MEDICINE AND SOCIETY

MEDICAL TRAINING TODAY
Debra Malina, Ph.D., *Editor*

Beyond Moral Injury — Can We Reclaim Agency, Belief, and Joy in Medicine?

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At some point amid peak-pandemic burnout, I came across a Twitter thread by Kathleen McFadden, then a chief resident at Massachusetts General Hospital. Expecting yet another depiction of the frustrations of our working lives, I skimmed her description of a busy morning with several new patients, one of whom was so preoccupied by having forgotten her Milk Duds that she couldn't give much history. The Milk Duds kept me reading; as any writer knows, a story can't include that sort of detail without returning to it. And sure enough, late in the evening, inundated with administrative tasks, McFadden sees a box of Milk Duds in the chiefs' candy basket and takes it to the patient.

Then McFadden surprised me. Rather than lecturing on humanity in medicine or lamenting our institutions' exploitation of our goodwill, she turned the conversation about well-being on its head. Although the Milk Duds kept her at the hospital far longer than intended (her patient suddenly opened up), for the first time that day she felt her work had meaning. So she wondered: What if improving our own well-being sometimes means spending more time at work rather than less?

McFadden has since quit Twitter, so I don't know how people reacted. But I imagine her opinion was unpopular: though few physicians would dispute the imperative to take good care of patients, many argue that individual clinicians shouldn't have to constantly work harder to overcome the system's shortcomings. That's why being told to be "resilient" is infuriating: it implies that individuals are responsible for solving systemic problems. It's also why well-being interventions often feel farcical. Rather than making doctors do modules on sleep hygiene, why not create work environments that don't force us to spend our nights managing exploding inboxes?

THE MORAL INJURY NARRATIVE

Such frustrations have contributed to a shift in the framing of widespread physician distress, from "burnout" to "moral injury."[1] If "burnout" places the onus on individuals to do yoga, for instance, "moral injury" recognizes such solutions' inadequacy by focusing on systemic problems that fundamentally compromise well-being. The term "moral injury" initially described the emotional wounds of soldiers whose duties forced them to relinquish their values; its application to physicians' distress highlights the sense of moral transgression clinicians may experience when the system prevents them from meeting patients' needs.

The concept has struck a chord with physicians and trainees. In a recent *New York Times Magazine* piece titled "The Moral Crisis of America's Doctors," Eyal Press, whose book *Dirty Work* details ethically compromising tasks of laborers in various occupations, explores how medicine's corporatization similarly places clinicians in moral binds.[2] Press devotes considerable attention to "young doctors in particular," who, he writes, are not merely contemplating how to resist; "some are mulling whether the sacrifices — and compromises — are even worth it."

If Press emphasizes how the system quashes well-being, McFadden highlights the individual's role in reclaiming it. In the context of medical training, the tensions between these two narratives force us to consider what well-being means, where our ideas about it come from, and whether it's still possible for the necessary sacrifices to feel worthwhile.

WELL-BEING AND MEANING

In an interview, McFadden told me she had never seemed destined to get where she is now: the first in her family to attend college, she struggled with standardized tests, couldn't afford test-prep courses, and had nobody to guide her through the requisite processes. Obtaining a medical education therefore felt like a tremendous privilege. In residency, she preferred the hardest days, the most rigorous criticism, the satisfaction of learning enough to prepare for the patients who would depend on her knowledge.

McFadden attributes some of her perspective to her Evangelical Christian upbringing. Prayers over meals, for instance, implicitly acknowledged that food was a gift, not a guaranteed right. Though this distinction spilled into McFadden's approach to training, as she strove to merit her title, even more fundamental to her physician mindset was the notion of a calling. To exist under "divine influence" was to give to others while expecting nothing in return. McFadden acknowledges that this mindset leaves her vulnerable to exploitation. But she identifies less as an employee of a system than as a doctor working for her patients. Though she stopped regularly attending church when she started residency, medicine offers its own higher purpose, driving her to give all she can to her patients. Knowing that she's done so is critical to her well-being.

At some point, however, giving all you can saps you of the strength to give any more. Though that point may be different for each person, duty-hour reform — the most substantial alteration of training in recent decades — was largely based on recognition that exhaustion compromises both trainee well-being and patient care. What McFadden is getting at, however — and what's lost when we fixate on hours worked — is the relationship of well-being to meaningful work.

For many reasons, this essential relationship is easy to overlook in our efforts to improve well-being, particularly among trainees. Meaning is deeply personal. Many trainees have families and outside lives that offer alternative sources of purpose and gratification. And we can't control all factors compromising meaning at work. What can program directors do, for instance, about high patient volume and turnover, the related pressure to finish rounds early so discharges can be completed, or the fact that documentation facilitates billing rather than critical thinking?

