**Why you should read this article:**

- To familiarise yourself with the concept of moral injury
- To understand why nurses may be particularly vulnerable to moral injury
- To learn about a practical framework and various interventions that can be used to mitigate the effects of moral injury

# Supporting nurse leaders to recognise and mitigate the effects of moral injury

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## Abstract

The concept of moral injury has been around for several decades, yet its effect on nurses remains under-recognised. Moral injury is defined as the biopsychosocial harm that arises from a violation of one's moral code, meaning that a person is powerless to uphold and enact what they believe is morally right. The coronavirus disease 2019 (COVID-19) pandemic has brought the issue of moral injury into focus because many nurses and other healthcare professionals have encountered potentially morally injurious events, resulting in increased pressure and emotional demands. It is essential that nurse leaders recognise moral injury if its effects are to be addressed. This article describes moral injury and its effects on nurses, and offers nurse leaders a practical framework for mitigating this issue. The framework aims to support nurse leaders to increase their understanding of moral injury, address any ethical challenges, ensure they are adequately prepared to provide support to nurses, and enhance their awareness of various interventions that can mitigate moral injury.

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## Keywords

**ethical issues, leadership, leadership frameworks, nurses' well-being, professional, professional issues, staff welfare, workforce**

MORAL INJURY has become an important concept in healthcare leadership, particularly since the start of the coronavirus disease 2019 (COVID-19) pandemic. In the House of Commons Health and Social Care Committee's (2021) inquiry into workforce burnout and resilience, moral injury was suggested as a more appropriate term than burnout and resilience because it better depicts the underlying causes of suboptimal mental health across the healthcare workforce, attributable to systems, working cultures and organisational factors. However, despite its effects being increasingly recognised, there appears to be a general lack of conceptual clarity and understanding of moral injury in healthcare (Mantri et al 2020).

## Definitions of moral injury

The concept of moral injury came from the military, but in healthcare its origin is in the concept of moral distress, a term which was coined by Andrew Jameton in the 1980s to portray the psychological conflict experienced by nurses during ethical dilemmas (Jameton 1984).

One of the most widely used definitions of moral injury is that provided by Litz et al (2009), who stated that it occurs when a person perpetrates, fails to prevent, bears witness to or learns about acts that transgress their deeply held moral beliefs or expectations. Hossain and Clatty (2021) described the 'long-lasting psychological and emotional effect that arises from actions taken that run in opposition to one's personal moral values or beliefs'. Lützén et al (2003) cited three preconditions to moral distress in nurses:

» Nurses are morally sensitive to the vulnerability of patients in their care.

» Nurses experience organisational or systemic factors preventing them from doing what they feel is best for patients.
» Nurses feel that they cannot influence or control the specific situation.

The terms moral distress and moral injury can be used interchangeably, but it is important to make a distinction between them. While moral distress may be transient and resolve on its own, researchers such as Čartolovni et al (2021) proposed that it may evolve into moral injury in certain circumstances. Moral injury can arise not only from a one-off, high-stakes situation, but also from a build-up of moral distress – particularly where there is no support for those affected to process the meaning and effect of morally distressing events. Therefore, it is crucial for nurse leaders to intervene early before such experiences result in long-lasting, psychological harm or injury to the individuals involved. Supporting staff through forums such as Schwartz Center Rounds (Whitehead et al 2021) or clinical supervision (Corley 2002) and providing opportunities to talk openly about psychologically challenging events are approaches that could help to prevent a morally distressing event from becoming a morally injurious one.

## Increased focus on moral injury in healthcare

There has been a proliferation of articles published on moral injury since the start of the COVID-19 pandemic. Williamson et al (2018) carried out a meta-analysis and systematic review of moral injury and identified 13 articles on the subject published between 2011 and 2017; however, a few years later they found that more than 190 relevant articles had been published since then (Williamson et al 2021a). As the UK was heading into lockdown in March 2020, Neil Greenberg, professor of defence mental health at King's College London, warned that healthcare professionals were going to have to make impossible decisions under extreme pressures with inadequate resources, which might cause some of them to experience moral injury (Greenberg et al 2020). This heralded the start of an increased focus on the phenomenon.

