Preventing Moral Injury in Medicine

Student Physician Stories of Moral Distress, Alienation, and Moral Imagination

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Katharine R. Meacham

Abstract

"Physicians aren't burning out; they are experiencing moral injury" (Talbot and Dean). That claim has struck a nerve among physicians. Moral injury occurs when people lose a sense of integrity—when what Buddhists call "right livelihood" is impossible, given the contradictions between their core values and identity and what they find themselves doing daily and in a system that ignores that lived experience. Moral injury results from traumatic ruptures between what people do and who they are. Physicians are re-naming as "moral injury" some manifestations of the dis-ease that has been called "burnout," and medical students, residents, and medical educators are exploring ways to prevent it. This paper explores the various conceptualizations of the dis-ease being experienced by physicians today through the lenses of both Marx's theory of alienation and through creative medical educators and students, who practice narrative medicine and point toward healing ways of acknowledging the suffering while living in creative tension with the potential dis-ease that faces those who, as Camus says in *The Plague*, "despite their personal afflictions...while unable to be saints but refusing to bow down to pestilences, strive their utmost to be healers" (287).

"Physicians aren't burning out; they are experiencing moral injury."[1] That claim has struck a nerve among physicians, who have one of the highest suicide rates of any profession.[2] Moral injury (MI) is a term first raised in connection with combat veterans, which has been expanded to other fields more recently.[3] Building on the work of Jonathan Shay and other trauma researchers, Dean and Talbot define it as the outcome of events that transgress or betray deeply held morals. When many physicians read that claim in a June 2018 *STAT* publication by physicians Wendy Dean and Simon Talbot, they responded with relief that there was a term they felt was appropriate for the widespread experience of so many.[4]

In this article, I assess the relationship among the following phenomena: *moral sensitivity, moral distress*, *burnout*, and *moral injury*. Some of these phenomena indicate individual ethical concerns, but I also discuss a systemic dimension. The work of the nineteenth-century philosopher Karl Marx provides a lens for looking at these experiences of moral distress, burnout, and moral injury. Paired with writings from contemporary medical students, Marx's analysis offers hope for preventing the worst of these phenomena—moral injury.

Physicians in practice and in training, say Dean and Talbot, appreciate the term "moral injury" rather than the more common term "burnout" because of the significance of the ethical insult, the systemic nature of the various causes, and the threat to integrity.[5] Burnout—goes the argument—implies that "if you do enough yoga, eat salmon salads, and get more exercise," you'll be more resilient.[6] Moral injury is caused by "Potentially Morally Injurious Events" (PMIEs) that "transgress deeply held moral beliefs

1. Simon Talbot and Wendy Dean, "Physicians Aren't 'Burning Out.' They Are Experiencing Moral Injury," *STAT*, July 26, 2018, https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/.
2. Pauline Anderson, "Physicians Experience Highest Suicide Rate of Any Profession," *Medscape*, May 10, 2018, https://www.medscape.com/viewarticle/896257.
3. Brett Litz and Patricia Kerig, "Introduction to Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications," *Journal of Traumatic Stress*, 32, no. 3 (2019): 341–49, https://doi.org/10.1002/jts.22405.
4. Melissa Bailey, "Beyond Burnout: Docs Decry 'Moral Injury' from Financial Pressures of Healthcare," *Fierce Healthcare*, February 5, 2020, https://www.fiercehealthcare.com/practices/beyond-burnout-docs-decry-moral-injury-from-financial-pressures-healthcare.
5. Wendy Dean, "The Real Epidemic: Not Burnout But 'Moral Injury' of Doctors Unable to Do Right by Patients," *WBUR*, January 24, 2020, https://www.wbur.org/commonhealth/2020/01/24/moral-injury-american-medicine.
6. Melissa Bailey, "Beyond Burnout: Docs Decry 'Moral Injury' from Financial Pressures of Healthcare," *Fierce Healthcare*, February 5, 2020, https://www.fiercehealthcare.com/practices/beyond-burnout-docs-decry-moral-injury-from-financial-pressures-healthcare.

and expectations."[7] These events may involve physicians participating in them actively, those caught up in a systemic perpetuation of these events, or those bearing witness to them. This article uses evidence from published physician writing and from unpublished manuscripts from third year medical students to describe the symptoms of the dis-ease.[8] Whether or not each person is experiencing PMIE as opposed to other stressors is part of the conversation. Marx's theory of alienation deepens the diagnosis. Creative medical educators and students, practicing narrative medicine, point toward healing responses for living in creative tension with the causes of dis-ease and its outcomes.

1. Etiology: Causes of the Dis-ease and Its Naming

Here is a story from a student after a night in the Emergency Department:

> **Context:** A small child, terrified from a car accident, with head trauma and crushed leg whose parents are in hospitals miles away; a young woman—the same age as the medical student—screaming in pain as broken glass is removed from every part of her body and exposed bone protrudes through her skin; two attempts at resuscitation on other patients, neither of which is successful; conversations with spouses and loved ones; return to the non-acute patients.
>
> *They see I'm flushed and dripping with sweat. After I ask one how he is he reflects . . . back [to] me. "How are you?" "I'm okay," I say calmly with a smile. I was okay. I wouldn't be later. But later is later, now is now. And now demands all of me so I give it.*
>
> *There's finally a pause in all the traumas. I …leave since I'll be getting up for clinic in a few hours. I pack my bag. The last thing I see as I'm walking out the door is the little boy, still lying in the bed, still totally alone.*
>
> *He stays with me even though I couldn't stay with him.*[9]

Consider this narrative as initial evidence that medical students undergo PMIE. The team working on many of these patients is even called "the trauma team." While that is a technical term in medicine, to students fresh to these nights, being "on trauma" is an appropriate term for their own experiences. Experiences like this are visceral, haunting, and become lodged in unresolved and unrelenting memory: "He stays with me even though I couldn't stay with him."