But beyond medicine's undeniable shortcomings, broader cultural forces have contributed to a conceptualization of well-being that may be antithetical to our professionalization. Psychologist Lisa Damour has described the "strange equation that has evolved in the discourse where being mentally healthy is equated with feeling good or calm or relaxed."[3] Damour explains why this myopic view of mental health can compromise psychological development; it also seems to threaten physicians' *professional* development, given the many decisions trainees must make. Do you stay late to speak to a grieving family member, care for a patient who became hypoxic as you were signing out, or remain in a grueling surgical case even when duty hours are violated? How do you make these choices despite the mantras urging you to set boundaries, eliminate toxicity, and take care of yourself?

Compounding these challenges is the near-religious fervor that the pursuit of well-being, narrowly defined, has assumed. Describing this phenomenon in a 2021 piece titled "The Empty Religions of Instagram,"[4] writer Leigh Stein argues that many young people shedding their religious ties are simply replacing one belief system with another. Noting that "personal growth influencers" have replaced traditional clergy, Stein focuses on writer Glennon Doyle, whose missive to her 2 million Instagram followers titled "Embrace Quitting as a Spiritual Practice" typifies this online brand of self-care as spiritual fulfillment. The particulars of these belief systems continuously evolve, but broadly speaking, such reverence suggests a fundamental fact about our natures: humans flounder in a meaning vacuum. For many of us, to be well is to believe in something.

Medicine has always offered me an inherent belief system; no matter how often I fail, I still believe there's something sacred in the possibility of making other people's lives a little better. To people becoming doctors in systems where that mission has been corrupted by corporate ones, however, medicine may feel less worthy of faith. And when attempts to improve well-being manifest as further work-hour reductions, it seems natural to concentrate on the clerical work for which we're held accountable rather than on direct patient care. Work thus becomes more transactional, increasing ennui, and many clinicians

want to do even less of it. Indeed, as one chief resident explained, in response to trainee unhappiness, we give them more personal days, seminars, retreats… and no one is any happier. Then the cycle repeats.

Is there any way to break this cycle? Or is medicine simply too far gone?

CATCH-22

In a 2022 radio interview, Terry Gross asked editor Robert Gottlieb about working on Joseph Heller's novel *Catch-22*, which introduced the term "Catch-22" into the lexicon.[5] Asked what it's like to have contributed to an enduring change in language, Gottlieb responds: "When a word comes into existence like that" and is "used and used and used… the reason is always that we need that word." Likening the ascendance of "Catch-22" to that of "Kafkaesque" (which is often invoked to describe dystopian workplaces), Gottlieb says, "It expresses something for people that there was no word for before."

"Moral injury" seems to fulfill such a need in medicine. By encapsulating the distress physicians feel when they can't give patients needed care, it names our pain. By acknowledging how the profit motive compromises care and exploits clinicians' goodwill, it identifies a cause. And by implicitly saying, "It's not your fault," it soothes our wounds. But if the resonance of "moral injury" lies in its recognition of the systemic factors destroying individuals, it can't tell us how individuals can help improve the system.

Press's article on physicians' moral injury features an emergency physician disillusioned by the ways our system fails patients.[2] Because of cost-cutting measures, the physician finds himself, one frigid night, as the lone doctor staffing a busy emergency department (ED). A woman with mental illness, frequent ED visits, and previous disruptive behavior arrives. Worried she will distract the staff from other patients, the physician determines that she isn't suicidal and, as she becomes combative, wheels her out of the ED into the cold. He is later haunted by his behavior, knowing that his former, idealistic self would be horrified. Press doesn't try to absolve the physician, as he highlights moral injury's manifestations, but he hints at the formulation's potential trap: When do the system's failures become our own?

The moral injury narrative is one of myriad cultural narratives blaming systems and structures for societal problems — and often implicating capitalism as the underlying culprit. Many of these narratives have validity: in many ways, pursuit of profit does seem to be medicine's root ill. Yet, as cultural critic Clare Coffee notes in "Failure to Cope under Capitalism,"[6] attributing societal failures to problems no individual can solve may induce paralysis. Given the role individual clinicians play in patients' lives, one question Coffee poses seems particularly relevant to medicine and training: "if important causality occurs on the macro level," do we have any "capability or responsibility for dealing with it at the micro"?

My mother, who hadn't planned on becoming a doctor, decided to go to medical school during the Vietnam War. The atrocities being committed left her feeling helpless, and medicine promised a concrete way to improve some people's lives, even if she couldn't comprehend how to help the world. Many generations have similarly perceived the world as falling apart. What seems specific to this moment is an erosion of the belief that physicians can make the world better simply by caring for the person in front of us.

If training requires accepting that agency, the moral injury narrative risks creating its own version of a Catch-22. We must acknowledge the structural forces constraining clinicians if we're to inspire systemic change, but fully embracing medicine's "capitalist hellscape"[7] narrative may obscure our own agency, convincing us that we're hapless victims of a corrupt system. That sense of disempowerment can harm both well-being and patient care, even though the anguish associated with not meeting patients' needs gave rise to moral injury's application to health care workers in the first place. How, then, can we recognize the system's failures without becoming its victims?