Studies have shown that nurses experience significantly higher levels of moral distress than other healthcare professionals (Kherbache et al 2022) and that there is a correlation between the likelihood of moral distress and the proximity, or closeness, to the patient that is inherent in person-centred care (Peter and Liaschenko 2004). The COVID-19 pandemic has placed unprecedented pressure on healthcare systems. During this period in particular, many nurses have experienced a build-up of moral distress as a result of facing ethically and morally challenging situations, encountering triage and prioritisation dilemmas, stepping up into new roles, coping with an overwhelming number of deaths and breaking bad news to families. As a result, moral injury has been deemed to be a 'parallel pandemic' (Borges et al 2021), with many nurses experiencing the adverse physical and psychological symptoms of moral injury, including guilt, shame, disgust, anger and a sense of disillusionment (Williamson et al 2020, 2021b).

Hossain and Clatty (2021) identified a significant shift in terms of ethical approaches as a result of the pandemic, from a patient-centred, deontological approach whereby the duty of care and the rights and needs of the individual patient are considered sacrosanct, to a utilitarian approach whereby the focus is on pursuing the outcome that achieves the greatest benefit for the greatest number of patients, considering the wider population health needs. Furthermore, factors such as staff and resource shortages, patients and families experiencing moral distress themselves and unprecedented demand on services due to the pandemic all increase the risk of moral injury. Several studies have identified the effect that the resulting healthcare rationing can have on moral injury (Huffman and Rittenmeyer 2012, Wall et al 2016), with Burston and Tuckett (2013) finding that unsafe staffing levels contributed to the highest intensity and frequency of moral injury.

### Interventions

The introduction of a range of interventions – albeit with varying degrees of success – has accompanied the increased focus on moral injury, although there is no validated treatment for it. These interventions include workshops to increase understanding of the concept, moral empowerment initiatives, interventions to improve knowledge and practice around ethics, reflective debriefing and reflective practice, narrative writing, multidisciplinary briefings, nursing ethics huddles and the use of various models. One such model for nurse leaders is the 4As to Rise Above Moral Distress (American Association of Critical-Care Nurses 2004), which comprises four stages:

» Ask if staff, or the leader themselves, are feeling or exhibiting any signs of moral distress.
» Affirm and validate feelings by openly talking to others and making a commitment to address the issue.

## Key points

- Moral injury occurs when a person perpetrates, fails to prevent, bears witness to or learns about acts that transgress their deeply held moral beliefs or expectations
- Studies have shown that nurses experience significantly higher levels of moral distress than other healthcare professionals
- Nurse leaders have an important role in providing supportive interventions before, during and after an event involving potential moral injury
- The framework described in this article provides a starting point for nurse leaders attempting to mitigate moral injury

» Assess the underlying causes of moral distress.
» Act to address the specific causes, turning the negative effects into motivation for improvement.

Moral injury needs to be explicitly recognised and those experiencing it should be equipped with the knowledge, language and confidence to accurately describe and reflect their experience. This is the starting point in equipping the workforce for future challenges and targeting effective interventions for mitigating moral injury. Nurse leaders have an important role in this, providing supportive interventions before, during and after a potentially morally injurious event.

## Framework for recognising and mitigating moral injury

In the authors' clinical experience, nurse leaders have reported that at times they feel overwhelmed when attempting to support their teams during challenging and emotional situations. Therefore, to increase nurse leaders' confidence, knowledge and understanding of moral injury and how to mitigate its effects, the authors have developed a framework as part of their roles working for Dementia UK. The framework breaks down this leadership challenge into three phases that take nurse leaders from a position of understanding and awareness through to intervention and action. Figure 1 shows the moral injury framework for nurse leaders.

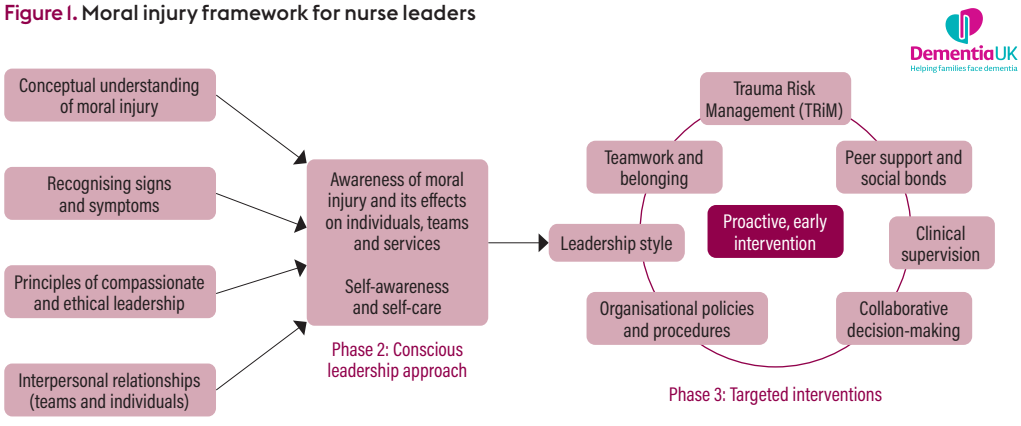
### Phase 1 – discovery and understanding

