Moral Distress, Mattering, and Secondary Traumatic Stress in Provider Burnout: A Call for Moral Community

Elizabeth G. Epstein, PhD, RN
Julie Haizlip, MD, MAPP
Joan Liaschenko, PhD, RN
David Zhao
Rachel Bennett, MSN, RN
Mary Faith Marshall, PhD

ABSTRACT

Burnout incurs significant costs to health care organizations and professionals. Mattering, moral distress, and secondary traumatic stress are personal experiences linked to burnout and are byproducts of the organizations in which we work. This article conceptualizes health care organizations as moral communities—groups of people united by a common moral purpose to promote the well-being of others. We argue that health care organizations have a fundamental obligation to mitigate and prevent the costs of caring (eg, moral distress, secondary traumatic stress) and to foster a sense of mattering. Well-functioning moral communities have strong support systems, inclusivity, fairness, open communication, and collaboration and are able to protect their members. In this article, we address mattering, moral distress, and secondary traumatic stress as they relate to burnout. We conclude that leaders of moral communities are responsible for implementing systemic changes that foster mattering among its members and attend to the problems that cause moral distress and burnout. Key words: burnout, mattering, moral community, moral distress, secondary traumatic stress
depression and suicidality among health care professionals.” However, the Academy presented their catalog of concerns in this order: quality and safety, patient satisfaction, turnover and reduction of work effort, and health care costs. Personal costs, including the emotional costs of caring, were last in this litany. The references for the personal costs section pertained only to physicians and medical students, although nurses experience similar rates of burnout. We believe that, hierarchically, personal costs should be the primary concern in addressing burnout among all clinicians and in eliminating its root causes, not least because to do so is humane. Indeed, Maslach et al. defined burnout as a syndrome of emotional exhaustion, depersonalization, and diminished personal achievement, not as a problem of quality, safety, or satisfaction. When clinicians’ professional integrity is violated, they cannot be physically and psychologically sound or give their best in caring for others.

The 2019 National Academies of Sciences, Engineering, and Medicine (NASEM) report and the joint Critical Care Societies Collaborative were comprehensive in their calls to action. The NASEM’s most important recommendations exhort health care organizations to honor their responsibilities to foster clinician and learner well-being. At the local level, this can only be achieved by reconceptualizing and reshaping the work environment and reducing administrative burden. At the national level, the NASEM rightly calls for policy initiatives to reduce stigma associated with burnout and address and reframe the application (and perhaps the goals) of electronic medical record systems and other technologies that impede the abilities of clinicians to deliver the best health care. The Critical Care Societies Collaborative challenged leaders based in the intensive care unit (ICU) and hospital administrators to mitigate and rectify risk factors for and known causes of burnout such as “workload, lack of control over work environment, insufficient rewards, and a general breakdown in the work community.” We admire the scope of this vision in assessing the burnout landscape and the breadth of the call to action, but we do take issue, however, with their retrograde claim that “In contrast to nurses, physicians may less frequently experience moral distress, most likely because physicians are responsible for making the patient care decisions.” The NASEM and Critical Care Societies Collaborative understand that although the costs of caring are borne by individual providers, organizations are responsible for mitigating and preventing these costs. The 2 groups exhorted funding agencies, professional societies, patient advocacy groups, and policy makers to assume collective responsibility for creating healthy ICU work environments. Recognizing every health care organization as a moral community with inherent and fundamental obligations to each of its members is the starting point for meaningful change.

Moral communities are groups of people bound together for a common moral purpose that transcends personal interests and promotes the well-being of others. Physician Edmund Pellegrino and nurse Mila Aroskar first voiced the case for the role of individual clinicians as members of moral communities. Austin went further, asserting that health care environments are moral communities because they facilitate interdisciplinary collaboration and bear responsibility for creating environments that support healthy debate and genuine dialogue for the purpose of ensuring high-quality patient care. In their study of oncology providers and administrators, Pavlish et al. found that the characteristics of a moral community include open, respectful team relationships; timely communication; accessible and ethics-minded leadership; and access to ethics resources. Moral communities are not limited to teams or even to the bedside; the health care facility, in toto, is a moral community.