While the term was first used in 1995 with reference to the experiences of combatants and war veterans, MI is being recognized internationally and across many domains.[10] The relatively rapid public and journalistic acceptance of the term MI means that these terms are used in widely varying ways in empirical studies and academic discussion about definitions, distinctions, and nuances across domains and disciplines—especially in the popular, journalistic conversation compared with the research of academic trauma scholars. In medicine, academic research has explored ideas of *burnout*, *moral distress*, and some other terms (e.g., *compassion fatigue*). Most of the conversation in medicine about MI, however, has been in narrative, personal reflection, blogs, interviews, and opinion pieces—some in peer-reviewed journals, but fewer empirical studies in medicine or medical education on MI as an outcome of PMIE.

The narratives in this article indicate dis-ease of various sorts: moral sensitivity, moral distress, and perhaps—the bruises and dis-ease that could become moral injury (PMIE). As Dr. Wendy Dean says, the key issue is the *moral* indignity—experiences that challenge a person's integrity, calling, and meaning. Many of these same students and physicians also have narratives that exhibit moral imagination and

7. Simon Talbot and Wendy Dean, "Physicians Aren't 'Burning Out.' They Are Experiencing Moral Injury," *STAT*, July 26, 2018, https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/.
8. Alternative medicine practitioners have used the term "dis-ease" to highlight the experiences of people who may have diagnosed "diseases." Ira H. Sloan, MD, uses it with our medical students at the UNC School of Medicine Asheville Campus and we find it a very useful distinction.
9. Julia Draper, unpublished. Used with permission.
10. Brett Litz and Patricia Kerig, "Introduction to Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications," *Journal of Traumatic Stress*, 32, no. 3 (2019): 341–49, https://doi.org/10.1002/jts.22405.

hold hope for moral courage.[11] This article is not intended to serve as an empirical study—rather, it points to the importance of addressing the PMIE that medical students experience in significant ways so that they are not driven into despair or into leaving the profession into which they went to help people heal and for which many went into debt both financial and personal. When the outcome is potential moral injury, it is a core challenge to a person's identity and integrity: *What have you destroyed in me? You have destroyed, simply—with all my past life—the idea that I have always had of myself.*[12]

2. Differential Diagnosis of the Dis-ease

In medicine, the process of "distinguishing between two or more conditions which share similar signs or symptoms" is called the *differential diagnosis (Ddx)*.[13] In this article, I use the term Ddx not in its technical sense but as a metaphor to explore the different ways of conceptualizing the moral dis-ease students and physicians are experiencing. The Ddx of medicine's ethical dis-ease includes: *moral injury or moral distress*, at a psychological level, *burnout* and/or *compassion fatigue*,[14] and a more superficial/managerial level: *work-life balance*.[15] Burnout and moral distress are commonly used diagnoses for the dis-ease experienced by physicians and medical students.[16]

2.1. Moral Sensitivity and Moral Distress

Moral sensitivity means—at the most basic level—that a person identifies an ethically challenging situation and can imagine ways of responding. A study of the relationship between moral sensitivity and moral distress defines moral sensitivity as "the ability to identify the existing moral problem and understand the moral consequences of the decisions made on the patient's part . . .. In healthcare, morality is an interrelated and dynamic process that is suggested by moral sensitivity."[17] To be able to see such challenges and respond is essential to being human.

Medical sociologist and ethicist Daniel Chambliss, echoing Socrates, says: "The greatest ethical danger . . . is not that when faced with an important decision one makes the wrong choice, but rather that one never realizes that one is facing a decision at all."[18] Moral sensitivity—seeing ethical issues and feeling some dis-ease—not moral distress, but the moral quickening that occurs when one identifies an ethical challenge—is an indicator that the distressed person's moral intuitions are alive and well. This does *not* mean that *moral uncertainty*—where there may be more than one morally reasonable resolution—is problematic and dangerous for bringing on a kind of moral distress.[19] On the contrary, the kind of ethical

11. Brett Litz and Patricia Kerig, "Introduction to Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications," *Journal of Traumatic Stress*, 32, no. 3 (2019): 341–49, https://doi.org/10.1002/jts.22405, 342. This paper will not explore the conversation about the relationship between MI and Post-Traumatic Stress Disorder (PTSD), but it is important to note that there is an ongoing conversation about that unsettled relationship in the academic research on moral injury.

12. Vincenzo Di Nicola, "Two Trauma Communities: A Philosophical Archaeology of Cultural and Clinical Trauma Theories" in *Trauma and Transcendence: Suffering and the Limits of Theory*, edited by Eric Boynton and Peter Capretto (New York: Fordham UP, 2018), 17–52. Di Nicola is quoting a line from the poet Pier Paolo Pasolini.

13. "Differential Diagnosis," *Lexico* (Oxford UP, 2020), https://www.lexico.com/en/definition/differential_diagnosis.

14. Shane Sinclair et al., "Compassion Fatigue: A Meta-Narrative Review of the Health Care Literature," *International Journal of Nursing Studies* 69 (2017): 9–24, https://doi.org/10.1016/j.ijnurstu.2017.01.003. The conclusion of this study says this: "In the last two decades, compassion fatigue has become a contemporary and iconic euphemism that should be critically reexamined in favour of a new discourse on healthcare provider work-related stress."

15. If the diagnosis were simply work-life balance, then there is a quantitative prescription to fix it: assess priorities; make/negotiate changes at work and at home and test it. Given the evidence of the experience and the research, this is completely inadequate to respond to the seriousness of the symptoms of the dis-ease physicians have.

16. Liselotte N. Dyrbye et al., "Personal Life Events and Medical Student Burnout: A Multicenter Study," *Academic Medicine* 81, no. 4 (2006): 374-84; Colin P. West et al., "Interventions to Prevent and Reduce Physician Burnout: A Systematic Review and Meta-Analysis," *The Lancet* 388 (2016): 2272–81.

17. Nasrin Nejadsarvari et al., "Relationship of Moral Sensitivity and Distress among Physicians," *Trauma Monthly* 20, no. 2 (2015), https://doi.org/10.5812/traumamon.26075.

