Society of Critical Care Medicine
The Intensive Care Professionals

Moral Injury Well-Being Toolkit

Developed for the Society of Critical Care Medicine
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How Will This Toolkit Help Me?

This toolkit is intended to be a starting point for critical care teams to practice identifying and discussing ethical dilemmas and sources of moral injury before a crisis or behavioral breakdown occurs.

Objectives:

- Define moral injury and differentiate it from related concepts such as burnout, compassion fatigue, and moral distress
- Identify the key factors that contribute to moral injury in healthcare settings
- Explore the concept of moral injury within the context of critical care, as revealed through insights shared by SCCM focus group participants
- Provide case-based scenarios to critical care teams as a means of promoting open discussion and engagement on moral and ethical topics

Introduction

The Society of Critical Care Medicine (SCCM) established the Moral Injury Peer Support Forum to provide outreach support to critical care clinicians to encourage self-healing and improved well-being and to identify common themes and needs related to moral injury, stress, and burnout. The Moral Injury Peer Support Forum was funded in part by a cooperative agreement with the Centers for Disease Control and Prevention (grant number 1 NU50CK000566-02-00). The Centers for Disease Control and Prevention is an agency within the Department of Health and Human Services (HHS). Its contents do not necessarily represent the policy of CDC or HHS, and should not be considered an endorsement by the Federal Government.

The goal of this project was to develop guidance to enhance understanding of moral injury and knowledge resources for critical care clinicians. The well-being of the critical care workforce requires that all team members have the ability to recognize and support each other when faced with occupational sources of burnout, trauma, loss, and moral injury. Peer support also involves addressing system and institutional factors that contribute to or increase the risk of moral injury.

This project focused on moral injury and its implications for critical care team members. While the concept of moral injury applies across many specialties and disciplines, the content of the Moral Injury Support Forum specifically reflects the experiences and knowledge of critical care team members. This project has two components:

1. Information about moral injury, peer support interventions, and training resources available for the SCCM community
2. Scenarios of critical team members' experiences of moral distress and moral injury to be used for group discussions

Key Concepts

Many terms are used to describe the physical, emotional, social, and spiritual impact of working in healthcare. These terms are often used interchangeably or are used to describe the overall effect of occupational stress. For example, the term "burnout" has been used to label fatigue at the end of a stressful shift or a reason for leaving the healthcare workforce. Similarly, the concepts of moral distress and moral injury are often conflated, although they are very different. The following operational definitions are used in this guide:

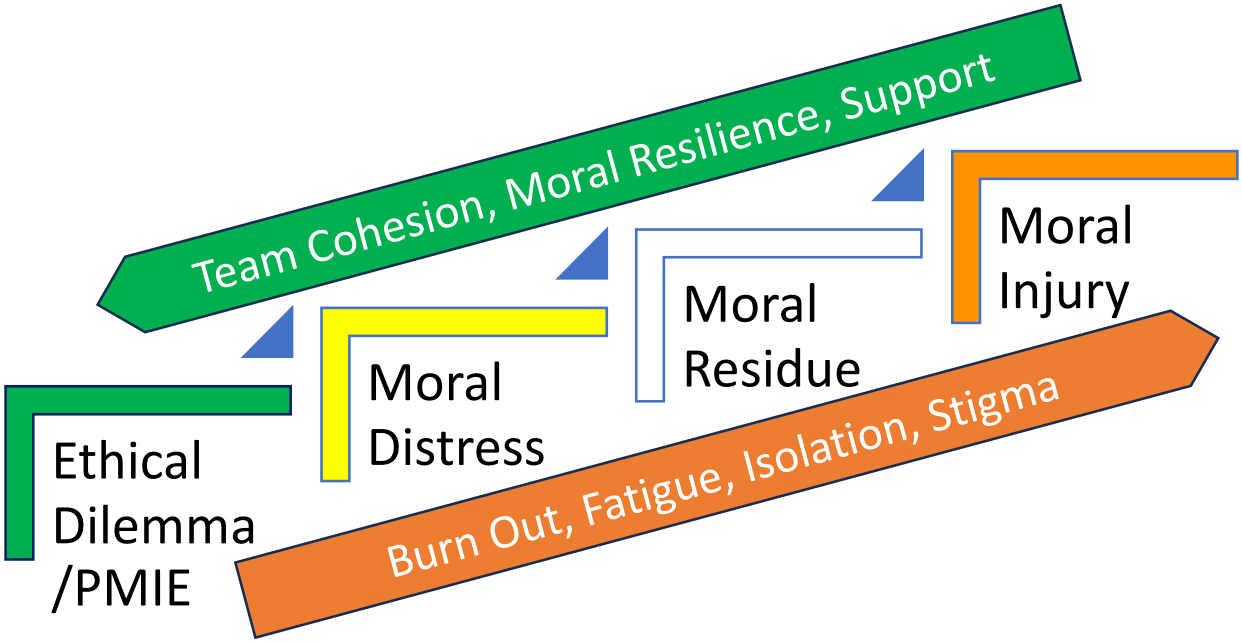
- **Burnout:** Chronic workplace stress due to an imbalance between job demands and resources. It is characterized by feeling emotional exhaustion from work, detachment and cynicism about work, and/or reduced professional efficacy.[1]
- **Compassion fatigue:** Physical and mental exhaustion and emotional withdrawal experienced by those who care for sick or traumatized patients over an extended period of time.[2]
- **Stress injury:** Severe and persistent distress or loss of functioning caused by disruptions to the integrity of the brain, mind, or spirit after exposure to overwhelming stressors. Examples include persistent changes in role performance (work, home, friends) or coping behaviors (problem-solving, emotional regulation, increased use of comfort substances) in response to fatigue, loss, trauma, or moral distress.[3]
- **Ethical dilemma:** Situation in which a choice needs to be made between competing values or ambiguity exists as to the best option, and any decision will have consequences.[4]
- **Moral distress:** Psychological disequilibrium that occurs when someone believes they are involuntarily complicit in unethical actions. They are doing something that they believe to be morally wrong but have little power to act differently or to change the situation.[5]
- **Moral residue:** Reactive distress that remains after moral distress.[6]
- **Potentially morally injurious event (PMIE):** Events associated with people doing or failing to do things (acts of commission and omission) or that involve being exposed directly or indirectly to others' transgressions (bearing witness) that violate deeply held values and beliefs.[7]
- **Moral injury:** A type of moral suffering characterized by exposure to circumstances that violate someone's moral values and beliefs in ways that erode integrity, moral capability, and perception of basic goodness and create distress on a psychological, behavioral, social, or spiritual level.[8] Moral injury can result in stress injury behaviors including increased guilt, shame, and self-blame for acts of commission and omission and anger, resentment, and a sense of betrayal for bearing witness to transgressions.
- **Moral resilience:** A person's capacity to sustain, restore, or deepen integrity in response to moral adversity. Characteristics that strengthen moral resilience include personal integrity, relational integrity, buoyancy, self-regulation, self-stewardship, and moral efficacy.[9]

From Ethical Dilemma to Moral Injury

An ethical dilemma does not always lead to a moral injury. Most often, we learn and grow from the experience of ambiguity and difficult choices. Wisdom in healthcare does not necessarily come from things that go right or are easy. The pathway from an ethical dilemma to moral injury is influenced by many factors. SCCM members described how the factors of experience, team cohesion, organizational support, and fatigue can be protective or reactive in the transition from a moral dilemma to the changes in behavior of moral injury. We can think of a continuum from moral distress to moral injury (**Figure 1**). Factors that contribute to moral injury include the level of organizational demands that produce

burnout, emotional and physical fatigue, lack of support from peers or the organization, stigma related to adverse events, and severity of the transgression (acts of omission, commission, or bearing witness). Factors that reduce the risk of moral injury include peer support and team cohesion, skills and experience that support moral resilience, and organizations that use wise practices to recognize and address adverse events.

Figure 1. Moral Injury Continuum



Focus Group Themes

This project involved the formation of SCCM member volunteer focus groups to explore moral injury specifically in the context of critical care and to provide scenarios for team discussion. The major themes are shown in **Table 1**.

Table 1. Major Focus Group Themes

Themes	Challenges	Actions
System issues	Major driver of distress: • Clinician values experienced as secondary to patient, family, and system • Nonacademic settings lacking support resources • Giving up: I tried and I cannot change things • Callous communication: conveys that you do not matter • Lack of support increases risk of moral injury	• Use the SCCM Well-Being Toolkit solutions and tips for common system issues • Use a 3D approach for unnecessary stressors: ○ Discover: Identify and describe the issue ○ Discuss: Have the team discuss the issues and who else needs to know or can help ○ Do something: Take action to address issues within your control and escalate issues that need different resources • Seek support and connection with leaders

