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Commentary

Eliminating burnout and moral injury: Bolder steps required.

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In our article, "10 bold steps to prevent burnout" [1], we promoted using institutional metrics, improving work conditions, fostering career development, and legitimizing self-care. Yet physician burnout rates have climbed inexorably from 27% in 2000 to 43% in 2019 and close to 50% during the pandemic [2]. There is now a rapidly developing focus on moral injury (MI), with trauma from adverse experiences workers feel powerless to stop. Despite all that we know about burnout and MI, the trauma, regrettably, continues.

Why is it so hard to make this epidemic of injury, trauma, and burnout stop?

An improved understanding of MI may inform our collective approach. MI occurs when we "perpetuate, bear witness to or fail to prevent an act that transgresses our deeply held moral beliefs" [3]. While PTSD focuses on threats to mortality, MI invokes threats to our morality. It involves "double binds" where workers find it impossible to do what is ethically required. [4] Power hierarchies perpetuate MI, and MI is inversely related to an organization's ethical climate, and directly related to intent to leave a practice. [5] Examples include providing aggressive care when the outcome feels futile, caring for too many patients, and observing unaddressed inequities based on gender or race.

A brief MI Scale [6] shows a high correlation ($r = 0.57$) with burnout, suggesting MI and burnout are overlapping constructs. Most authors agree that clear terminology is required to avoid placing blame on the suffering individual. A conceptual framework linking work conditions [7] to moral distress [4], moral injury [3] and burnout [2,8] is proposed in Fig. 1.

While leaders suffer burnout and injury, organizations rarely address it. Despite cost effectiveness analyses showing value in burnout reduction [8], organizations have remained slow in efforts to address burnout. Highlighting institutions placing a priority on burnout reduction (e.g. Stanford, NHS Lothian/Scotland, Mayo Clinic and Mount Sinai, NY, USA) can show this work is possible and impactful.

Burnout and injury are terrible outcomes because they represent human suffering that is fully avoidable. (Moral dilemmas are not [4], but MI is.) Burnout is associated with time pressure, lack of control, chaotic environments, inefficient teamwork, and insufficient focus on values [7]. MI results from unresolved adverse circumstances of moral consequence [3]. All of this can be addressed.

With PTSD prevalence running 10−30% [9], clinician mental health needs are high. Our proposals will require leaders to show commitment and devote resources; in return, these actions can reduce trauma and despair among those who devote their lives to caring for others. It is now time to care for them.

(1) Put burnout and MI reduction on organizational dashboards. Develop partnerships between Chief Executive Officers (CEOs) and Chief Wellness Officers (CWOs), making burnout and injury reduction organizational goals. CWOs can inform CEOs of evidence-based strategies for burnout and injury reduction.
(2) Prioritize mental health support for healthcare workers. Implement buddy programs, on-demand psychological support, wellness consultations and real-time burnout monitoring through pulse surveys.
(3) Monitor workload and time pressure for clinicians. Make "invisible work" count. Indirect patient care, mentoring and committee work contribute to heavy workloads; revise work metrics to include all work.
(4) Redesign workflows to reduce inefficiencies. Team-based care is effective in "sharing the care" and reducing burnout.
(5) Develop standardized approaches to reducing MI. Annual engagement surveys can measure exposure to injurious events (such as overly aggressive care and excessive workloads),4 link these to burnout metrics,7 and provide ethical and organizational support to reduce MI exposure.
(6) Re-engineer chaotic environments. Chaos is associated with adverse clinician outcomes7. Assess the physical space for numbers of persons to comfortably work within it, and reduce stress from data entry (e.g. with scribes).
(7) Enhance supportive cultures, focusing on values, quality, equity, and cohesion. Measure and promote supportive organizational cultures to reduce burnout and injury rates toward zero.
(8) Provide flexibility at the beginning and end of day. The bind for parent clinicians is often dropping off children at child care or picking them up at day's end. Attention to beginning- and end-of-day schedule flexibility can reduce stress and show the organization is compassionate.

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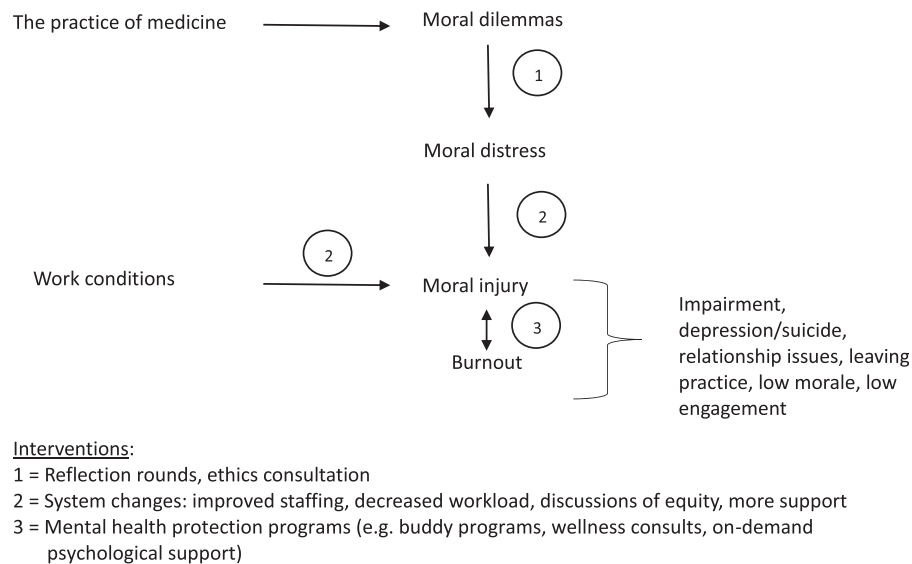E-mail address: mark.linzer@hcmed.org (M. Linzer).

The practice of medicine → Moral dilemmas

Moral dilemmas → (1) → Moral distress

Moral distress → (2) → Moral injury

Work conditions → (2) → Moral injury

Moral injury ↕ (3) Burnout

Moral injury / Burnout } Impairment, depression/suicide, relationship issues, leaving practice, low morale, low engagement

Interventions:
1 = Reflection rounds, ethics consultation
2 = System changes: improved staffing, decreased workload, discussions of equity, more support
3 = Mental health protection programs (e.g. buddy programs, wellness consults, on-demand psychological support)

Fig. 1. Conceptual Model for Moral Injury and Burnout Prevention
Work conditions = time pressure, chaos, work control and aspects of organizational culture (quality emphasis, values alignment, communication, trust and cohesion).

(9) Support the primacy of clinician-patient relationships. Allow sufficient time for interactions during visits to develop trust and promote lasting relationships [10].

(10) Optimize physician trust in the organization. Measure trust and ensure it is developed through creating a learning (continuously improving) health system.

May these proposals help us to invest wisely in our healthcare workforce, and thus our patients, as we create more sustainable health systems for the future.

Declaration of Competing Interest

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