18. Daniel Chambliss, *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics* (Chicago: Chicago UP, 1996), 59.

19. Carina Fourie, "Who Is Experiencing What Kind of Moral Distress? Distinctions for Moving from a Narrow to a Broad Definition of Moral Distress," *AMA Journal of Ethics* 19, no. 6 (2017): 578–84. https://doi.org/10.1001/journalofethics.2017.19.6.nlit1-1706. Dr. Fourie says that one kind of moral distress can occur from moral uncertainty—a feature of an

wrestling involved in moral uncertainty—aka moral sensitivity—is important: it is a sign of awareness, noticing, being present—with ethical sensibilities engaged. Not even seeing ethical issues is a different—and much bigger—problem. How those moments are named, acknowledged, and addressed may influence whether those moments of moral sensitivity become moral distress, or whether, when identified and addressed collaboratively, these moments can be catalysts for creative change.[20]

Moral distress, on the other hand, can occur when moral sensitivity is ignored, rebuffed, or creative and courageous responses are prevented. Consider the phenomenon of moral distress as a possible symptom of moral injury. Epstein and Hamric make this claim: "A hallmark of moral distress is the presence of constraints, either internal (personal) or external (institutional) that prevent one from taking actions that one perceives to be morally right . . . the result of a perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action."[21] Moral distress was first coined by Andrew Jameton in 1984 to identify the experience of nurses who are prevented by institutional and hierarchical forces from acting ethically.[22] Researchers began seeing that there was evidence of moral distress across disciplines in healthcare, as well as in domains outside of healthcare.

On the other hand, moral distress that is unrelenting can have what Epstein and Hamric call *a crescendo effect*. The research on moral distress tracks two dimensions: initial distress and reactive distress, which is now called *moral residue*.[23] Moral residue refers to what feelings and self-judgments remain after a morally distressing situation's initial appearance or even after its resolution. Moral distress—without identification and intervention—will tend to increase, or crescendo, toward greater moral distress, leaving greater moral residue.[24]

What is not explicitly identified but is a question for future research is whether unaddressed and untreated moral distress with the concomitant crescendo effect, can result in moral injury (MI). While some of the research on MI appears to be discussing specific incidents, many of the physicians using the term MI seem to be responding not to acute incidents but to multi-dimensional systemic issues, which cannot be identified as specific events that occur and then fade. Wendy Dean, MD, puts it this way: "From our conversations over the past year, we have learned that moral injury resonates because it suggests a broadly shared cause for the seemingly solitary experience of burnout. In other words, moral injury lets us understand that we are burned out as *individuals* because each of us is trying, in vain, to compensate for the dysfunctional way health care is structured for *everyone*.[25]

ethically challenging situation. What is unclear from her article as well as from the vast number of articles on promoting resiliency skills for physicians, students, nurses, is whether the resiliency training is aimed at reducing this broader kind of moral distress or whether it is aimed at enabling morally distressed physicians, students, and nurses engage their moral imagination and moral courage to address the morally distressing situation.

20. The author did a study in 2012-13—(poster at the American Society for Bioethics and Humanities and at a conference for the Consortium of Longitudinal Integrated Clerkships)—comparing a group of third year medical students in a longitudinal integrated clerkship (LIC) with a group in a traditional third-year rotation program. The LIC students had an integrated "ethics and humanism" program, whereas the control group had more optional and less regularly scheduled opportunities for ethical reflection. At the end of the year, the LIC students were both more aware of ethical issues than the traditional students, and they also revealed more moral distress. This could indicate that awareness of ethical issues, nurtured by a curriculum, can lead to moral distress that allows students to see the ethical issues—the point this paragraph argues. See also J. D. Lantos, "Moral Distress and Ethical Confrontation: Problem or Progress?" *Journal of Perinatology* 27 (2007): 201–02. Dr. Lantos argues for the importance of moral distress as a stimulant for noticing and addressing moral issues in this 2007 article; Nasrin Nejadsarvari et al., "Relationship of Moral Sensitivity and Distress among Physicians," *Trauma Monthly* 20, no. 2 (2015), https://doi.org/10.5812/traumamon.26075.

21. Elizabeth Epstein and Ann Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *Journal of Clinical Ethics* 20, no. 4 (2009): 332.

22. Ibid.

23. Ibid.

24. Conversations with Mary L. Caldwell, M.A., M.Div., Clinical Ethicist at Mission Hospitals, Asheville, NC, have helped me understand *moral distress* much more deeply, as many of her consults involve addressing moral distress among nurses, physicians, and medical staff. The definition of *moral injury* in healthcare settings has been a growing field of academic study. While some of the researchers on MI, appear to be discussing individuals and discrete events, other researchers are focusing on the systemic causes and systemic effects.

25. Wendy Dean and Simon G. Talbot, "Moral Injury and Burnout in Medicine: A Year of Lessons Learned," *STAT*, July 29, 2019, https://www.statnews.com/2019/07/26/moral-injury-burnout-medicine-lessons-learned/.

Most of the moral distress research on nurses has to do with specific events that have the potential to cause "moral injury." These Potentially Morally Injurious Events (PMIE) are analyzed as acts of commission (acting in morally transgressive ways) or omission (failing to act virtuously).[26] Some of the narratives in this article report events, but some of these PMIE may be more like the tip of the iceberg, revealing the systemic issues in medicine that are more about injustice and a betrayal of the calling into medicine than about individually potentially injurious events that a student or physician experiences. Future research then may explore whether moral distress that crescendos might result not only in moral residue but in moral injury.

