Moral Injury in Medicine

The Human Costs of Practicing in a Profit-Driven System

Overview: Physicians for a National Health Program (PNHP) conducted a national research project using physician focus groups, a national physician survey, physician interviews, and patient focus groups to examine how health care financialization—the shift from promoting health to extracting wealth—shapes the realities of patient care and leads to moral injury. Physician moral injury arises when clinicians are prevented from delivering evidence-based, optimal patient care due to systemic constraints beyond their control, particularly those imposed by the profit-driven goals of the health care industry. Rather than reflecting individual weakness or burnout, moral injury captures the ethical harm clinicians experience when financial imperatives override clinical judgment and patient needs. Our research also focuses on how these profit-driven structures disproportionately harm racially marginalized communities, deepening longstanding inequities in access, quality of care, and health outcomes.

Profit-driven priorities undermine patient care and health outcomes

- Across care settings, physicians described how financialized practices such as prior authorization, coverage denials, productivity quotas, and documentation demands interfere with patient care. Among 1,207 surveyed physicians:
  - 35% reported being required to care for more patients than they could safely manage.
  - 44% often or always felt that lack of insurance approval or service availability (e.g., post-acute care, physical therapy) prevented medically necessary treatment.
  - 47% often or always felt unable to provide optimal care due to inadequate time.
- Physician interviews also revealed:
  - Visit length, treatment decisions, and documentation are dictated by productivity benchmarks, billing codes, and insurer rules rather than clinical judgment or patient need.
  - Substantial time spent navigating administrative hurdles, while patients experienced delays, fragmented care, or outright denial of medically necessary services.

Financialized health care deepens racial and structural inequities

- Clinicians described confronting structural racism and seeing how financialized care worsens disparities, particularly for racially minoritized communities, under-resourced patients, and people facing language or immigration-related barriers.
- Among surveyed physicians:
  - 57% reported moderate or severe distress related to working in systems that failed to treat vulnerable patients with dignity and respect.
  - 41% often or always felt complicit in structural racism perpetuated by their health systems.
- Among interviewed physicians:
  - Doctors described differential treatment based on insurance status, racial bias in diagnosis and treatment, and fewer resources devoted to patients perceived as “less profitable.”

Corporate and institutional pressures drive physician moral injury

- When clinicians know what care is needed, but are blocked by insurers or corporate administrators, moral injury follows. Of 1,207 surveyed physicians:
  - 62% reported moderate or very high distress related to cost-cutting priorities.
  - 50% often or always felt betrayed by a healthcare system that hinders their ability to provide good patient care.
  - 49% often or always felt the financial goals of their organization conflicted with their goals of best patient care.
- Interviewed physicians repeatedly emphasized that they entered medicine to care for patients with compassion and advocate for equity, only to find themselves constrained by systems that prioritize revenue and cost containment.
- Patient focus groups documented how corporate acquisitions and productivity mandates accelerate physician departures, leading to clinic closures, loss of services, and dramatically longer wait times for care.
- Patients described the system in terms like "convoluted," "corrupt," "overwhelming," "expensive," "inequitable," and "dysfunctional."

What This Means: A system designed for revenue extraction will continue to fail patients and clinicians. Doctors work tirelessly to advocate for their patients, but the structural constraints of the system often erode these efforts, forcing improvised solutions. Meaningful relief requires structural change that removes profit incentives from care delivery. Focusing on physician "burnout" obscures the real problem. Despite widespread use of wellness initiatives, physicians reported these approaches fail to address the structural causes of distress. They emphasized that no amount of resilience training can negate a system that systematically obstructs ethical, evidence-based care.

Policy Recommendations: Immediate reforms should focus on de-financializing care and reducing racial and economic inequities within the existing system. These include returning the Medicare and Medicaid programs to public or nonprofit administration, expanding automatic and presumptive eligibility, and eliminating work requirements for social welfare programs. Lasting equity and sustainability require structural reform. Ultimately, PNHP recommends a single-payer, universal health care system that eliminates the profit motive from financing care; removes barriers such as prior authorization, cost-sharing, and medical debt; and guarantees comprehensive coverage for all. A single-payer system would directly address the root causes of physician moral injury, improve patient care, and dismantle the structural inequities that disproportionately harm racially marginalized and underserved populations.