Liaschenko and Peter suggest that the most important ethical issue of the 21st century is the relationship between moral agents and the institutions in which they are embedded. If health care organizations are moral communities, how well they function depends on how seriously their leadership and staff take their responsibilities as members. We believe moral communities that attend to their roles in the costs of caring are able to limit damage and repair fractured relationships at the interpersonal and interprofessional levels.

In this article, we differentiate among matters, moral distress, and secondary traumatic stress (STS) as they relate to burnout syndrome. This discussion is grounded in the context of moral community and moral injury, recognizing that although mattering, moral distress, STS, and burnout are personal experiences, they are also the byproducts of, and are
imposed by the systems in which we work. We conclude that organizational leaders, as agents in moral communities, are ultimately responsible for engendering mattering and addressing the problems that cause moral distress and burnout.

Mattering

Michael is a nurse in the pediatric ICU. He worked the night shift caring for S.L., an 11-month-old infant who had a complex repair of a congenital heart defect. Unexpected complications resulted in prolonged cardiopulmonary bypass in the operating room and a tenuous, low cardiac output state with associated dysrhythmias overnight. Michael and the on-call physician were troubled by the child’s deterioration and felt their experiences with S.L. over the past several hours would be valuable for the daytime team as they created their daily plans. Michael waited beyond the end of his shift to participate in bedside rounds and share that information with team. Shortly before the team arrived at S.L.’s bedside, her parents called and asked to speak with Michael. He went to the nurse’s station to take the call. When the interdisciplinary rounding team arrived, the daytime bedside nurse made the team aware that Michael had been waiting to contribute to the discussion. The team needed to be efficient (the surgeon had already been called to come to the operating room for today’s patient and the cardiologist was due in clinic), and they did not know how long Michael would be on the phone. Should the team wait for him to return or proceed with rounds because they are time pressured, the daytime nurse is present, and Michael is not currently available? He could always join in if he gets back in time.

In this situation, the choice to deliberately include or exclude Michael affects far more than the team’s efficiency. It conveys the message of whether or not Michael matters to the team. Simply put, mattering is about “adding value and being valued.” Do Michael’s expertise and contributions add value to this patient’s care, and does Michael feel valued as a member of the team? Research in other fields indicates that a clinician’s sense of mattering can positively contribute to job satisfaction and resilience. Conversely, not mattering may contribute to burnout.

Mattering was first described by Rosenberg as the perception that one makes a difference in the lives of others and is somehow significant in the world. It is a subjective yet tangible manifestation of the fundamental human needs of self-determination, self-efficacy, and belonging. Social psychologists have demonstrated positive relationships between mattering and psychological well-being; there are negative ramifications when people feel they do not matter.

Investigators have begun to explore the importance of mattering at work. Given that making a difference in the lives of others is integral to the professional identities of health care providers, a sense of professional mattering may be of particular significance. For some, mattering may be intrinsic. However, in a recent study, Haizlip et al demonstrated that many health care providers require external validation. Such validation can come from casual expressions of gratitude, recognition of professional excellence by peers or the organization, or an act that demonstrates that others care. Simple things are often the most influential in conferring mattering. When assurances are absent, we are vulnerable to feelings of isolation, devaluation, and disengagement. Haizlip et al postulated that a sense of mattering may buffer the daily stressors of health care providers and potentially diminish the incidence of burnout; their data support that hypothesis. In survey data from more than 500 nurses, physicians, social workers, and therapists, a significant negative correlation was demonstrated between mattering and burnout ($r = -0.51; P < .01$).