2.2. Burnout

Burnout—defined as emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment—has been studied extensively in nurses, physicians, and students, and a commonly proposed remedy includes mindfulness practice and resiliency skill training. [27] If the dis-ease is appropriately called *burnout*, then there is some evidence that such practices can help reduce stress, renew focus, and provide resources for resiliency.[28] The problem with those interventions, however, according to physicians who are in the conversation about "burnout and resiliency" vs. "moral injury," is that calling it "burnout" and recommending that students and physicians need to get more tools to strengthen their resiliency tends to blame the victims: strengthen your resiliency, rather than addressing the systemic ethical issues that are feeding the moral distress and leading toward producing the much more serious dis-ease of moral injury. The conversation among physicians is not univocal: some continue to use *burnout* as the defining term for the dis-ease afflicting so many in medicine.[29] Others—the ones given voice in this article—argue that *burnout* as a metaphor does not address the threat to integrity in the way that *moral injury* does.[30]

Furthermore, using tools such as meditation, yoga, and other wellness initiatives as if they are merely techniques trivializes both the seriousness of the dis-ease of moral distress or moral injury as well as the depth of teaching and wisdom traditions from which yoga, meditation, and mindfulness emerge. While these interventions have proven helpful for individuals in coping with milder forms of burnout, they do not "fix" either severe burnout or moral injury.[31] If dis-ease is systemic, where the students'/physicians' integrity is at stake—then intrapsychic/psychological remedies may serve to pacify the emotional distress of the individual, but do nothing to address either of the threats to moral integrity. The popular conversation in

26. Brett Litz and Patricia Kerig, "Introduction to Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications," *Journal of Traumatic Stress*, 32, no. 3 (2019): 341–49, https://doi.org/10.1002/jts.22405.

27. Colin P. West et al., "Interventions to Prevent and Reduce Physician Burnout: A Systematic Review and Meta-Analysis," *The Lancet* 388 (2016): 2272–81; Camille Adair, "Burnout vs. Moral Injury: Does It Matter What We Call It?" *Kevin MD*, May 14, 2019, https://www.kevinmd.com/blog/2019/05/burnout-vs-moral-injury-does-it-matter-what-we-call-it.html. The same point is made in a podcast entitled "Stop Saying Burnout!" by a physician who calls himself ZDOGG: *Slightly Funnier Than Placebo*.

28. Colin P. West et al., "Interventions to Prevent and Reduce Physician Burnout: A Systematic Review and Meta-Analysis," *The Lancet* 388 (2016): 2272–81.

29. Tim Locke, "Global Physicians' Burnout and Lifestyle Comparisons," *Medscape*, February 14, 2019, https://www.medscape.com/slideshow/2019-global-burnout-comparison-6011180; Liselotte N. Dyrbye et al., "Personal Life Events and Medical Student Burnout: A Multicenter Study," *Academic Medicine* 81, no. 4 (2006): 374-84; Colin P. West et al., "Interventions to Prevent and Reduce Physician Burnout: A Systematic Review and Meta-Analysis," *The Lancet* 388 (2016): 2272–81.

30. Camille Adair, "Burnout vs. Moral Injury: Does It Matter What We Call It?" *Kevin MD*, May 14, 2019, https://www.kevinmd.com/blog/2019/05/burnout-vs-moral-injury-does-it-matter-what-we-call-it.html; Wendy Dean, "The Real Epidemic: Not Burnout But 'Moral Injury' of Doctors Unable to Do Right by Patients," *WBUR*, January 24, 2020, https://www.wbur.org/commonhealth/2020/01/24/moral-injury-american-medicine; Melissa Bailey, "Beyond Burnout: Docs Decry 'Moral Injury' from Financial Pressures of Healthcare," *Fierce Healthcare*, February 5, 2020, https://www.fiercehealthcare.com/practices/beyond-burnout-docs-decry-moral-injury-from-financial-pressures-healthcare.

31. I am indebted to the work of Stephanie Citron, PhD, who founded and consults with Resources for Resilience and Reconnect for Resilience—an Asheville, NC-based training group that has extensive experience working with first-responders—police, people in the criminal justice system, teachers and students, for an understanding of the excellent skills-training that resiliency work can provide. This program is very clear that they are not providing therapy or in-depth psychological healing. Nevertheless, they have evidence that resiliency skills training give people more tools for responding to moral distress and other stressful situations.

publications such as *Kevin, MD* includes claims such as these—by a nurse-physician team, discussing the terms *burnout* vs. *moral injury*:

> The new message—the true message—has little to do with burnout and what we lack. It has to do with the moral injuries we suffer from the slings and arrows we attempt to dodge (not always successfully) in order to care—and advocate—for our patients to the best of our ability. Sadly, some of us are mortally wounded . . . as attested to by statistics gathered of our friends and colleagues who have died, and continue to die, by suicide.

This same nurse-physician team says that calling the dis-ease afflicting physicians by its more appropriate name—*moral injury*—provides hope and encouragement for acting collaboratively with courage, engaging moral imagination, and moving toward systemic change:

> We need to revisit the words, ideas, and high ideals of our patron saints: Sir William Osler and Florence Nightingale. They are as relevant and inspiring today as they were more than a century ago. They can help remind us why we chose our professions. And when we remember. . . the feelings of cynicism, hopelessness, and 'being stuck' (we've experienced for far too long) will be banished. We will rediscover our strength and fortitude that had been shrouded in darkness, under the opaque guise of us not having enough "resilience."
>
> When we begin to come together, learn we have common purpose and common ground, and start cultivating that ground, two things will happen: 1) we will know we are not alone; and, 2) we will become a unified force to be reckoned with. We will be part of a burgeoning cadre of colleagues—scattered near and far—who also believe change is possible and can happen—because we are prepared to make it happen.[32]

2.3. Alienated Labor

One way to imagine the work of medical students and practicing physicians is through a thought experiment, with an unlikely lens: by using the early writings of the nineteenth-century philosopher Karl Marx, who was living in western Europe as the Industrial Revolution was creating wealth for the owners of factories and at the expense of the living and working conditions of the people who worked in the factories. Marx was struck by what happened to the humanity of the workers—as well as the owners—in these factories. The workers were called "hands" because they were valued only for their hands—repetitively doing the same motions all days—thus removing them from even seeing the finished product they were making. This is in contrast to the ancient Greek philosopher, Aristotle, whom Marx studied. Aristotle argued that one crucial aspect of being human was to create things. Marx saw that the factory hands were dehumanized because they were separated from the process of making a product, from the satisfaction of completion, from the reasons for doing it, and even from themselves as creative and creating human beings. He called this kind of factory work "alienated labor."

Imagine alienated labor to be another metaphor through which to examine the kind of moral distress suffered by medical students. Marx identifies four types of alienated labor: the worker is alienated from the product, the process, the work itself, and from both herself and what it means to be human.[33] Using the lens of alienated labor, we can imagine the ways in which PMIE or unaddressed moral distress with its crescendo effect could become moral injury. Below are examples of Marx's four types.

