Triggers and factors associated with moral distress and moral injury in health and social care workers: A systematic review of qualitative studies.

1 University of Hertfordshire UH

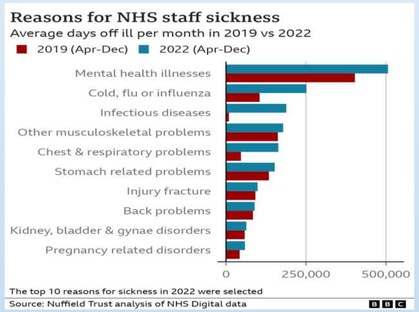
E Beadle[1], A Walecka[2], A Sangam[2], J Moorhouse[2], M Winter[1], H Munro Wild[1], D Trivedi[1], **A Casarin**[1].

[1]Department of Psychology, Sport, Geography, School of Life and Medical Science. [2] Intensive Care Unit.

2 NHS Royal Free London NHS Foundation Trust

Context

Recent UK data collected by the British Medical Association[3] suggests experience of moral distress in health and social care workers is common. Of more than 1,900 doctors surveyed, 78.4% reported that moral distress resonated with their experience. 59.6% of respondents experienced moral distress in the 12 months prior to the pandemic but 96.4% said the pandemic had exacerbated the risk of moral distress. 51.1% felt the same about moral injury. Mental health-related issues are indeed the first reason for absence by NHS staff, with an increase in cases between 2019 and 2022, as shown in the diagram on the right.



3. bma-moral-distress-injury-survey-report-june-2021

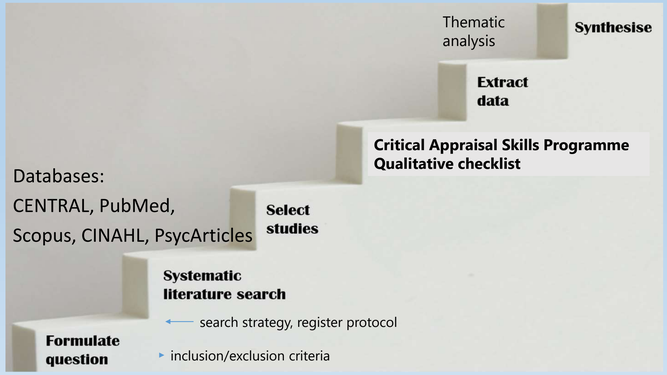
Aims and Objectives

Aim - To examine the views and experiences of moral distress/injury in health & social care workers (HSCW)

Primary objective - To explore the causes and triggers of moral distress/injury in HSCWs

Secondary objectives - Psychological safety, diversity, impact of major events, potential interventions

Methods

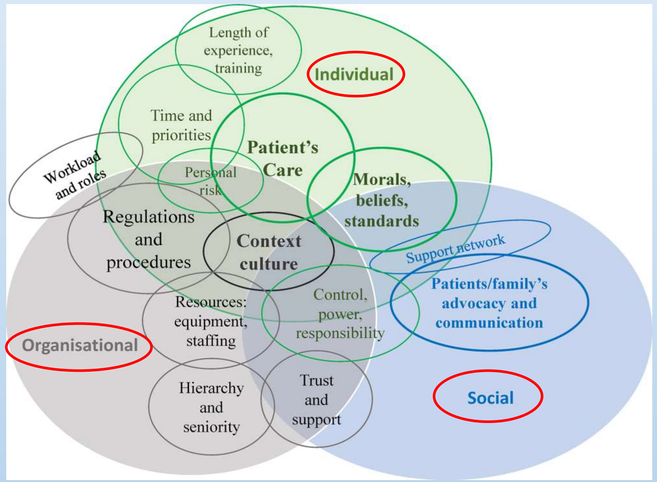


Modified from methodology and standards - University of Oslo Library

Results

51 studies (53 reports) were included, 1188 participants in total, 45.4% of which were nurses. Other categories were: doctors, healthcare assistants, physiotherapists, midwives, psychologists, social care workers, managers. Most papers came from Canada, USA and the UK. The majority were published in 2021-2023.

The figure below shows **causes and triggers descriptive themes** identified by thematic analysis of quotes extracted from the papers.



The themes were included in three categories: individual, organisational and social factors. There were not enough moral injury specific articles to separate its causes and triggers from the distress' ones. The **analytical themes** attempting to explain the origins of moral dilemmas, as identified by the reviewers, were: be in someone else's shoes (empathy versus detachment); professional experience leads to autonomy but increasing responsibility; prioritizing what comes first: me, the patients, the organisation? counting on others and the importance of a social circle of support; top-down approach and effects of hierarchy; struggling to meet demand, especially during crisis.

Secondary objectives: 1) To investigate what professionals think of **psychological safety**, described by participants as originating from the fear of consequences when speaking out, feelings of not being heard, and linked to a sense of powerlessness.

2) To explore the effect of **diversity and cultural differences** and the effects on moral distress: only 2/3 of papers reported ethnicity of participants and none discussed it. None reported the level of education of participant either. There were some references to different healthcare settings and the organisational culture e.g., treating or not-treating non-paying patients, but not their influence.

3) To look at **major events/disasters** and their influence on moral distress: 16 studies specifically considered CoVID-19. Themes emerging form the discussion were: the need for management support, the heighten issues of hierarchy and seniority, the impact of top-down regulation and policy decisions, protective equipment and safety, lone-working and isolation.

Additional findings: Reviewers identified further factors related to moral dilemmas, their negative **consequences** and potential solutions. Short-term consequences of moral distress/injury examples are: stress, fear, guilt, doubt, frustration and anger; physical responses (hypertension, panic attacks, sickness). Longer-term consequences are: wanting or needing to leave role or profession, fear of retribution at speaking out, social consequences, cynicism, compassion fatigue and burnout. Participants mentioned **coping strategies** at a personal level – healthy/constructive (work/life balance, exercise) or unhealthy/deconstructive (substance abuse, isolation) – and peer and organisational support - debriefing, shared understanding and raising awareness.

Implications for practice and future research

To address individual, organisational and social causes and triggers, employers should aim at creating an environment where people feel safe to speak up, feel empowered to achieve an optimal work-life balance.

Educational materials and sessions for healthcare workers should aim at providing employees with tools to: identify red flags and symptoms in themselves and others; report issues promptly; build a supportive network, in and out the workplace. Clear information on regulations and procedures should be provided, and management decisions should be made with a bottom-up approach.

Further exploration of the following aspects would provide important insights to tackle moral distress and prevent moral injury: the role of culture, ethnicity, religion, and other social determinants of health; influence of different care models and systems; impact of roles and seniority; contextual factors; and mitigation strategies.