Experience	• In early career, there is more doubt and less skill at navigating moral dilemmas • In later career, there is more experience and greater loading of moral residue	• Need to forewarn and educate novices • Training that prepares for PMIEs
Power dynamics	• Lack of autonomy increases risk • Deference to titles among close workers creates social distance (respect vs. power)	• Fairness and equity reduce risk • The little things matter (connection)
Morals and values	• Dynamic change over time • Stigma and labeling reduce willingness to talk about difficult topics	• Context matters. Unit and team microcultures and narratives have an impact
Moral injury vs. burnout	• Burnout is easier to understand and recognize than moral injury • Burnout increases the risk for moral injury	• Retrospective knowing. Often we do not know how injured we are until we can look back and see how we have changed. A trusted peer is often needed to see ourselves • Learn and practice moral repair strategies

Perspective	• Observed difference between how participants talked about PMIEs. Some used internalizing language rather than externalizing language. It is likely that internalizers and externalizers will describe the same experience in very different terms	• Develop skills for discussing PMIEs before they happen
		• Getting to neutral by using the STOP strategy:
		  ○ Stop and pause reactions
		  ○ Take a breath
		  ○ Observe what you are feeling and how others are reacting
		  ○ Proceed mindfully

3D = Discovery, Discussion, Do Something; PMIE = potentially morally injurious event.

Peer Support/Team Intervention Considerations

The environment of care and organizational context matters. Building a foundation of individual and team communication strategies for a broad range of experiences will help prepare the team to address PMIEs. There are several effective ways to address a team member in distress or show behavior changes related to a stress injury. Having at least one strategy that all team members know and practice can create a common foundation and help to integrate new team members. Having team-based strategies to engage in solution-based actions will promote team and organizational changes to reduce the risk of moral injury.

There are many evidenced-based strategies for helping teams support each other and create a team culture that provides space for having difficult conversations and for everyone to be at their best during stressful circumstances. Some foundational practices for teams include:

- Awareness: What am I feeling. What am I thinking?
- Self-regulation and self-efficacy: We have choices! Interrupting automatic thoughts and actions can expand choices.
- Seeing the good: Building a platform of positive emotion and positive regard
- Perspective-taking: Hm, that's interesting. Help me understand.
- Humility: Have I changed my mind today? How might I be wrong?
- Practicing compassion and gratitude toward peers

It is important to acknowledge that there is no immunity to stress injury. Each of us will react to a stressor. Sometimes the first indication that a peer is in distress or has a stress injury is when they respond in a different way from their usual behavior. One strategy from the Stress First Aid approach is useful to support a peer in distress.[10] The OSCAR communication strategy is used to recognize when a peer is in distress, determine whether assistance is needed, and begin to identify support resources.

OSCAR Communication:

- **Observe:** Actively observe behaviors and look for patterns.
- **State observations:** State your observations of the behaviors, just the facts without interpretations or judgments.
- **Clarify roles:** State why you are concerned about the behavior to validate why you are addressing the issue.
- **Ask why:** Seek clarification and try to understand the other person's perception of the behaviors.
- **Respond:** Provide guided options. Clarify concern if indicated; discuss desired behaviors and state options in behavioral terms.

PMIEs also highlight opportunities for improvement and the need for solution-based actions that go beyond individual and team support to include practices, policies, and organizational culture that contribute to the risk for moral injury. The 3D approach—Discovery, Discussion, and Do Something—is one strategy for developing solution-based actions. Discovery involves recognizing a PMIE. Discussion involves the team actively discussing the event and making everyone on the team aware of the issue. Do Something involves taking actions that promote learning from the experience, engaging leaders to understand organizational factors that contributed to the PMIE, and using a quality and safety process to enact policies, procedures, and processes to mitigate future risks.

The ethical dilemma scenarios in this toolkit are structured to enhance participants' knowledge and skills to increase self- and team awareness, recognize when behaviors may indicate a moral injury, and begin the 3D process.

Empowering Critical Care Teams:
Ethical Dilemma Scenarios for Proactive Discussions on Moral Injury

These scenarios serve as starting points for critical care teams to facilitate the identification and open discussion of ethical dilemmas and sources of moral injury. With eight predesigned scenarios and one blank template, teams can proactively engage in discussion before crises or behavioral breakdowns occur. Various group discussion strategies are provided, empowering teams to enhance their ethical decision-making skills and cultivate a supportive environment for addressing morally challenging situations effectively in clinical practice. The following is an example of one strategy for using the scenarios:

1. Consider a naturally occurring time at which the multiprofessional team gathers for clinical rounds, professional development, or other training activities. Integrate brief discussions about ethical dilemmas into the training or meeting cycle.
2. The short scenarios can be read as part of the discussion, which is expected to take 15 to 50 minutes, depending on how engaged the team is.
3. Identify a team member to be a facilitator, whose role is to help structure and move the dialog forward but need not be an expert in moral ethical challenges. Some teams rotate the facilitator role. The facilitator will select a scenario or write one for the team. Some teams may choose to ask for a facilitator from the ethics service if the team already exhibits evidence of stress injury.
4. The facilitator's introduction will note that this time is devoted to team discussion of moral and ethical challenges. Most teams find it useful to set some ground rules for the discussion, such as a reminder that there is no single right answer when discussing moral ethical challenges. It is important to approach the dialog with curiosity rather than judgment. Team members should be supportive and respectful of each team member during the discussion and in any follow-up conversations. Consider any additional ground rules that your team may find helpful.
5. The facilitator should guide the team in a brief focusing and grounding breath exercise. One strategy is to have the team do two cycles of four-square breathing. Inhale for a count of four, hold for a count of four, exhale for a count of four, hold for a count of four, and repeat.
6. The facilitator should provide copies of the scenario with the discussion questions but without the facilitator considerations.
7. The facilitator should have the team members read the scenario. Some facilitators may choose to read the scenario aloud.
8. The facilitator should use the guiding questions to prompt discussion. Some team members may add content to the scenario. Some teams may start with the scenario and then switch the topic to a current or recent team experience. If this happens, the facilitator should acknowledge that the discussion has moved to a different issue and ask whether the team would like to discuss this issue instead. If yes, then continue to use the guiding questions as a framework for the discussion.
9. The facilitator should conclude by acknowledging some of the common themes or concerns, thanking the team members for coming together, and stating that starting a dialog when moral distress occurs can reduce the risk of moral injury.

Scenario 1: Cardiac Arrest

As a respiratory therapist during code, I am at the head of the bed watching the code unfold and I feel invisible. Even if I see something, like misplaced hands for the compressions, I feel as though I cannot speak up. If we do a debrief after the code, it is usually the physician who talks about how the code went, with little input from the team. We talk about a team environment and yet when you are actually engaged in an intense clinical situation, our voices may not be heard.

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Scenario 2: Drug Shortages

Pharmacists during COVID had a lot of drug shortages. There was constant pressure to determine which patient should get the next dose of a critically short drug. I had a physician get within one inch of my face and accuse me of killing the patient because I would not release a drug that had been prioritized for other patients. We had three doses left and that patient was not even number four on the list.

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Scenario 3: Recognition

COVID really highlighted the differences among the multiprofessional team. All clinical staff were working hard, long hours, with limited resources. The nurses were getting double and sometimes triple bonuses to come in and work. Nothing like that was ever available to the pharmacy. Most of our pharmacy team worked double shifts and picked up extras without any support or acknowledgment. I think about managing scarce resources, triaging medications, trying to find safe alternatives, and searching the literature for the efficacy of off-label medications. Often when I got home I had so many questions. How fast should I be verifying the orders? Did I miss something? Did I not get to someone who could have benefited from optimizing the current meds or trying a different antibiotic? About one year into the pandemic, senior management released a paper that described how difficult it was to work from home, all the extra meetings needed to manage staffing challenges, and how good the administration was meeting the hospital's needs. It was really insulting.

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Scenario 4: Disrespect

There is a power hierarchy in healthcare. There are times, especially when the demands and stress increase, when rude and discourteous behaviors emerge. I have a pretty stiff nursing spine, so I will speak up to a physician when they try to bully me. But there are times when their behavior gets out of control. I felt like there was really no recourse, and little by little I felt my spine getting chopped away. Maybe we let some physicians get away with more disrespect than other team members. I have been a nurse for a long time and I can usually find a way to talk with the physician about the disrespect and try to figure out what they are really angry about. I really worry about new team members as they do not have the experience or confidence to address disrespectful behaviors and they tend to take it to heart.

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Scenario 5: Beyond Burnout

The institutional demands on clinical decisions over time really take a toll. You have to do something when you think it's not indicated or maybe even harmful, which can add a lot of pressure and adds to the fact that you get this feeling of not being in control. One of my physician colleagues looked different; the spark was gone. When I asked how he was doing he told me, "I don't give a darn anymore. I'm here to work from 8 til 6 and whatever I need to do. I do what the family wants. I don't care if they want to torture their loved one to death. I don't care anymore. I don't. I leave at 6, and then my life starts because I've tried. I've tried for many, many years to change things. It's impossible."