Considering the real and perceived hierarchies in health care teams and the pace at which work must be accomplished, it is understandable that people may feel that they do not matter. Interpersonal relationships diminish as patient loads increase, electronic health records stymie attention to care, and institutions function at maximum capacity. Time to get to know one’s patient and to converse with colleagues disappears. Our communications are increasingly electronic and impersonal. Opportunities to know one another, support one another in difficult circumstances, and understand each other’s perspectives are vanishing. Systems frustrate our abilities to know we are adding value and being valued. It is increasingly difficult in health care systems to know that one matters; yet, current research indicates it is important that each of us perceives
we add value and are valued not only by our patients but by our peers, interprofessional team members, and the organization or system.14

Moral Distress

Dana is a nurse in the medical ICU. Her patient, Mr B., a 68-year-old man with a long history of heart failure and renal disease, was admitted 2 weeks ago with pulmonary edema. He is intubated, receiving multiple medications to support his blood pressure and heart function, and lacks decisional capacity. In addition, he has developed calciphylaxis and has inadequate perfusion to his feet. Mr B’s pain is poorly controlled because of his tenuous heart condition. Tears fall from his eyes as he writhes in pain with any position changes or procedures. At a recent family meeting, the attending physician tells the patient’s son, Mr B’s only living relative, that his father’s condition is grave and recovery is unlikely. Mr B.’s son is not sure what his father would have wanted in this situation; thus, he feels he must continue to request aggressive treatment to give his father a chance to recover. Dana, several other nurses, the respiratory therapist, and the resident feel helpless in the face of Mr B.’s suffering. After 10 years of nursing practice in the medical ICU, Dana wonders whether Mr B. will be the patient who breaks her will to keep practicing.

Moral distress occurs when clinicians are constrained from taking what they believe to be ethically appropriate actions or are forced to take actions they believe are ethically inappropriate.21-23 As a result, they feel complicit in acting unethically and are unable to fulfill important professional obligations.23 In the scenario of Mr B., Dana and her colleagues are unable to meet their professional obligation to minimize unnecessary suffering. Although the health care team is confident Mr B. will not survive this hospitalization, they may not have adequately conveyed this to his son. Another professional obligation—truth telling—is likely not being met.

Moral distress involves providers and organizations in 2 ways. First, being morally distressed is a personal experience, whereas the causes of moral distress originate from the system (eg, poor team communication, lack of administrative support, powerful hierarchies that impede collaborative practice). Second, repeated experiences of moral distress can lead to professional burnout and intention to leave, affecting the individual health care provider and the organization. The heart of the matter is that what is right for a patient is not being done. Moral injury occurs when clinicians must carry out a wrong action because a system dictates it. The system is thus responsible for righting the wrong and for preventing moral injury.

Moral distress occurs in various professions (eg, nursing, medicine, respiratory therapy, social work, pharmacy)24-29 and settings (eg, intensive care,26-30 oncology and bone marrow transplantation,27,39 pediatrics,33,40,41 home-based palliative care,42 mixed settings).27,29,43 According to findings of most studies on the subject, nurses have higher levels of moral distress than do physicians,27,29,32,34,39 although this is not always the case.35,40 In studies of mixed settings, ICU clinicians tend to have higher levels of moral distress than non-ICU clinicians.27,29,40,43

Measures of Moral Distress

Several instruments have been developed to measure moral distress. Corley’s original 32-item Moral Distress Scale (MDS) was designed to evaluate critical care nurse moral distress in end-of-life situations.44 As research on moral distress has evolved, root causes of moral distress have been identified for non-nurse health care professionals and for health care professionals in non-ICU settings. In 2012, the MDS was revised to capture the root causes of moral distress for a broader array of health care professionals and settings.43 The revised MDS (MDS-R) was initially tested with 206 intensive care nurses and physicians and found to have good reliability (Cronbach α values for the total sample, the subset of nurses, and the subset of physicians were 0.88, 0.89, and 0.67, respectively) and validity via hypothesis testing.43 In later studies with various settings and providers, the MDS-R continued to demonstrate good reliability with Cronbach α greater than 0.75.24,25,29,31,33

