Expanding Moral Injury
Why Resilience Training Won’t Fix It

The summer of 2020 posed some unique and specific challenges when I began residency training in family medicine, from the masks that placed a new barrier between myself and patients, to the surges of COVID-19 infections that overwhelmed my hospital, to the travel limitations that impeded my ability to visit loved ones. I expected to feel overwhelmed by the combination of a rigorous training program and global pandemic. Instead, each day I felt a growing sense of dread about the work that I was being asked to do: Treat COPD (chronic obstructive pulmonary disease) with inhalers and other medications my patients needed but could not afford. Discharge patients to untenable home situations knowing they would be doomed to return in a matter of days. Recommend mental health services while recognizing it would take months for patients to be seen.

Although I was prepared for the inefficiencies and long hours, what overwhelmed me was the experience of working within a system that actively prevented me from providing the care that patients needed. I was not merely revealed and intensified conditions whose inception far predate this moment. Long-standing issues stemming from a culture that prioritizes market values and upholds a White-centered patriarchal power structure have contributed to a system increasingly incapable of providing adequate care for many patients. As a student, I viewed medicine as a vocation, allowing me to engage with people experiencing terrible illnesses: debilitating strokes, metastatic cancers, and life-threatening infections. In these moments, often some of the worst moments in people’s lives, I thought I could provide comfort and healing through a combination of human connection and medical therapies. The reality that has struck me since I began residency is far different. Often our best-case scenario is one of temporary stabilization, without addressing the underlying causes. At worst, we become complicit in causing harm.

Thus, upon entering the workforce as a physician, I find myself with a clear view of the consequences of systems of inequity driven by social hierarchies based on wealth, race, and other demographic distinctions. feeling burned out so much as suffering from moral injury. However, as I explored this experience as a Black American, I found the roots of the problem to be more fundamental to our society than described in many current discussions of moral injury.

The concept of moral injury has been proposed as an alternative framework to the phenomenon of burnout, which was initially conceptualized as an issue of workplace stress experienced by health care professionals who labor for long hours, are beholden to an insurance infrastructure that limits autonomy, and must interact with inefficient and fragmented electronic health record systems that make it harder for them to spend time with patients.1 Moral injury, on the other hand, is the distress incurred when a person is unable to uphold their core values and beliefs. As a physician, I and other health care professionals took an oath to do no harm. The COVID-19 pandemic challenged these vows, forcing many clinicians to provide suboptimal care due to resource limitations, staffing shortages, and restrictions on visitors. However, from my perspective, the pandemic centers on individual rather than community-level interventions, leaving many with mental illness to some combination of homelessness, jail, or early death.

Furthermore, many of the people I care for have been systematically preyed on by hundreds of years of exploitation due to the color of their skin, perpetuating states that foster sickness. I care for people educated in underresourced school systems, who have difficulty reading medication instructions and understanding nutrition labels. I care for people who have direct experience with the prison-industrial complex, who then struggle to reenter society as full citizens. I care for people who live in food swamps, where it is easier to purchase alcohol, cigarettes, and potato chips than fresh produce. I care for people whose communities have been deliberately divested of resources and who cannot afford stable phone plans, let alone housing, while neighbors police departments continue to grow.

These are the inhospitable conditions from which I begin the work of trying to care for people. I then ask patients to engage with me in a health system built on the
use of their bodies to produce the very advancements they are often unable to access. When they can participate, the same system drives me to see them as quickly as possible, rewards me for prescribing medications rather than educating, and values the physical procedures I perform more than the authenticity, vulnerability, and skillful communication required to engage in conversations about lifestyle, where the roots of many chronic illnesses are found.

Thus, upon entering the workforce as a physician, I find myself with a clear view of the consequences of systems of inequity driven by social hierarchies based on wealth, race, and other demographic distinctions. It is these antecedent conditions that, unacknowledged and unaddressed, create the fertile ground in which moral injury blossoms. Individuals like me enter the medical profession with a desire to heal, only to grapple with a society that actively undermines patients' health.

In attempting to ameliorate moral injury to enable the true work of healing, resilience training, wellness lectures, and other workplace interventions are but Band-Aids on a much deeper wound. I don’t have a 3-point action plan to solve this problem. I am tired. For those who are experiencing a similar weariness after working under the duress of moral injury, creating opportunities for rest, finding refuge in others who share your experience, and allowing yourself to recover are radical actions. Organizations can certainly work to support rest, refuge, and recovery. Particularly for racial and ethnic minority groups within the medical system, our presence alone is a revolutionary act as we navigate spaces that were never intended for us, and bear witness to suffering that often affects those who look most like us.

Rhonda Magee, a professor of law whose work integrates mindfulness with social change, defines justice as “love in action for the alleviation of suffering.” 3 In order to truly alleviate suffering, we must understand the roots of moral injury in our society and acknowledge the ways we propagate and shape that society with our individual thoughts and actions. Only by directly engaging with the manifestations of these forces in our lives can we hope to heal ourselves and those that seek our care.

Conflict of Interest Disclosures: None reported.
Additional Contributions: I thank Patricia Luck, MBChB, Taiwo Alonge, MD, and the members of the Highland Family Medicine writing seminar for their editorial feedback. They were not compensated for their contributions.