Phase 1 involves nurse leaders applying an ethical leadership style that enables them to understand issues related to moral injury. The nurse leader develops an awareness of moral injury, acquiring knowledge of its effects and recognising the signs of moral injury in individuals and teams. These signs include a range of moral emotions, including emotional distress, guilt and shame (Williamson et al 2021b). Moral injury can also engender feelings of ineffectiveness, helplessness and low self-worth, as well as decreased job satisfaction and staff turnover (Rathert et al 2016).

A systematic review of the effect of moral injury on mental health outcomes found a small but significant link between potentially morally injurious events and post-traumatic stress disorder and depression (Williamson et al 2018). Moral injury may also manifest as disengagement and 'moral silence', whereby nurses no longer raise concerns or advocate for patients (Varcoe et al 2012). Recognising the signs of moral injury can be particularly challenging for nurse leaders because nurses may emotionally withdraw and not verbalise their true feelings due to concerns about the potential consequences of doing so and difficulties in talking about events associated with shameful emotions.

Research has consistently shown that leadership style can have a significant influence on team culture. Maffoni et al (2020) and Wall et al (2016) found that where leaders enact an ethical vision of patient care and role model values-based decisions, this results in lower levels of distress among teams. This is known as an ethical leadership style. Nurse leaders can influence the ethical climate of an organisation through the way in which they perceive and manage ethical challenges. Being aware of and adopting an ethical leadership style is an important starting point for any nurse leader facing the challenge of mitigating moral injury.

**Figure 1.** Moral injury framework for nurse leaders

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Ethical leadership has been shown to reduce emotional exhaustion and increase work engagement by empowering nurses to have greater authority in decisions about patient care (McKenna and Jeske 2021). Nurse leaders can demonstrate ethical leadership by explicitly recognising the moral components of decisions, and by considering the consequences and potential harm that decisions and actions can have on others. On a practical level, this means viewing ethical issues from multiple perspectives, proactively seeking different viewpoints and demonstrating an openness towards ideas and challenges, while encouraging others to do the same.

### Phase 2 – conscious leadership approach

Phase 2 involves nurse leaders taking some time to ensure their own preparedness and resilience ahead of any targeted interventions. Moral injury can have a profound effect on all healthcare professionals, including nurse leaders. Research has shown that healthcare managers are at risk of moral injury when having to cascade organisational directives they may not personally agree with, when making challenging rationing decisions and seeing the firsthand consequences of decisions on the staff they directly manage (Mitton et al 2011).

In this phase, the emphasis is on leaders developing confidence in their ability to develop interventions. Most nurse leaders use reflective processes to improve their understanding of themselves, their leadership style and their own resilience in coping with complex and stressful situations. The authors' clinical experience suggests that leaders often forget that they will need to develop their own emotional reserves when working with colleagues. This phase also encompasses nurse leaders seeking assistance from others and connecting plans to mitigate moral injury with broader organisational structures that provide support and promote staff well-being.

Nurse leaders should understand their organisation's systems for employee support. Throughout the COVID-19 pandemic, there has been an increase in internal and external programmes to assist nurses, such as employee assistance programmes and the Nightingale Frontline leadership support service (Bond et al 2022). These resources may form part of interventions for mitigating moral injury.

When planning interventions to counter the effects of moral injury on individuals and teams, it is important to recognise that several interventions may be necessary and what may be effective in one setting or team may not be effective in another. During phase 2, nurse leaders should be aware of the multifaceted effects of moral injury and develop plans that involve a range of interventions and approaches.

### Phase 3 – targeted interventions

Phase 3 involves nurse leaders deploying a range of interventions in response to moral injury and examining the effectiveness of these interventions. Table 1 provides a summary of interventions and approaches for mitigating moral injury.

