lack of skills or inability to create a positive reframe can lead to a constellation of symptoms that are detrimental to the individual provider. Nevertheless, system rigidity, inability to recognitize pain and pressure, and goals perceived as unachievable can also lead to frustration. Physicians may experience growing frustration if they are unable to influence their systems. Thus, experiencing personal frustration, combined with an inability or lack of energy or time to influence a system can snowball.

Just as we counsel our patients that good medical care involves not only engagement with the medical system, but also individual engagement in their care (eg, nutrition, exercise), this problem requires a multicomponent solution. While advocating and working for a system that induces less moral injury, frustration, and burnout, physicians need to examine the resources available to them and their colleagues in a more immediate way.

Physician distress is a serious problem with both personal, patient, occupational, and public health costs. Thus, it is important that we

grapple with the complexity of a multiconstruct definition amenable to multilevel interventions. The concept of moral injury is an important component and opens additional lines of both clinical inquiry and intervention. However, in our view, to subsume all burnout under this construct is overly reductive.

In closing, this topic is too important not to discuss. Let the conversations continue!

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To the Editor: We applaud Dean and her colleagues for their thought-provoking commentary on clinicians' distress, a problem that has surged in recent years and has now reached epidemic proportions.[1] Their argument focuses on the language used to define and frame clinical distress. Do we label this distress as *burnout*, as *moral injury*, or as something else? Moral injury occurs any time clinicians are impeded from doing the right thing at the right time in the right way; or even worse, doing the wrong thing to serve the needs of health system stakeholders other than the patient. These other stakeholders may include administrators, corporations, insurance adjusters, and others.

Naming the problem correctly is crucial to finding the solution. The name frames the discussion and impacts the solution. Burnout implies difficulty coping with the many stresses of health care and of personal responsibility for the problem. The solution would therefore be to help individuals to cope with their stresses. Moral injury on the other hand implies a corrupt system; thereby, reframing the discussion to systems issues and suggesting solutions by changing the business of health care delivery.

These authors state that current clinical distress is due to moral injury and not to burnout. Therefore, the business in which health care is performed needs to change.

The authors define the drivers of moral injury in our current system, mostly as (1) a massive information technology overload that has largely overtaken the patient as center of attention; and (2) the profit motive of the health care corporation and its shareholders. A focus on making profits has increased in the wake of falling reimbursements; the result is pressure on clinicians to see more patients more quickly and to do more even when not necessary. This has diverted the focus on healing patients to a focus on making profits. These major drivers of clinician distress—the electronic health record and the pressure to bill more—are fundamentally driven by the corporatization of American medicine in which profit is the measured outcome.

Thus rather than having their highest loyalty to patients and their families, clinicians now have other loyalties—the electronic health record, insurers, the hospital, the health care system, and even their own salaries.

Therein lies the moral injury felt by increasing numbers of clinicians, leading to soaring rates of clinical distress. Many physicians are now recognizing moral injury as the basis of their pain. For example, Gawande has described unceasing computer data entry as a cause of physician distress and physician loneliness in the interesting essay, "Why Doctors Hate Their Computers."[2] Topol has suggested that corporate interference and attention away from patient care is a reason doctors should unite and organize for a more healthful environment.[3] Ofri has gone so far as to suggest

that the health care system is surviving because it can exploit its physicians for every drop of energy, diverting the focus of clinical encounters on billing rather than healing.[4] However, it may be simplistic to imply or state that all clinical distress is related to moral injury. Other factors in caring for the sick and dying also can cause distress to health care providers. Physicians work long, hard hours and listen to many stories of distress and suffering from patients. Some of this is internalized and processed as one's own suffering. Clinicians also have enormous amounts of information to absorb and assimilate, keep long hours, and are often sleep deprived, all of which may harm their well-being. In addition, clinicians may have work/life imbalances, be hesitant to reveal their weaknesses, and have perfectionist personalities. Still other factors may also be involved, such as a hostile environment in which managers can overuse their power; racism that can limit opportunities for advancement; and/or a family-unfriendly environment.

Just as the treatment of cancer depends on good surgery, radiation and/or chemotherapy *as well as* reducing underlying predisposing cause (ie, smoking, drinking, obesity, antiviral therapy) and leading a healthy lifestyle, so too treatment of clinical distress needs a multipronged approach. Fixing the business framework is an important step forward but may not always be enough. We agree with the authors' suggestions for improvement: bringing administrators and clinicians into conversation with each other, making clinician satisfaction a financial priority, assuring that physician leaders have cell phone numbers of their legislators, and reestablishing a sense of community among clinicians. However, none of these goals will be easy to accomplish and some may be impossible to realize in some settings.

A necessary corollary to the suggestions by Dean and colleagues is research. Much research is needed to discover all of the factors of clinician distress, whatever we name the problem. We need to know vulnerabilities of different populations of clinicians and differences in prevalence in different types of health care systems.

It is likely that physicians in a government-owned health care system, such as the US Department of Veterans Affairs (VA) hospitals, have lower distress since there are no corporate interests or profit motives. In our experience, we have noted that many VA providers are expatriates of private health care systems due to their moral distress. If profit making and corporatization are important factors in distress, then clinicians in the VA system should have much lower distress; however, this is not known.

We also need research in pilot projects that relieve clinician distress. These could relate to collegial activities to bring physicians—and administrators—together in community, allowing more time with patients than the usual 15-minute allotments, allowing more time for creative, narrative experiences in medicine, developing forums for discussion and resolution of distress-inducing situations, etc.