A SENSE OF POSSIBILITY

My grandfather was a physician writer who literally believed that transmitting stories across generations could fix medicine's problems. After practicing rheumatology for 50 years, he wrote a best-selling memoir about his own experience with illness.[8] About 15 years later, when he was in his late 80s and I got into medical school, he decided he wasn't done. The memoir, published

in 1988, had raised many problems (chief among them medicine's commercialization); now he wanted to fix them. So despite his advanced Parkinson's disease and some associated dementia, he began writing another book, intended to be an exchange of letters and stories between him and me that would somehow restore the sanctity of the profession. That I never wrote my half didn't seem to faze him.[9]

Initially, the letters and stories he sent me were full of wisdom. He told me I must always strive to be worthy of the title "Doctor." That I would have to learn to live with the mistakes I would certainly make. That patients didn't expect me to play God but, instead, to be present with them when I couldn't. Yet as his mind unravelled, so did the stories. They lacked a coherent theme, a path forward, actual solutions to the problems he'd observed. The early letters would pop up again 70 pages later. The patients who taught him critical lessons all started having the same name, so I couldn't keep them straight. And sometimes the "story" was simply a joke he'd heard at lunch in his assisted living facility. His conviction that our book would save medicine was nevertheless unwavering. And so for 7 years, my medical educations unfolded in parallel. In one, I learned how to treat disease; in another, I became complicit in a delusion.

The last time I visited my grandfather was shortly before I finished residency, just shy of his 94th birthday. I knew he wasn't doing well, but somehow I still expected our usual routine. I would kneel at the base of his motorized chair, and he would take my hands, ask me when I would be coming home again, ask whether "we had anything in press," and then tell me he'd just remembered another story. But this time, I could barely wake him. His limbs were unusually still. His cardigan had been replaced by a sweatsuit, free of crumbs because he'd stopped eating. So I took his hand, kissed his forehead, and told him I had come to Oregon from Boston to see him, that I missed him, that I was ready to work. And when he barely stirred, I said, "Don't you have another story for me?" And he said, "I finished my half."

In *Rough Sleepers*, a recent biography of physician Jim O'Connell, who's devoted his life to caring for Boston's homeless population, Tracy Kidder contrasts the joy O'Connell has found in his work with the joylessness many physicians experience.[10] In a related podcast interview, Kidder was asked about the nature of professional joy — his own and O'Connell's.[11] "Joy," he said, "is not the same thing as pleasure." Indeed, "it partakes of difficulties, sadness, sorrow." Noting that even O'Connell, a trained philosopher, can't precisely define joy, Kidder said, "I think we kind of recognize it when we experience it."

I doubt I'll ever write my half of the book: the conceit has always felt somewhat trite, I still can't find the necessary emotional distance, and I have no idea how to fix medicine. But as I struggle to propose a path forward for training, believing, like my grandfather, that teaching people to be good doctors is foundational to systemic improvement, I realize that he taught me something essential about education: All trainees deserve to be guided by physicians who see in them the possibility of making medicine better. That sense of possibility is critical not just to well-being, but to recognizing — and preserving — the joys that remain.

Though I never believed stories could save medicine, I wonder whether the circulating narratives about our terrible work environments dissuade us from seeking out moments of joy. Clearly, many clinicians and trainees work in unfavorable conditions; it's impossible to separate these realities from our reactions to them. So any suggestion that the problem is our attitudes rather than the pressures we face is enraging. But I think the fear of eliciting this rage — the sense that describing the joys of physicianhood could be misconstrued as dismissing systemic problems — creates a social pressure to embrace the angst. As vascular biologist Mark Lindsay tweeted in late 2021, "Nothing makes medtwitter so angry as when someone mentions enjoying their profession."[12]

What might a remaining joy look like? For some physicians, it's resecting a pancreas. For some, stopping death. For others, witnessing the wonders of human idiosyncrasy, like a woman who can't sleep without a Milk Dud under her tongue. For me, though I complain a lot, there are still many — patients, friendships, clarity of purpose, the sense of having a place in this world. But one joy I didn't anticipate is working with trainees. Patients have always moved me. What surprised me is how moving it is to watch a trainee transform. To own a tough situation, to know what I don't, to be the only person with whom a patient will speak, to stay when some-

one gets sick and text me later to ask, in the face of loss, "What could I have done differently?" — to become, in essence, a doctor.

We owe it to trainees to place them in more circumstances that allow these transformations. Doing so will require rethinking how trainees spend their days. But it will also require believing that joy remains possible.

Disclosure forms provided by the author are available at NEJM.org.

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This article was published on January 24, 2024, at NEJM.org.

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DOI: 10.1056/NEJMms2311042