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Scenario 6: End-of-Life Discussion

End of life is a huge area for moral distress and injury. I specifically remember one experience where the physicians described vasopressors as drugs that support your heart. As a pharmacist, I thought, "What a cute way to describe a vasopressor." In some ways the equivalent of beating a horse that is exhausted, dying, and trying its best, and there is no more effort to give. And I remember thinking I wish that I had more of a role. To provide a more accurate description of what a vasopressor is doing in this moment in time for that particular patient from a pharmacist's perspective. Just hoping or wanting to help the family make a decision, because it felt like we were giving all these nice euphemisms that were ultimately, at least from my perspective, extending the suffering of this patient without changing the ultimate outcome.

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Scenario 7: Adverse Event

A nurse with five years' intensive care experience has six months in the current medical ICU as a traveler. One of the assignments was an elderly patient admitted with severe hyperglycemia, COPD, and sepsis. The patient had a long history of poorly controlled diabetes and multiple comorbidities. The patient was stabilized in the MICU and was pending a transfer to one of the medical units. The nurse was preparing to hang a new bag of NS. As the nurse entered the room, the patient was attempting to stand and was at risk of falling. The nurse called for help and put the IV bag on the bedstand. Other team members came to assist. After getting the patient safely in bed, the other team members left, the nurse changed the IV bag and continued care of other assigned patients. The patient started to have slurred speech, mental status changes, and confusion. During the patient assessment, it was determined that the infusing IV solution was D5W. The patient was treated with insulin and the transfer was canceled. The nurse was sure that NS was brought into the room. The nurse constantly replayed the event and felt significant guilt. The quality and safety review was experienced as blaming and accusatory and included questions about how many other errors had been made and not reported. The nurse felt isolated from other nurses, with some nurses openly stating, "This is what happens when they hire travelers."

Guiding questions:

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2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
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3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Scenario 8: Shared Decision-Making

I was trained as a physician to have primary responsibility for making medical decisions. Then the pendulum swung toward shared decision-making and now I am just a provider—a widget in the organization. My morals, my values shouldn't affect patient care. It should be just the patient and family moral and values. So now we're in this realm of shared decision-making, which is good on paper but very messy in practice. Now that isn't working either. I'm a pediatric intensivist, which means I work with families. First, it assumes that patients and families know what their values are and what morals lead to having those values. Second, it assumes that those values and morals are static over time and don't change. And third, it assumes that, as a provider, I know how to get people in different levels of emotional distress to identify their values and come up with a plan that aligns with those values, given the constraints of medicine. Shared decision-making gets even more challenging as complexity increases:

- We have a patient who's been abused, a baby who was previously healthy and then sustained an inflicted injury, and then the biological family is still making decisions for the baby.
- A previously healthy child who's had a severe traumatic brain injury and is going to live in a severely compromised state.
- Surgical innovation versus human experimentation, trying to get these children's hearts to function until they can hopefully undergo transplant.

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Scenario Template: Describe a team or individual experience that could be a source of moral injury or the behaviors of a peer who has a moral injury.

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Facilitator Considerations:

1. Behaviors
2. Sources
    a. Omission
    b. Commission
    c. Bearing witness
3. System issues
4. Questions
5. Strategies

Facilitator Considerations Discussion Guides

This section contains the scenarios with an additional section of considerations and potential questions to support the facilitator when engaging the team and promoting discussion. The facilitator's role is to help structure and move the dialog forward but the facilitator need not be an expert in moral ethical challenges. Some teams rotate the facilitator role. The facilitator will select a scenario or write one for the team.

Facilitator actions

1. The facilitator's introduction will note that this time is devoted to team discussion of moral and ethical challenges. Most teams find it useful to set some ground rules for the discussion, such as a reminder that there is no single right answer when discussing moral ethical challenges. It is important to approach the dialog with curiosity rather than judgment. Team members should be supportive and respectful of each team member during the discussion and in any follow-up conversations. Consider any additional ground rules that your team may find helpful.
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Facilitator considerations:

1. Behaviors. Self-censoring. Being passive during an event in which everyone would typically be expected to be assertive in their role.
2. Sources:
    a. Omission. Not speaking up or calling out issues during the code.
    b. Commission. Is there a risk that the RT could make mistakes in this scenario?
    c. Bearing witness. Potential sense of betrayal related to exclusion. Potential concern about interprofessional communication related to other clinical decisions.
3. System issues. Potential hierarchical influences that may contribute to suppression of input from team members or self-censoring even when feedback is expected.
4. Questions. Do other team members have similar experiences? Does this experience occur only during codes or are there other scenarios in which the RT feels invisible?
5. Strategies. Change the debriefing so that every discipline contributes. Have the facilitator of the debriefing listen rather than speak about what happened. Assess and discuss team communication across a range of clinical issues.
6. Organizational strategies.