The MDS-R was revised again because of an abundance of new evidence of several additional causes of moral distress and was renamed the Measure of Moral Distress for Healthcare Professionals (MMD-HP) to avoid confusion.27 Data from several studies using the MDS-R, a comprehensive literature review, and root of causes identified from moral distress consultations were used
collectively to identify new root causes, remove uncommon or irrelevant root causes, and combine similar root causes. The MMD-HP includes new items that target system-level causes that compromise patient care (eg, excessive documentation, lack of bed capacity, lack of resources). They may capture causes of moral distress experienced by an even wider range of health care professionals. Like the MDS and the MDS-R, the MMD-HP is used to assess both the frequency and level of disturbance of the root causes; it also is used to measure longer-term moral distress. Initial testing with 706 providers from 2 institutions suggested good reliability (Cronbach \( \alpha \) for total sample, nurses, physicians, and other providers were 0.93, 0.93, 0.90, and 0.94, respectively). The instrument behaved as expected (eg, MMD-HP scores were negatively correlated with hospital ethical climate scores, and higher MMD-HP scores were associated with intention to leave), suggesting it is a valid measure of moral distress.27

The Moral Distress Thermometer (MDT) was developed to measure short-term, in-the-moment moral distress.44 Its validity was examined through hypothesis testing; MDT and MDS-R scores were moderately correlated \((r = 0.40; P < .01)\), and MDT scores were lower for those who had never considered leaving a position than for those who had left a position or who had considered leaving but did not \((F_{2,264} = 26.8; P < .001)\) in a sample of 529 adult and pediatric nurses.45 The MDT may be useful as a before-and-after instrument for intervention research, in clinical settings to gauge current levels of moral distress, or in other situations to evaluate day-to-day moral distress. Missing from current measures is a means to evaluate moral residue and its accumulation over time, both of which are critical factors in intention to leave and burnout.

**Moral Distress in Critical Care**

In studies of moral distress among critical care, emergency department, and advanced practice nurses, in addition to mixed critical care professionals, common root causes and links to burnout,36,37 intention to leave,46 job satisfaction,34,35 and value congruence have been identified.41,47 Common causes of moral distress in critical care clinicians include end-of-life issues such as initiating life-sustaining treatment that only prolongs dying and acceding to a family’s wishes for continued aggressive treatment that is not in a patient’s best interest.25-26,31,34,46,48 Other common causes are team-level issues such as undercompetent colleagues, poor communication, and administrative constraints in the interest of reducing costs.23,26,33,34,46,48,49 These causes also occur in noncritical care clinicians and have been identified in studies of mixed settings.24,27,29,38,40,43,50

In mixed-setting studies, understaffing has been found to be more problematic than in studies focusing only on critical care providers.27,29,40 Trautmann et al46 found this in their study of emergency department advanced practice nurses. Several new items in the MMD-HP that address system-level problems such as lack of resources and excessive documentation were ranked among the top causes of moral distress in a study of ICU and non-ICU nurses, physicians, and other health care professionals.27 Understanding about the instrument’s factor structure and its applicability in understudied health care settings and professionals will emerge as more studies are published.

**Moral Distress and Burnout**

The consequences of moral distress affect patients, providers, and organizations. Wiegand and Funk46 found that providers were concerned about the negative effects (eg, prolonged suffering and dying, undignified dying, inappropriate treatment) of morally distressing situations on patients. For nurses and other clinicians, moral distress can lead to distrust, helplessness, and avoidance of patients and can also affect their likelihood of speaking up in the future, especially if speaking up in the past is believed to have failed.36,37 Alternatively, clinicians can feel hypervigilant in morally distressing circumstances, which increases their focus and attention on the situation and may facilitate their ability to advocate for their patients.26

Moral distress is linked to burnout and intention to leave a position. Between 10% and 26% of health care providers—nurses, physicians, and other professionals—are currently considering leaving their position because of moral distress.27,29,34,40,43,46,50 In addition, several studies provide evidence to support a link between moral distress and burnout. Correlations between moral distress and burnout scores typically range from 0.27 \((P = .001)\) to 0.43 \((P < .001)\).33-35,30,51 Although there is
evidence that moral distress is an independent predictor of burnout, much more work is needed in this area to better understand the connection between the concepts.