2.3.1. Alienation can occur from the "product"—the healthy patient—to the student's dismay:

> I am . . . afraid that I have lost pieces of myself. I have seen people flayed apart and been exposed to various

32. Camille Adair, "Burnout vs. Moral Injury: Does It Matter What We Call It?" *Kevin MD*, May 14, 2019, https://www.kevinmd.com/blog/2019/05/burnout-vs-moral-injury-does-it-matter-what-we-call-it.html.

33. Karl Marx, *Economic and Philosophical Manuscripts of 1844* (Moscow: Progress Publishers, 1959), https://www.marxists.org/archive/marx/works/download/pdf/Economic-Philosophic-Manuscripts-1844.pdf.

> forms of physical and emotional trauma. . . . I strive to be as empathetic as I can, but I . . . put up barriers for my own sanity. I remember screams of a patient's daughter and wife [in the ED my first time]. I remember not sleeping that night and feeling deeply troubled. . . . A year later I have been on numerous codes many of which resulted in bad outcomes. During these I practiced intubations and interpreting [tests and labs]. I'm afraid that I'm forgetting that these are real people. They are not manikins or paid actors. They are people with a story and loved ones. I am protecting myself but I don't want to. I don't want to become accustomed to other's suffering.[34]

There is an irony in using a Marxist analysis of alienation for what can happen to medical students and physicians—as this student quote exemplifies—is the very mechanistic metaphor of the Marxist model to begin with: alienation—is from "the product." Using Marx's term "product" evokes a mechanistic, dehumanized view of a patient. Marx's categories underscore the factory-like atmosphere that many physicians and trainees find themselves fighting against. When this student practices removing himself from the patient, the first form of alienation—from the "product"—is accomplished.[35]

2.3.2. The second form of alienation—from the process—can occur through increased specialization and through increased separation of the physician from the patient by technology.

There were no specialists in medicine in the United States until the 1930s. By 2015, 67 percent of US physicians were specialists and subspecialists.[36] The electronic medical record (EMR) was designed to promote communication among a team of people caring for a patient, to support the health of the patient, to provide access for the patient to her physician-team. It becomes a billing machine.[37] The EMR Danielle Ofri, MD, a physician at Bellevue Hospital and who teaches at New York University Medical School, says that the EMR "has burrowed its tentacles into every aspect of the healthcare system."[38] She claims:

> Medicine has devolved into a busy-work-laden field that is slowly ceasing to function. Many of my colleagues believe that we've reached the inflection point at which we can no longer adequately care for our patients. The E.M.R. isn't the only culprit, but it's certainly the heavy-hitter.
>
> Medicine traditionally puts the patient first. Now, however, it feels like documentation comes first. What actually transpires with the patient seems like a quaint trifle, something to squeeze in among the primary tasks of getting everything typed into the E.M.R.[39]

An American Medical Association/Dartmouth College School of Medicine study provides this example of how the EMR alienates physicians from patients:

> The EMR [has] turned a document that [transfers] medical information to physicians and nurses into something to justify billing to Medicare and BCBS. It's totally abdicated the responsibility to transfer what you did, what happened to the patient and what you think . . .. [You have to complete their] review of systems . . . you ask [about] cataplexy, they say no, click. I don't even know what cataplexy is, they don't know what cataplexy is.[40]

34. Blaise Ellery, Unpublished essay. Used with permission.
35. Katharine Treadway and Neal Chatterjee, "Into the Water—the Clinical Clerkships," *New England Journal of Medicine* 364, no. 13 (2011): 1190–93; Melanie Neumann et al., "Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents," *Academic Medicine* 86, no. 8 (2011): 996–1009; Robyn A. Latessa et al. "Graduates' Perceptions of Learning Affordances in Longitudinal Integrated Clerkships: A Dual-Institution, Mixed-Methods Study," *Academic Medicine* 92, no. 9 (2017): 1313–19, https://doi.org/10.1097/ACM.0000000000001621.
36. James E. Dalen, et al., "Where Have the Generalists Gone? They Became Specialists, Then Subspecialists," *American Journal of Medicine* 103, no. 7 (2017): 766-68, http://dx.doi.org/10.1016/j.amjmed.2017.01.026.
37. Simon Talbot and Wendy Dean, "Physicians Aren't 'Burning Out.' They Are Experiencing Moral Injury," *STAT*, July 26, 2018, https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/.
38. Danielle Ofri, "The Business of Health Depends on Exploiting Doctors," *New York Times*, June 8, 2019.
39. Danielle Ofri, "The Patients vs. Paperwork Problem for Doctors," *New York Times*, November 14, 2017.
40. Lacey Colligan et al., "Sources of Physician Satisfaction and Dissatisfaction and Review of Administrative Tasks in Ambulatory Practice: A Qualitative Analysis of Physician

Thus, alienation from the process of the physician caring for the patient is accomplished. This category of alienation does not fit neatly into the research on PMIE, as it is a systemic issue—not a discrete, acute event or series of events. The narratives from practicing physicians, however, reflect this kind of alienation and it points to potential moral injury from the accretion of insult after injury to the process of what it means to care for patients as a physician.

2.3.3. The third form of alienation is from the calling into medicine: to help, to heal, and when possible, to cure:

> I wonder if medicine is really any different [from other professions], or if we just tell ourselves it is to try to justify everything that we put ourselves through. . . . Caring about patients may motivate you to work harder at certain aspects of your job . . . but . . . won't even get you the basic respect of your peers in many circles. What will get you [respect] . . . is charting promptly, getting patients discharged . . . feigning impossible levels of enthusiasm for every task you are assigned, and . . . making things easier for your superiors . . . I want sincerity in all my interactions. I want to direct my energy toward meaningful purposes. I want to be in an environment where wanting those things isn't interpreted as a sign of weakness or lack of dedication.[41]

This example indicates moral distress—perhaps not at the level of moral injury, but it reflects an alienation from the profession. Consider the neo-Aristotelian virtue ethics that Alasdair MacIntyre introduced in *After Virtue*: those qualities that make a practice (in this case medicine) fulfilling have to do with the kinds of meaningful purposes that this student seeks in medicine and found lacking in his experience. What contributes to excellence in medicine is promoting health, and that which interferes with that telos/that "end" is unvirtuous/alienated from the excellence in medicine.[42] Again, this is the kind of alienation that does not come from a discrete potentially morally injurious event (PMIE) but from students experiencing less than a year of the difference between what brought them into medicine and the reality of that with which physicians today wrestle.