Scenario 2: Drug Shortages

Pharmacists during COVID had a lot of drug shortages. There was constant pressure to determine which patient should get the next dose of a critically short drug. I had a physician get within one inch of my face and accuse me of killing the patient because I would not release a drug that had been prioritized for other patients. We had three doses left and that patient was not even number four on the list.

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Facilitator considerations:

1. Behaviors. Anger, shouting, and blaming. Physician aggressively blaming the pharmacists. This may be displacement, in which the physician is responsible for making clinical decisions but does not have the resources to carry out the treatment. The medication shortage and the clinician aggression could be a source of moral injury for the pharmacist.
2. Sources:
    a. Omission. Not being able to provide a needed drug. Acts of omission can include inability to take action due to external challenges.
    b. Commission. None identified. Risk for commission could be choosing an alternative medication that was less effective or had greater risks.
    c. Bearing witness. Potential sense of betrayal by the hospital if the medication is available but the hospital is choosing not to have more on hand.
3. System issues. Failures within the larger system (supplies, policies, staffing, etc.) can create a sense of betrayal or lack of support for both the pharmacist and physician.
4. Questions. Was there a restorative dialog between the physician and pharmacist after the interpersonal conflict or was there a continuation of conflict over other issues? What system issues contributed to the shortage? (A national shortage occurs in a different context than a cost containment shortage.) What was the communication between pharmacy and all physicians related to drug shortages and the process for prioritizing patients?
5. Strategies.
6. Organizational strategies.

Scenario 3: Recognition

COVID really highlighted the differences among the multiprofessional team. All clinical staff were working hard, long hours, with limited resources. The nurses were getting double and sometimes triple bonuses to come in and work. Nothing like that was ever available to the pharmacy. Most of our pharmacy team worked double shifts and picked up extras without any support or acknowledgment. I think about managing scarce resources, triaging medications, trying to find safe alternatives, and searching the literature for the efficacy of off-label medications. Often when I got home I had so many questions. How fast should I be verifying the orders? Did I miss something? Did I not get to someone who could have benefited from optimizing the current meds or trying a different antibiotic? About one year into the pandemic, senior management released a paper that described how difficult it was to work from home, all the extra meetings needed to manage staffing challenges, and how good the administration was meeting the hospital's needs. It was really insulting.

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Facilitator considerations:

1. Behaviors. Exhaustion. Perceived inequity between different work groups. Multiple moral/ethical challenges related to limited resources and untested treatment options.
2. Sources:
    a. Omission. Concern about missing a critical piece of information when reviewing pharmacy orders or not recognizing a medication that could help a patient while conserving limited medications for another patient.
    b. Commission. Concern about making an error that could harm a patient or waste a limited resource.
    c. Bearing witness. Perceived inequity in pay and acknowledgement. Potential sense of betrayal when reading a paper about administrative challenges that reinforces a disconnect between administration and clinical staff.
3. System issues. Supply chain issues. Considerations of support for team members who are not as visible as other team members.
4. Questions. In what ways did guiding ideals or values about commitment to others, stoicism, striving for excellence, contribute to taking on double and extra shifts? Was the burden shared by everyone who worked in the pharmacy or was there a sense of inequity within the pharmacy team?
5. Strategies. Greater sense that senior administration understood and acknowledged the efforts of all team members. Making sure that team members with less visible roles are understood and supported as work demands increase across the hospital.
6. Organizational strategies.

Scenario 4: Disrespect

There is a power hierarchy in healthcare. There are times, especially when the demands and stress increase, when rude and discourteous behaviors emerge. I have a pretty stiff nursing spine, so I will speak up to a physician when they try to bully me. But there are times when their behavior gets out of control. I felt like there was really no recourse, and little by little I felt my spine getting chopped away. Maybe we let some physicians get away with more disrespect than other team members. I have been a nurse for a long time and I can usually find a way to talk with the physician about the disrespect and try to figure out what they are really angry about. I really worry about new team members as they do not have the experience or confidence to address disrespectful behaviors and they tend to take it to heart.