Moral Distress Interventions

Few studies of interventions to mitigate or address common causes of moral distress have been published. It is possible, however, that efforts centered on building and supporting a strong moral community may be the antidote to moral distress. This could mean identifying common sources of moral distress and addressing them directly by, for example, developing policies to clarify responses to situations of intractable conflict between clinicians and/or families or by creating unit-based procedures for holding regular, interprofessional team meetings and for requisite consensus-based care plans for patients with complex conditions. It could also mean developing interventions to address nascent moral distress through moral distress consultation, ethics-related discussion forums such as Pediatric Ethics and Communication Excellence (PEACE) rounds and unit-based ethics conversations, moral distress mapping, and narrative forums such as “writing wrongs.” Supporting relationships, effectively managing conflict, and ensuring access to such resources as adequate staffing and ethics consultation may go a long way toward preventing situations in which clinicians feel trapped into doing the wrong thing.

Secondary Traumatic Stress and Compassion Fatigue

Mitch has been an acute care pediatric nurse practitioner in the pediatric ICU for 8 years. Over the years, he has witnessed the joy and sadness, hope and angst, suffering and survival of many children and their families. For the past 2 days, Mitch has been managing the care of 3-year-old Meghan, who was found at the bottom of a neighborhood swimming pool by a lifeguard. Meghan’s mother is devastated and inconsolable. She was at the pool with Meghan and her 2 older sisters. After several more days, it is clear that Meghan will not survive. The entire family and many staff are sobbing as Meghan is extubated and dies in her mother’s arms. Mitch remembers the other child, David, who drowned earlier this summer in a nearby lake where the family was enjoying a community picnic. He has flashbacks to that situation—that distraught family, that sweet-faced little boy, who was so precious to his parents, grandparents, and siblings. The sadness weighs heavily on his soul. He asks himself whether he has just witnessed the last death he is capable of witnessing. “I think I’ve reached my limit,” he says quietly to himself.

Conceptual Conundrums

Secondary traumatic stress (STS) describes the psychological experience of caring for traumatized or suffering others, as opposed to the direct experience of trauma or suffering oneself. In health care and other human service work, there is general agreement that STS is work related and a natural consequence of caring for traumatized people. Providers who experience STS can develop STS disorder (STSD), which involves a series of symptoms mirroring those of primary posttraumatic stress disorder, such as intrusive thoughts, avoidance behaviors, and hyperarousal. There is some conceptual ambiguity, however, because STS is closely related to other concepts such as compassion fatigue (CF), vicarious traumatization, and burnout. Here, we discuss STS and CF, their similarities and differences, and their relationship to burnout.

In 1995 Figley defined STS as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress from helping or wanting to help a traumatized or suffering person.” For health care providers, STS typically involves not only knowledge of the event but also active engagement in caring for or treating the person who suffered the event. Less applicable to health care providers is the circumstance in which the traumatized person is (or reminds one of) a significant other. Treating traumatized patients generates predictable emotional responses such as sadness and anger, which can occur with a single exposure. Secondary traumatic stress becomes a disorder when diagnostic criteria—an array of symptoms within the categories of intrusion, arousal, and avoidance—are met (although STSD is not currently included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition). Thus, although STS is an almost expected “cost of caring,” STSD is more serious and disruptive.

Compassion fatigue shares many of the same components of STS, and the 2 terms are often used interchangeably. Figley noted that
because STS is a natural occurrence, it should not be thought of as negative or derogatory. Hence, CF was offered as a more positive, “friendlier” term that emphasizes the centrality of the role of compassion among caregivers and downplays the role of stress or distress.