Another student writes a fifty-five-word story that reflects his rejection of the cynicism he sees a medical professional association supporting:

> **1961:** AMA hires Reagan to fight Medicare by "speaking out against socialized medicine."
>
> **July 2019:** Our class thinks, "How could doctors advocate against their patients' interests?"
>
> **December 2019:** Dark money from physician staffing companies kills surprise out-of-network billing reform. AMA supports "market-based" solutions to protect patients, echoes dark money ads about "insurance company rate setting."[43]

This is a student who usually wrote about the importance of patient connection, of listening, of working toward collaboration with patients and of his hopes for doing medicine in ways that align with his reasons for entering this profession. It can be seen as the third form of alienation—from meaningful work.[44]

Here a physician objects to the professional "standards" that are unrelated to caring for individual patients: "And we were really angry with the medical profession because they kept on saying 'You know, we have to maintain standards,' blah blah blah, but I mean none of them were out there in the places where people needed care. So it was intensely hypocritical, and made me very angry, and still makes me very angry."[45]

When organizational and social structures prevent living out that calling, the results can be

and Staff Interviews," *American Medical Association*, 2016, https://www.ama-assn.org/media/13506/download.
41. Zach Martin, Unpublished essay. Used with permission.
42. Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 3rd ed. (U of Notre Dame P, 2007).
43. Zach Fisher, Unpublished essay. Used with permission.
44. Karl Marx, *Economic and Philosophical Manuscripts of 1844* (Moscow: Progress Publishers, 1959), https://www.marxists.org/archive/marx/works/download/pdf/Economic-Philosophic-Manuscripts-1844.pdf, 28-35.
45. Miles Little et al., "Virtuous Acts as Practical Medical Ethics: An Empirical Study," *Journal of Evaluation in Clinical Practice* 17 (2011): 948–53, http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2753.2011.01730.x/full.

moral distress and potential moral injury that separates the practitioner from the calling into medicine. This systemic issue raises threats to professional identity and integrity.[46]

2.3.4. The final form of alienated labor Marx identifies results in alienation from what it means to be human—from the patient, from one's community, family, and self.

Part of what it means to be human means to be an ethical being. When and if students and physicians become alienated from ethical agency, this leads to a depth of moral distress that is most likely to crescendo into moral injury. When the features of the first three kinds of alienation are compounded, the alienation from the patient, from the process of doing medicine, and from the professional integrity of the calling, there is a depth of injury possible that is difficult to reconcile with what it means to be human.

Danielle Ofri, MD, says, "Grief is an overwhelming emotion for anyone who faces tragedy, so it is surprising how little attention it receives in medicine, where caregivers face death more regularly than in most any other profession."[47] Unfortunately, Ofri observes, grief in medicine is "largely unacknowledged. With no time or space to give grief its due, burnout, callousness, PTSD, and skewed treatment decisions are a risk."[48] This is the level of alienation Marx's stage four is discussing, and it is the lived experience that physicians and medical students must either address or ignore—with dangerous consequences.

Another experienced physician puts it this way:

> As physicians, we are often so rushed and preoccupied that we do not always take the time to grieve. As a profession confronted on a daily basis with anguish, suffering, and pain, we do not often discuss how things, such as a patient's death, affect us. This may be in some way our own intentional attempt to mitigate the loss, which is an inevitable part of our work. Or perhaps, it is part of the medical culture in which we have been trained.[49]

Physicians and students bear witness to and wrestle with tragedy on a daily or weekly basis. Tragedy cannot be "fixed," and education in responding to those moments is found elsewhere—philosophy, literature, religion, art. Physician and medical trainee suicide rates are particularly poignant: between 300-400 physicians every year kill themselves.[50]

A new documentary, entitled *Do No Harm*, focuses on physician suicide; it begins:

> Jumping off hospital rooftops, hanging themselves in janitorial closets, overdosing on drugs—they're A students and their suicides are often like well-planned school projects. Doctors are our healers, yet they have the highest rate of suicide among any profession. Medical students and families of physicians touched by suicide come out of the shadows to expose this silent epidemic and the truth about a sick healthcare system that not only drives our brilliant young doctors to take their own lives but puts patients' lives at risk too.[51]

The tragedy presented by this phenomenon echoes the physician-narrator of Camus's *The Plague*, Dr. Rieux, who says, "What filled his breast was the passionate indignation we feel when confronted by the anguish all men share."[52] At heart, the physician's ultimate challenge is to be to be human in the face of tragedy.[53]

46. Brett Litz and Patricia Kerig, "Introduction to Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications," *Journal of Traumatic Stress*, 32, no. 3 (2019): 341–49, https://doi.org/10.1002/jts.22405.
47. Danielle Ofri, *Intensive Care: A Doctor's Journey* (Boston: Beacon Press, 2013), loc. 1130
48. Danielle Ofri, *What Doctors Feel: how emotions affect the practice of medicine* (Boston: Beacon Press, 2013), 120.
49. Gordon Giddings, "The Ties That Bind: A Reflection on Physician Grief," *Support Care Cancer* 18 (2010): 1356-57, https://doi.org/doi-org.libproxy.lib.unc.edu/10.1007/s00520-010-0949-z.
50. Matt Hoffman and Kevin Kunzmann, "Suffering in Silence: The Scourge of Physician Suicide," *MD Magazine*, February 5, 2018, https://www.mdmag.com/medical-news/suffering-in-silence-the-scourge-of-physician-suicide.
51. Robyn Symon, *Do No Harm: Exposing the Hippocratic Hoax* (Symon Productions, 2020), http://www.donoharm-film.com/.
52. Albert Camus, *The Plague* (Vintage International, 1991), 244.
53. Conversations with Arlene Davis, JD, RN, Clinical Ethicist at Memorial Hospital in Chapel Hill, NC, and faculty in the

Just as a problem exists in not even seeing ethical issues, so it is a problem that some medical researchers and teachers do not see the moral injury caused by the medical system. For example, one of the most widely cited articles on physician burnout uses the following metaphor: "Students must be taught the concept that physicians are themselves therapeutic instruments and as such require calibration."[54] The metaphor of the physician as a therapeutic instrument sadly reinforces medicine as a mechanical, dehumanized practice. It further exacerbates the dis-ease, because it does not address the foundational issues. If the practice of medicine requires being human and confronting the tragic, pretending this is not the case deepens the alienation.