An important yet overlooked issue in this discussion is that clinician distress, regardless of its name or cause, is a public health crisis. Clinician distress not only affects the clinician most directly and most crucially, but also affects every person in his/her community. Physicians who are distressed for whatever reason deliver less adequate care, make more medical errors, and are less invested in their patients. Patients of distressed clinicians have less favorable outcomes and suffer more. Medical errors are now the third leading cause of death in the US. Much of this is due to inadequate care by focusing attention on profit-making over health improvement and to clinician distress. Clinician distress due to moral injury or any other factor is a public health crisis and needs much more attention, research, and prioritization of clinician satisfaction.

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To the Editor: The September 2019 editorial "Reframing clinician distress: moral injury not burnout" argues for a renaming of what has been called *burnout* to *moral injury*.[1] The article by Dean, Talbot, and Dean compares the experience of health care providers to soldiers and other service members who have served in combat and suffer as a result of their experiences. I would like to comment on 2 areas: Whether the term *burnout* should be replaced with *moral injury*; and the adequacy of the recommendations made by Dean, Talbot, and Dean.

Briefly, my own credentials to opine on the topic include being both a physician and a soldier. I served in the US Army as a psychiatrist from 1986 to 2010 and deployed to various hazardous locations, including South Korea, Somalia, Iraq, and Guantanamo Bay, Cuba. Since my retirement from the Army I have worked as a psychiatrist on different front lines, with both veterans and the chronically mentally ill and often homeless population.

Moral injury is a term that was popularized by Johnathan Shay after the Vietnam War, especially in his masterful book *Achilles in Vietnam*.[1] Most authors who have written on the subject of moral injury, including myself, think of it as feelings of guilt and shame related to (1) killing civilians (especially children or innocents); (2) surviving while other comrades did not; and/or (3) feeling betrayed by the government they served.[2,3]

While also arising in combat settings, moral injury is related but separate from posttraumatic stress disorder (PTSD). It comes from an affront to our morals rather than our physical well-being. It is not considered a medical diagnosis, treatments are experimental, and the literature is anecdotal.

I have mixed feelings about equating the moral injury from combat to working as a physician or other health care provider. On the one hand, certainly health care providers may sacrifice health and safety to taking care of patients. They may feel guilty when they cannot do enough for their patients. But does it rise to the same level as actually combat and having numerous comrades killed or maimed?

On the other hand, working on an inpatient psychiatry ward with an inner-city population who generally have severe mental illness and are often on phencyclidine and related drugs, has its own share of risks. Unfortunately, physical attacks on staff are way too common.

The term *burnout* also has a robust background of research into both causes and possible solutions. Indeed, there was even a journal devoted to it: *Burnout Research*.[4] Moral injury research is on different populations, and generally the remedies are focused more on spiritual and existential support.

Which brings me to the recommendations and solutions part of the editorial. I agree that yoga and meditation, while beneficial, do not curb the feelings of frustration and betrayal that often arise when you cannot treat patients the way you feel they deserve. The recommendations listed in the editorial are a start, but much more should be done.

Now comes the hard part. Specifically, what more should be done? All the easy solutions have already been tried. Ones that would really make a difference, such as making an electronic health record that allows you to still look at and connect to the patient, seem to elude us. Many of us in the health care industry would love to have a single payer system across the board, to avoid all the inequities cited in the article. But health care, like climate change, is mired in our political deadlocks.

Therefore, I will finish by focusing on one of their recommendations, which is achievable: tie the incentives for the executive leadership to the satisfaction of health care providers, as is done for patient satisfaction. That is both doable and will benefit various institutions in the long run. Health care providers will be more likely to stay in a health care system and thus patient satisfaction improves. Win-win.

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Response: We appreciate the very thoughtful and thorough responses of Mehta. Mehta, Padgett, Ascensao, and Ritchie. Common themes in the responses were the suggestion that supplanting the term *burnout* with *moral injury* may not be appropriate and that changing the underlying drivers of distress requires a multifaceted approach, which is likely to require prolonged effort. We agree with both of these themes, believing the concept of moral injury and mitigation strategies do not benefit from reductionism.

Burnout is a nonspecific symptom constellation of emotional exhaustion, depersonalization, and a lack of a sense of accomplishment.[1] Because it is nonspecific, the symptoms can arise from any number of situations, not only moral injury. However, from our conversations over the past 15 months, moral injury fuels a large percentage of burnout in health care. In a recent informal survey conducted at the ORExcellence meeting, almost all respondents believed they were experiencing moral injury rather than burnout when both terms were explained. When clinicians are physically and emotionally exhausted with battling a broken system in their efforts to provide good care—when they have incurred innumerable moral insults, amassing to a moral injury—many give up. This is the end stage of moral injury, or burnout.

We absolutely agree research is necessary to validate this concept, which has been applied only to health care since July 2018. We are pursuing various avenues of inquiry and are validating a new assessment tool. But we do not believe that intervention must wait until there are data to support what resonates so profoundly with so many and, as we have heard dozens of times, "finally gives language to my experience."

Finally, we would not suggest that civilian physician experience is equivalent to combat experience. But just as there are multiple etiologies for posttraumatic stress disorder (PTSD), such as combat exposure, physical abuse, sexual assault, there are likely multiple ways one can incur moral injury. Witnessing or participating in a situation that transgresses deeply held moral beliefs is the prerequisite for moral injury rather than physical danger. In different contexts, physicians and service members may ultimately face similar accumulated risk to their moral integrity, though of widely disparate intensity, frequency, and duration. Physicians face low-intensity, high-frequency threats over years; service members more often face high-intensity, less frequent threats during time-limited deployments. Just because moral injury was first applied to combat veterans—as was PTSD—does not mean we should limit the use of a powerfully resonant concept to a military population any more than we limited the use of Letterman's ambulances or Morel's tourniquets to the battlefield.[2,3]

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