Although Stamm noted that attempts to draw clear lines between the 2 concepts have been unsuccessful, her proposed Professional Quality of Life (ProQOL) model implies some distinction between the concepts by defining CF as comprising both STS and burnout. In a study of 167 pediatric providers, STS and CF were highly correlated \((r = 0.79; P < .001)\), and 62% of the variance in CF was accounted for by STS. Thus, STS and CF appear to be closely related but are not exactly the same concept. Some authors have suggested that chronic or cumulative exposure to suffering is what distinguishes CF from STS. Peters defines CF among nurses as “a preventable state of holistic exhaustion that manifests in physical decline in energy and endurance, emotional decline in empathic ability, and spiritual decline as one feels hopeless or helpless to recover as a result of chronic exposure to others’ suffering.” Although STS can occur in a single instance, CF applies when clinicians have cared for multiple suffering patients over time and have experienced “too much sadness” and “too much death” and simply can do so no more.

For the purposes of this article and because the literature about STS and CF among health care providers is expansive, we have focused mainly on the concept of STS in terms of measurement and its impact on health care providers. Our discussion of burnout extends into the CF literature because there are helpful connections to be drawn there.

**Measures of STS**

Three instruments are commonly used to measure STS: the Secondary Traumatic Stress Scale (STSS), the ProQOL, and the Compassion Fatigue Scale–Revised. The ProQOL is a 29-item scale measuring STS, compassion satisfaction, and burnout. Overall, each scale has demonstrated acceptable reliability (for the ProQOL STS component, STSS, and the CF Scale STS component, Cronbach \(\alpha = 0.81, 0.93,\) and 0.80, respectively) and validity. Stamm noted that STS and burnout items. The 3 scales are similar but have important differences (Table). The STSS and ProQOL include at least 1 item for each of the 3 subcomponents of STS: (1) intrusive thoughts (eg, disturbing dreams or thoughts, reliving the trauma experienced by the other), (2) avoidance behaviors (eg, memory gaps about work, avoiding certain situations or activities), and (3) hyperarousal (eg, feeling jumpy, feeling on edge). The CF Scale–Revised includes no avoidance-behavior items. The unique items of the STSS measure hyperarousal and avoidance behaviors.

**Health Care Providers Affected by STS**

Secondary traumatic stress has been identified in mental health professionals, social workers, trauma workers, clergy, and nurses and physicians. Among nurses, different specialties have been evaluated for STS, including emergency department, intensive care, oncology, pediatric, and mental health nurses. Although less frequently studied, physicians’ experiences of STS have been evaluated, especially among pediatricians and neonatologists, and oncologists. We found no studies of STS among advanced practice nurses.

Although above-normal levels of STS among clinicians have been reported in many studies, the prevalence of severe STS varies widely, from 0% to 52%. In 3 studies, researchers used the STSS to identify clinicians who met diagnostic criteria for STS and found that about half of the participants met criteria for 1 dimension (arousal, avoidance, or intrusion). Dominguez-Gomez and Rutledge and Quinal et al reported that approximately half of their participants had high scores in 2 dimensions and fewer had high scores in all 3 dimensions. Ratrout and Hamdan-Mansour reported that 52% of the participants in their study met criteria for high to severe STS. Although challenges to identifying prevalence exist because of differences in participant populations and instruments used to measure STS, CF, and instrument scoring, there is enough evidence to suggest that STS is not uncommon among health care providers.

Studies in which the prevalence of STS was evaluated among intensive care or emergency department clinicians have predominantly included nurses but also include physicians, chaplains, and child-life specialists.
### Table: Item Comparison for STSS, ProQOL, and CF Scale–Revised Instruments