As recently as 2017, but before Drs. Talbot and Dean began advocating for the use of the term MI instead of burnout, Deborah Lathrop identified the major changes in the medical system and the corporatization of medicine as contributing to what Kenneth Doka calls "disenfranchised grief"—"grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported."[55] Dr. Lathrop opens her discussion with a listing of the changes that the practice of medicine has undergone in the past two decades:

- The trend from running a private practice to becoming employees (changes in authority, level of autonomy, role, and responsibilities)
- Implementation of electronic health records
- Trend toward team-based vs. physician-visit–based care and the rise of a midlevel practitioner presence
- Insurance product refinement (pre-authorizations, panel size changes)
- Increasing regulatory and administrative aspects
- Evolving credentialing requirements.[56]

These are precisely the kinds of changes that lead to alienation from the patient, the process, and the profession, and Lathrop's article goes on to identify the grief produced by these systemic changes. While she uses the term "burnout," nevertheless, she sees the outcome being "disenfranchised grief" that leads to physician suicide and loss of meaning. This lends more credence to the call from physicians to identify potentially morally injurious changes in the cultural/organizational/political/technological/economic systems that comprise contemporary medicine. It encourages creative, courageous social and cultural changes in systems that go far deeper than incorporating stress management techniques or encouraging physicians to create more resilience in their lives outside of medicine. How can students and physicians experiencing moral injury live in creative tension with this reality, engage moral imagination, and work with moral courage? There are hints of hope in the narratives created by medical students who are in a creative model of medical education.

Medical students are in a very different position from the nineteenth-century factory workers about whom Marx was writing, and they have the privileges of education and social prestige that medicine brings. With creative and sensitive medical education that helps them identify ethical issues and humanistic encounters, and that encourages them to write, draw, create, act courageously, and imagine different systems, they have opportunities to rewrite their own stories, and to help reconstruct the broken systems in healthcare today.

Department of Social Medicine, UNC School of Medicine Chapel Hill, have helped me think about this category.

54. Liselotte N. Dyrbye et al., "Personal Life Events and Medical Student Burnout: A Multicenter Study," *Academic Medicine* 81, no. 4 (2006): 380; See also, Colin P. West et al., "Interventions to Prevent and Reduce Physician Burnout: A Systematic Review and Meta-Analysis," *The Lancet* 388 (2016): 2272–81; ZDoggMD, "Stop Saying Burnout!"

55. Deborah Lathrop, "Disenfranchised Grief and Physician Burnout," *Annals of Family Medicine* 15, no. 4 (2017): 375, https://doi.org/doi.org/10.1370/afm.2074. Lathrop quotes Kenneth Doka's definition.

56. Deborah Lathrop, "Disenfranchised Grief and Physician Burnout," *Annals of Family Medicine* 15, no. 4 (2017): 375–78, https://doi.org/doi.org/10.1370/afm.2074.

3. Healing Narratives—Perhaps Preventing Moral Injury?

Naming the Trauma, Exploring the Moral Distress, and Engaging Moral Imagination

Creative approaches to medical education are acknowledging the depth of the need to address moral distress so that it does not become moral injury. Educational models such as longitudinal clerkship programs (LIC) create a relational model of education: students stay all year in the same place—with a panel of patients they care for, under preceptors who get to know them, and with a group of peers.[57] Students have safe spaces to write, listen, and share their stories of trauma-primary and secondary, alienation, name their moral injury, as well as experience moments of hope.[58] They observe individual and social ethical issues in medicine. Together, they inspire each other to reimagine stories other than the dominant narratives. It is a way to engage and ignite moral imagination—"the ability to envision a wide range of possibilities for understanding and resolving a particular ethical challenge."[59] This mutual listening and storytelling is an incubator for healing medicine.

Researchers who work on moral injury experienced by combat veterans emphasize that narrative has the potential to address moral injury—if and only if there is a "trustworthy community of listeners."[60] This mutual storytelling occurs in a LIC Ethics and Humanism program on one campus.[61] For example:

Witness[62]

A man struck by an aberrant car.

Brain swelling beyond return to his previous life.

100 people in support waiting outside the ICU doors.

I sob after I leave.

Months later,

I meet

The woman who hit him

Alone, crushed, traumatized

Her mind broken.

Both lives destroyed by an inattentive moment.

I am a witness.

As this fifty-five-word story indicates, medical students have at least cameo performances in tragic plays, vignettes, and epics in which their patients are main characters. Tragedy—experienced alone—alienates. Tragedy—shared through theater, music, art, literature, poetry, and/or story—reminds people that we are not alone—and that we are human beings living in a world with aching tragedy and with love.

Student writing like this can address the moral injury of witnessing tragedy. It uses the two features of Aristotle's definition of literary tragedy: *peripeteia* (sudden reversal) and *catharsis* (recognition). In this particular fifty-five-word story, the perspectives of each of the three characters named—the patient, the driver, and the medical student—are crafted so that the sudden reversal of fortune—the peripeteia—is three-way. The limitations of human life, the limitations of medicine: naming these bring a catharsis/recognition for the narrator, who is left with one role—that of a witness.[63] When shared with empathic listeners—other medical students in the same program—the catharsis is shared, and the power of art to provide

57. Robyn A. Latessa et al. "Graduates' Perceptions of Learning Affordances in Longitudinal Integrated Clerkships: A Dual-Institution, Mixed-Methods Study," *Academic Medicine* 92, no. 9 (2017): 1313–19, https://doi.org/10.1097/ACM.0000000000001621.