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Facilitator considerations:

1. Behaviors. Feeling diminished and "spine getting chopped away" by disrespectful communication. Potential power differential and dynamics that undermine professional identity.
2. Sources:
    a. Omission. Risk of self-censoring or giving up.
    b. Commission. Risk of not standing up for novice team members and being complicit in continuing the disrespectful behavior.
    c. Bearing witness. The institution possibly condones or does not address disrespectful behavior with individuals in positions of power.
3. System issues. Culture of respect versus culture that does not check disrespectful or aggressive behavior. Sources of stress that trigger displacement of anger or aggression toward others.
4. Questions. Is this a consistent pattern or is it episodic? Does the disrespectful person have a trusted peer who could check in with them or provide a calming influence?
5. Strategies: Acknowledge the behavior with the disrespectful person and ask what they are frustrated or worried about. Often, the source of disrespect and anger in a healthcare setting is a challenge to core beliefs and guiding ideals.
6. Organizational strategies.

Scenario 5: Beyond Burnout

The institutional demands on clinical decisions over time really take a toll. You have to do something when you think it's not indicated or maybe even harmful, which can add a lot of pressure and adds to the fact that you get this feeling of not being in control. One of my physician colleagues looked different; the spark was gone. When I asked how he was doing he told me, "I don't give a darn anymore. I'm here to work from 8 til 6 and whatever I need to do. I do what the family wants. I don't care if they want to torture their loved one to death. I don't care anymore. I don't. I leave at 6, and then my life starts because I've tried. I've tried for many, many years to change things. It's impossible."

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Facilitator considerations:

1. Behaviors. An observed change in behavior that included a sense that this is more than exhaustion: "the spark was gone." With minimal prompting, a clinician disclosed to a trusted peer a description of surrendering a core value of healthcare: caring.
2. Sources:
    a. Omission. None identified.
    b. Commission. Acting in a way to satisfy family demands that was equated with torturing the patient.
    c. Bearing witness. Perceived pressure from the institution: policies, procedures, protocols, or standard work that undermines or conflicts with clinical decision-making and physician autonomy to direct patient care.
3. System issues. Striving for quality by reducing variation to the point where nuanced decisions are difficult. Potential challenges in communication or making changes.
4. Questions. How long has this physician felt as though he did not care? Was there a particular event or experience in which emotional and professional detachment was the only option? What happened in the past when he challenged preset clinical expectations? Has he faced punishment during the compliance/credentialing process for not following a protocol? How are the residents and fellows that he supervises doing? Is it time to restructure his role to include work that is meaningful?
5. Strategies. Consider referral to employee assistance program, if trusted, for confidential stress and coping support. Explore whether there is something that still connects with his passion that he can engage in. Encourage a referral to a peer mentor or coach who is appropriate for a senior and experienced physician.
6. Organizational strategies.

Scenario 6: End-of-Life Discussion

End of life is a huge area for moral distress and injury. I specifically remember one experience where the physicians described vasopressors as drugs that support your heart. As a pharmacist, I thought, "What a cute way to describe a vasopressor." In some ways the equivalent of beating a horse that is exhausted, dying, and trying its best, and there is no more effort to give. And I remember thinking I wish that I had more of a role. To provide a more accurate description of what a vasopressor is doing in this moment in time for that particular patient from a pharmacist's perspective. Just hoping or wanting to help the family make a decision, because it felt like we were giving all these nice euphemisms that were ultimately, at least from my perspective, extending the suffering of this patient without changing the ultimate outcome.

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Facilitator considerations:

1. Behaviors. Not feeling part of the team or contributing their particular expertise to a complex decision. Being an observer rather than a participant in the team.
2. Sources:
    a. Omission. Not providing a more precise description of a medication effect.
    b. Commission.
    c. Bearing witness. It is implied that, even after the family meeting, the pharmacist did not approach the team to share the observation.
3. System issues. Potential communication silos and barriers. Implication that this team has professional boundaries and knowledge lanes.
4. Questions. Does the pharmacist perceive this effect throughout the unit or with certain individuals? To what extent does this team have multiprofessional discussions before the patient and family end-of-life or comfort measures discussions? Are post-discussion debriefings held with the team?
5. Strategies: Consider developing lay language for patient/family information for the most common medication classes used at end of life. Consider a multiprofessional process to prepare for and review end-of-life discussions that require a multiprofessional team.
6. Organizational strategies.