<table>
<thead>
<tr>
<th>Subcomponent: Avoidance</th>
<th>Subcomponent: Intrusive Thoughts</th>
<th>Subcomponent: Hyperarousal</th>
</tr>
</thead>
<tbody>
<tr>
<td>ProQOL^b</td>
<td>STSS</td>
<td>CF Scale-Revised^b</td>
</tr>
<tr>
<td>I feel depressed because of the traumatic experiences of the people I [help].</td>
<td>I felt discouraged about the future.</td>
<td>I experience troubling dreams similar to those of a client of mine.</td>
</tr>
<tr>
<td>I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].</td>
<td>I avoided people, places, or things that reminded me of my work with clients...</td>
<td>I have experienced intrusive thoughts after working with especially difficulty clients/patients.</td>
</tr>
<tr>
<td>I can’t recall important parts of my work with trauma victims.</td>
<td>I noticed gaps in my memory about client sessions. I had little interest in being around others.</td>
<td>I have had flashbacks connected to my clients.</td>
</tr>
<tr>
<td>Subcomponent: Intrusive Thoughts</td>
<td>Subcomponent: Hyperarousal</td>
<td></td>
</tr>
<tr>
<td>As a result of my [helping], I have intrusive, frightening thoughts.</td>
<td>I had disturbing dreams about my work with clients....</td>
<td>I experience troubling dreams similar to those of a client of mine.</td>
</tr>
<tr>
<td>Because of my [helping], I have felt “on edge” about various things.</td>
<td>My heart started pounding when I thought about my work with clients.</td>
<td>I have had flashbacks connected to my clients.</td>
</tr>
<tr>
<td>I feel as though I am experiencing the trauma of someone I have [helped].</td>
<td>It seemed as if I was reliving the trauma experienced by my clients.</td>
<td>I have suddenly and involuntarily recalled a frightening experience while working with a client/patient.</td>
</tr>
<tr>
<td>I am preoccupied with more than one person I [help].</td>
<td>I thought about my work with clients when I didn’t intend to.</td>
<td></td>
</tr>
<tr>
<td>I think that I might have been affected by the traumatic stress of those I [help].</td>
<td>Reminders of my work with clients upset me.</td>
<td></td>
</tr>
<tr>
<td>I find it difficult to separate my personal life from my life as a [helper].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcomponent: Hyperarousal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I jump or am startled by unexpected sounds.</td>
<td>I felt jumpy.</td>
<td>I am losing sleep over a client’s traumatic experiences.</td>
</tr>
<tr>
<td>I had trouble sleeping.</td>
<td>I had trouble concentrating.</td>
<td>I expected something bad to happen.</td>
</tr>
<tr>
<td>I was easily annoyed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CF, Compassion Fatigue; ProQOL, Professional Quality of Life; STS, secondary traumatic stress; STSS, Secondary Traumatic Stress Scale.
^a Data were derived from Stamm,^61 Bride et al,^66 and Adams et al. ^67
^b STS items only.
In a recent meta-analysis of determinants of STS, however, significant effects related to work setting, years of practice, or other demographic variables were not found. In addition, in a qualitative study authors did not assess whether the triggers of CF and burnout were correlated \( r = 0.56; P < .01 \) and that 32% of the variance in CF was accounted for by burnout. Similarly, in a study of neonatologists, 58% of the variance in CF was accounted for by burnout, and Stamm reported a 34% shared variance. Hamama et al found significant correlations between STSS and burnout in nurses \( r = 0.61; P < .01 \) and doctors \( r = 0.47; P < .01 \). In studies evaluating CF or STS and burnout, several predictors of burnout were identified, including less perceived social support, a decreased sense of trust, poor organizational commitment or work environment factors (eg, safety, time pressure), high workload, and emotional depletion. In addition, in a qualitative study to identify coping mechanisms as well as triggers of CF and burnout, researchers found work-related triggers such as repeated exposures to sadness and death, staff shortages, excessive workload, and lack of managerial support to be particularly relevant. The study authors did not assess whether the triggers affected CF or burnout.

In sum, STS is common among clinicians caring for patients. There are no clear differences in STS for critical care clinicians versus those in other professional domains or for nurses relative to physicians. Interestingly, the phenomenon differs conceptually from both moral distress and mattering and yet still correlates to burnout in some way. The experience of STS is both natural and expected, and yet it can become problematic, especially when symptoms entail the 3 psychological and behavioral domains.