#### *Taking proactive, early intervention*

Intervening as early as possible may mitigate the effects of moral injury across teams. Moral injury can lead people to experience intense negative perceptions of themselves (Williamson et al 2021a), and as a result healthcare professionals may find it challenging to verbalise their distress to colleagues or line managers and may be reluctant to seek help. It is also likely that staff will not recognise their experience as moral injury and therefore will not be aware of the specific support available to manage their distress. Consequently, nurse leaders need to be upfront and proactive in offering support. This involves:

- Checking that support mechanisms are available to all staff and promoting resources that staff can access for support.
- Raising awareness of moral injury in the workplace, while explicitly recognising and naming moral injury and supporting others to recognise the signs and symptoms in themselves.
- Differentiating between resilience and moral injury. Maben and Bridges (2020) suggested that there has been an 'overemphasis on nurses being "resilient" in the face of understaffing' and that treating resilience as an individual trait is seen by nurses to 'let organisations off the hook'. In contrast, 'institutional constraints' are considered to be the main source of distress in the context of moral injury (Jameton 1984).
- Promoting a culture where individuals are not held accountable for system issues over which they have no control (LaSala and Bjarnason 2010).

#### *Adopting a supportive leadership style*

According to de Veer et al (2013), nurses who experience a task-focused, or instrumental, leadership style are more likely to have higher levels of moral distress than where

a supportive, relationship-focused leadership style is exercised. Compassionate leadership has been frequently discussed over the past few years, and is considered to be a supportive, relationship-focused leadership style.

West et al (2020) described the principles of compassionate leadership as:

- Attending – listening with fascination.
- Understanding – coming to a shared understanding of the underlying causes of stressors.
- Empathising – responding empathetically to concerns.
- Helping – co-creating solutions through considered actions, including addressing institutional obstacles.

Nurse leaders can use a compassionate leadership style to mitigate moral injury by establishing a culture where staff feel able to express their feelings about issues that are affecting them. Nurse leaders should also acknowledge that staff who have experienced a potentially morally injurious event should be treated as 'moral equals', thus opening up a genuine opportunity for moral dialogue, rather than imposing an authoritarian view where leaders expect others to follow what they consider to be right.

### *Embedding a collaborative decision-making approach*

Hierarchical relationships and low professional autonomy can intensify moral distress among nurses (Burston and Tuckett 2013, de Veer et al 2013). Nurse leaders can help to establish a structure and culture which supports shared governance and collective leadership, facilitating collaborative decision-making and ensuring that nurses influence the design of services and decisions around prioritisation.

Silverman et al's (2021) US study of nurses caring for patients with COVID-19 found that moral distress was caused by nurses not feeling 'heard' in care-planning decisions, particularly when this resulted in them not being able to advocate for patients. Ensuring that nurses' voices are heard is a common theme in research and commentary on moral injury. According to Rowlands (2021), the most immediate risk associated with moral injury is that nurses will no longer articulate their experiences and concerns – entering a state of what Welborn (2019) termed 'internalised powerlessness' – because they do not believe that a moral conflict can be reconciled. Welborn (2019) further stated that this can lead to compromised patient care and outcomes.

**Table 1. Summary of interventions and approaches for mitigating moral injury**

| Intervention or approach | Actions that nurse leaders can take |
|---|---|
| Taking proactive, early intervention | Normalise conversations about ethics in the workplace |
| Adopting a supportive leadership style | Pay attention to the moral implications of organisational decisions for individuals and act as ethical role models |
| Embedding a collaborative decision-making approach | Encourage individuals to express their views, regardless of their hierarchical position, so that everyone has a 'moral voice' |
| Developing peer support and social bonds | Organise team check-ins |
| Facilitating teamwork and belonging | Promote a communal response to moral injury, rather than solely focusing on each individual's moral resilience |
| Ensuring clinical supervision is available and actually takes place | Prioritise clinical supervision with the explicit inclusion of morally complex cases |
| Formulating organisational policies and procedures | Ensure there is a process in place for reporting and acting on morally injurious concerns |
| Trauma Risk Management (TRiM) programme | Undertake this programme to become equipped with a structure and an approach for supporting staff |

### *Developing peer support and social bonds*

Nurse leaders can have a role in facilitating peer support for colleagues to mitigate the effects of moral injury. According to Rathert et al (2016), nurses who share experiences of their ethical dilemmas and learn from each other feel supported to cope, and this reduces the build-up of moral distress. In Abbasi et al's (2019) randomised controlled trial in Iran, 60 intensive care unit nurses took part in a group-based moral empowerment programme, and it was found that their moral distress had significantly decreased one month after the intervention. The programme comprised group discussion, the narration of experiences of moral distress, participation in an interprofessional environment, problem-solving and communication skills (Abbasi et al 2019).