Scenario 7: Adverse Event

A nurse with five years' intensive care experience has six months in the current medical ICU as a traveler. One of the assignments was an elderly patient admitted with severe hyperglycemia, COPD, and sepsis. The patient had a long history of poorly controlled diabetes and multiple comorbidities. The patient was stabilized in the MICU and was pending a transfer to one of the medical units. The nurse was preparing to hang a new bag of NS. As the nurse entered the room, the patient was attempting to stand and was at risk of falling. The nurse called for help put the IV bag on the bedstand. Other team members came to assist. After getting the patient safely in bed, the other team members left, the nurse changed the IV bag and continued care of other assigned patients. The patient started to have slurred speech, mental status changes, and confusion. During the patient assessment it was determined that the infusing IV solution was D5W. The patient was treated with insulin and the transfer was canceled. The nurse was sure that NS was brought into the room. The nurse constantly replayed the event and felt significant guilt. The quality and safety review was experienced as blaming and accusatory and included questions about how many other errors had been made and not reported. The nurse felt isolated from other nurses, with some nurses openly stating, "This is what happens when they hire travelers."

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Facilitator considerations:

1. Behaviors. Feelings of guilt and isolation.
2. Sources:
    a. Omission. Potentially missing a patient identification check before changing the IV bag.
    b. Commission. Hanging the wrong IV solution.
    c. Bearing witness. Accusatory quality and safety review.
3. System issues. Unknown nurse-to-patient ratio or acuity of other patients. There appears to be tension between regular nursing staff and travelers.
4. Questions. Did another nurse come into the room to help with D5W and walk out with NS? What happened to the NS bag?
5. Strategies: Using a nonjudgmental curiosity approach to the quality and safety review. Assigning a mentor/advocate for any team member who is at the center of an adverse event. Include environment of care and system issues as part of every quality and safety review.
6. Organizational strategies.

Scenario 8: Shared Decision-Making

I was trained as a physician to have primary responsibility for making medical decisions. Then the pendulum swung toward shared decision-making and now I am just a provider—a widget in the organization. My morals, my values shouldn't affect patient care. It should be just the patient and family moral and values. So now we're in this realm of shared decision-making, which is good on paper but very messy in practice. Now that isn't working either. I'm a pediatric intensivist, which means I work with families. First, it assumes that patients and families know what their values are and what morals lead to having those values. Second, it assumes that those values and morals are static over time and don't change. And third, it assumes that, as a provider, I know how to get people in different levels of emotional distress to identify their values and come up with a plan that aligns with those values, given the constraints of medicine. Shared decision-making gets even more challenging as complexity increases:

- We have a patient who's been abused, a baby who was previously healthy and then sustained an inflicted injury, and then the biological family is still making decisions for the baby.
- A previously healthy child who's had a severe traumatic brain injury and is going to live in a severely compromised state.
- Surgical innovation versus human experimentation, trying to get these children's hearts to function until they can hopefully undergo transplant.

Guiding questions:

1. What behaviors may indicate a moral injury?
2. What sources of moral injury are present in this scenario?
    a. Omission?
    b. Commission?
    c. Bearing witness?
3. What system/work environment issues contribute to the risk of moral injury?
4. What questions would you ask to increase understanding of the situation?
5. What strategies could be used to reduce the risk of moral injury?
6. What strategies could be used to address organizational issues?

Facilitator considerations:

1. Behaviors. Physician role change from the responsible clinician to a provider of services. The provider dialog often evokes a loss of identity, autonomy, and professional agency.
2. Sources:
    a. Omission. The primacy of family decision can conflict with evidenced-based ethical practice.
    b. Commission. The tension of carrying out procedures and treatment that can have lifelong implications for the family that may not and, in some cases will not, result in functional quality of life.
    c. Bearing witness. The fine line between emerging treatments and research. Navigating informed consent with families desperate for a miracle.
3. System issues. Some health systems push the envelope of medical research to the point that blurs the line between experimentation and treatment. The roles of physicians and nurse practitioners being constrained as providers of a service versus clinical professionals.
4. Questions. How do current trends in healthcare such as shared decision-making impact clinical decisions as complexity increases? Consider asking the team to discuss the three examples. What moral/ethical challenges doe we face as a team?

5. Strategies: In the grey area of emerging healthcare trends, it is important for teams to use case examples from the current practice setting to explore how the emerging practice impacts both low-risk, high-volume care and high-risk, low-volume care.
6. Organizational strategies.

Acknowledgments

SCCM would like to thank the following members for their invaluable contributions to the creation of the Moral Injury Toolkit:

Patricia A. Baker, RN, FCCM; Chase Bednarz, BA, NREMT; Lillian Liang Emlet, MD, MS, FCCM; David M. Hess, MD, FCCM; Robert MacLaren, BSc, MPH, PharmD, MCCM; Karsten J. Roberts, MSc, RRN, RRT-ACCS, FAARC; Andrea Sikora, PharmD, MSCR, BCCCP, FCCM; Jessica M. Turnbull, MD, MA

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