**Discussion**

Health care providers today work in complex, competitive, budget-driven organizations with multiple stakeholders, a plethora of standards and regulations, and a high demand for perfection because human lives are at stake. Invariably, the systems in which health care providers practice influence their ability to work effectively and to their highest potential. Lamentably, “most hospitals, medical centers, and practice groups operate under the framework that burnout and professional satisfaction are solely the responsibility of the individual physician” (and ostensibly other clinicians) when, in fact, there is shared responsibility for identifying and resolving burnout and advancing well-being and flourishing. Links between organizational-level issues and burnout are clear. According to a recent qualitative study of medical division directors’ perspectives on burnout, most respondents identified work characteristics related to current work conditions (eg, excessive workload demands, poor workplace climate, and misalignment between clinicians and administrators) rather than work characteristics existing under ideal circumstances (eg, patient illness severity, patient/family wishes), or individual factors (eg, work-life balance), as influential drivers of burnout. In a survey of physicians, 11% of the variation in burnout was explained by ratings of leadership, and each 1-point increase in leadership score was associated with a 3% decrease in burnout likelihood.

Talbot and Dean remonstrate that physicians are not burning out but are instead suffering from moral injury. Initially descriptive of effects on soldiers of their actions in war, moral injury is a concept only recently applied in the health care setting. It occurs “(1) when there has been a betrayal of what is morally right, (2) by someone who holds legitimate authority, and (3) in a high-stakes situation.” Moral injury is manifested by, among other things, shame, self-harm, poor self-care, substance abuse, self-loathing, decreased empathy, remorse, and self-condemning thoughts. Arguably, moral distress and moral injury are closely related and additional work is needed to determine whether they are, in fact, the same concept. Regardless, a critical idea inherent in this literature is the role of the organization in mitigating the experience of moral injury. According to Talbot and Dean: 

\[ \text{Eg} \]
The simple solution of establishing physician wellness programs or hiring corporate wellness officers won’t solve the problem. Nor will pushing the solution onto providers by switching them to team-based care; creating flexible schedules and float pools for provider emergencies; getting physicians to practice mindfulness, meditation, and relaxation techniques or participate in cognitive-behavior therapy and resilience training. What we need is leadership willing to acknowledge the human costs and moral injury of multiple competing allegiances. We need leadership that has the courage to confront and minimize those competing demands. We need leaders who recognize that caring for their physicians results in thoughtful, compassionate care for patients, which ultimately is good business.

Wible describes burnout as a victim-blaming and shaming term of oppression that covers up abuse of clinicians within a “dysfunctional and highly toxic health care system.” She argues that neither burnout nor moral injury suffice conceptually to encompass the harms done to physicians (and ostensibly other clinicians) and reframes this abuse as violations of human rights.

Investigation and implementation of systems-based interventions to address burnout and moral injury are crucial and should include studies of combined individual and systems strategies, as well as studies that include nurses and other nonphysician providers. Systems-based interventions that address factors such as mattering, moral distress, STS, and CF upstream from burnout may be especially effective. Broader solutions have been proposed, including recognizing health care providers as experts and respecting their input and knowledge, conveying privilege to the patient-provider relationship by allowing it (instead of insurance companies) to drive clinical decisions, training leaders in the skills to lead effectively, strengthening the organizational culture, and establishing a sense of moral community.

Conclusion

Well-functioning moral communities create and model inclusiveness and fairness, counter exploitation and marginalization, listen to care providers, are sensitive to power dynamics, provide adequate resources, and are collaborative in solving problems. Such organizations attend to the damaging effects that moral distress can have and the buffering effect that mattering can have on their most valuable resource—their providers.

REFERENCES

12. Prilleltensky I. Mattering at the intersection of psychology, philosophy, and politics [published online August 13, 2019]. Am J Community Psychol. doi:10.1002/ajcp.12388