Greenberg and Tracy (2020) encouraged healthcare leaders and supervisors to reinforce social bonds and incorporate opportunities for team check-ins and small group meetings to mitigate moral injury.

### *Facilitating teamwork and belonging*

Evidence has shown that the quality of teamwork determines care quality and staff well-being (Rosen et al 2018). 'Belonging' is one of the three core work needs to ensure well-being and motivation outlined by

West et al (2020), along with 'autonomy' and 'contribution'. Belonging is defined as 'the need to be connected to, cared for, and caring of others around us in the workplace, and to feel valued, respected and supported' (West et al 2020). Nurse leaders can also have a role in ensuring a sense of psychological safety, where team members feel comfortable to verbalise their concerns and emotions without feeling judged.

'Teaming' is a term coined by Edmondson (2012) to describe 'teamwork on the fly' – that is, coordinating and collaborating across different departments and organisations without the benefit of stable team structures. Teaming has become a feature of fast-changing environments where work priorities are constantly changing, requiring ad hoc groups of people to work together on discrete tasks. However, nurse leaders should also be aware of the significance and value of being part of a stable 'home team', since dropping in and out of teams can undermine a sense of belonging and connection (West and Dawson 2012). Nurse leaders should be particularly aware of autonomous practitioners and specialists who are outside of the stable home team and who therefore may not be as protected as others from the effects of potentially morally injurious events.

### *Ensuring clinical supervision is available and actually takes place*

The authors believe that clinical supervision is an essential tool to mitigate the effects of moral injury across individuals and teams. Corley (2002) found that undertaking clinical supervision for around 1.5 hours per week reduced nurses' levels of moral distress. However, in the authors' experience, clinical supervision for nurses is often sidelined at times of high emotional stress. It is crucial for teams to engage in critical self-reflection and reflective practice to enable them to better understand their practice and to support learning and growth. Nurse leaders have an important role in ensuring that this takes place in their teams.

### *Formulating organisational policies and procedures*

Nurse leaders need to formulate policies and priorities that reinforce the requirement for nurses to verbalise any concerns they have about morally complex situations (Lachman 2016). There should also be an appropriate 'chain of command' for staff to share and discuss issues so that leaders throughout the organisation know what is taking place at various levels (LaSala and Bjarnason 2010).

The authors hope that an increase in research into moral injury and people's experiences during the COVID-19 pandemic will inform guidelines for nurse leaders and their teams. The NHS England (2020) People Plan for 2020/2021 states that it is a 'moral imperative' for healthcare organisations to make sure that employees have the practical and emotional support needed to fulfil their roles.

### *Trauma Risk Management programme*

Many NHS trusts and emergency services are adopting the Trauma Risk Management (TRiM) programme, which originated in the British Armed Forces (Greenberg et al 2008). The TRiM programme is an evidence-based formal peer support system that focuses on early intervention through psycho-educational briefings, decompressing after a potentially morally injurious event and facilitating access to medical and psychological services. The TRiM programme can equip nurse leaders with a structure and an approach for supporting staff who are at risk of moral injury.

## Conclusion

Nurse leaders can significantly influence how individuals, organisations and systems manage the physical and psychological effects of potentially morally injurious events on the healthcare workforce. Therefore, it is important for nurse leaders to reflect on their response to such events and deploy interventions to mitigate the effects of moral injury. Failure to acknowledge and address moral injury may have consequences in terms of nurse retention, so nurse leaders cannot afford to ignore this issue.

The framework described in this article provides a starting point for nurse leaders attempting to mitigate moral injury. The authors expect this framework to be expanded on and developed further in the future as new evidence emerges through greater focus on the issue.

The research into, and practical application of, targeted interventions to mitigate moral injury remains limited at present, so further work is required in this area. All nurse leaders have a responsibility to raise awareness of the concept in their teams and to influence policy and practice so that the negative effects of the ethically and morally challenging situations that are a feature of nursing can be addressed collectively.

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