58. Martha Montello, "Narrative Ethics," *Narrative Ethics: The Role of Stories in Bioethics*, special issue, *Hastings Center Report* 44, no. (2014): 10. Montello's narrative ethics provides theoretical grounding for the Ethics and Humanism program at the UNC School of Medicine Asheville Campus. Moral imagination is practiced with the students, along with narrative competence and listening for/creating "mattering maps."

59. Mark Johnson, *Moral Imagination: Implications of Cognitive Science for Ethics* (Chicago: The U of Chicago P, 1993), 209.

60. Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Scribner, 1994), 188-93. Those traits include: "listeners strong enough to hear the story without injury," not denying the narrator's experience, willingness to experience the emotions the narrator conveys (188-189).

61. UNC School of Medicine Asheville Campus Ethics and Humanism Program

62. Katie Jordan, MD, Unpublished writing. Used with permission.

63. Colleen T. Fogarty, "Fifty Five Word Stories: 'Small Jewels' for Personal Reflection and Teaching," *Family Medicine* 42, no. 6 (2010): 400–02.

community is made real. Camus's narrator, Dr. Rieux, captures this tragedy and moral imperative: "To be an honest witness . . .. In a world where sorrow is so often lonely . . . it was up to him to speak for all."[64]

Here is a revisionist medical presentation of a "patient" (the student's grandmother), written by a student in a LIC, shared with a group of her peers:

> **Ida is a 90-year-old female with history of** (*cooking for family and friends*) **diabetes,** (*growing up smoking, later quitting*) **NSTEMI,** (*multiple bridge trophies*) **osteoporosis**, (*loss of her husband, friends and home country; continued strong will to survive*) **depression, and** (*violent loss of friends before their time and her home to religious persecution in Baghdad*) **anxiety.**[65]

This student's fifty-five-word story gives the patient a voice, and thus contrasts the richness of the patient's life with the depersonalized presentation the student had been taught. It contrasts the life of both the diseased person (e.g., the grandmother) and of the dis-eased practitioner (e.g., the medical student) with the deeper realities of the two characters. When shared with a "trustworthy community of listeners," there are healing possibilities.[66]

Greeshma Somashekar imagines systemic change, instead of being locked into fifteen-minute timeslots, fee-for-service, EMR-guided billing, and fragmented treatment for partial parts of a person; instead of centers for the health of communities and individuals who live in them:

> Is it too much to ask to create trauma-informed health care within a system that does not create additional secondary trauma—and treat individual patients as people not just problems to be fixed—and at the same time—address structural causes of dis-ease? . . . I have this dream of an alternate reality where we practice in clinics embedded in community centers with old people and tiny people keeping each other company and a grocery store that accepts food stamps and an open door policy and therapists of all kinds and needle exchange programs and rehab and afterschool tutoring and a library and vocational coursework. . . . I want to create environments where medical care is not necessarily the focus, but just one of many available resources on the journey to health.[67]

Rather than seeing this as utopian, this student is taking time to get an MBA on her way to completing her MD, so that she can, with a community of colleagues, live out this dream.

Leeallie Pearl Carter learns from the elders and she sees these opportunities:

> The life giving moments. . . . Reminding a thirty-two year old mother of three who had never had a vaginally penetrative experience that was not painful that she was not, her body was not, an object for the sexual gratification of others.
>
> To hand a patient something tangible; To help mothers hold the world together; To remind women and femmes that our existence is vital: our pain matters, our fears matter, our trauma matters, our hopes matter, our health matters.
>
> Medicine is an incredible opportunity to join with another person in their life journey. It offers the chance to support someone as they do their own healing work to make an offering of love.[68]

64. Albert Camus, *The Plague* (Vintage International, 1991), 302.
65. Unpublished manuscript. Used with permission.
66. Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Scribner, 1994). Shay argues that the most important way that healing from moral injury happens is in a community of peers. This is precisely the setting in which the longitudinal integrated clerkship's Ethics and Humanism curriculum happens over the course of a full year.
67. Greeshma Somashekar, unpublished essay. Used with permission.
68. Leeallie Pearl Carter, used with permission. Some medical schools with longitudinal integrated clerkships are listening to the *healers* in First Nations and Native American tribal groups as well as among aboriginal peoples in Australia and New Zealand. Patients in those places do not need to choose between the traditions and stories of their people and the ways that western medicine can diagnose, predict, and prescribe. Physicians who come from those communities do not have to reject their tribal wisdom and stories. This student spent much of the year in the Cherokee community in western North Carolina.

She practices the wisdom of looking seven generations back and looking forward to reimagining medicine that could honor and not appropriate the wisdom of Native elders—while connecting with patients caught between worlds.

Medical education that reconnects the mystery and the meaning of what it means to be alive provides hope for the next generation of physicians. It faces the abyss of trauma—secondary and primary, names moral injury, and encourages moral imagination. Camus's physician-narrator in *The Plague*, Dr. Rieux, captures the creative tension required for this calling: "He knew that the tale he had to tell . . . could be only the record of what had to be done, and . . . would have to be done again in the never ending fight against terror and its relentless onslaughts, despite their personal afflictions, by all who, while unable to be saints but refusing to bow down to pestilences, strive their utmost to be healers."[69]

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69. Albert Camus, *The Plague* (Vintage International, 1991), 308.

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Contributor Information

Katharine R. Meacham, Ph.D., Ed.M., is Course Codirector of the Ethics and Humanism Curriculum, University of North Carolina School of Medicine Asheville Campus; Adjunct Professor, University of North Carolina School of Medicine, Department of Social Medicine, Chapel Hill, N.C.; Professor Emerita of Philosophy and Religion, Mars Hill University, Mars Hill, N.C. She is the grandmother of four girls, the daughter of a woman who was not allowed to enter medical school in the 1940s because the dean of admissions—her father—rejected her because she was a "girl," the mother of two creative daughters, and the spouse of a justice-minded, open-hearted man.

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