Sounding the Alarm: Physician Moral Injury

PNHP Annual Conference
Washington, D.C.
November 2, 2025

National Survey Aims

Aim 1:

- Identify key systemic contributors to moral distress among a national cohort of physicians

Aim 2:

- Evaluate the association between severity of moral distress and physicians' current consideration to leave their jobs

Aim 3:

- Assess the association between physicians' demographic, professional, and practice characteristics and severity of moral distress

Survey Design

Independent Variables & Covariates

Demographic characteristics

- Gender identity
- Racial/ethnic background

Professional characteristics

- Clinical specialty
- Years practicing medicine
- Self-rated level of burnout
  - None → Complete burnout
- Have you considered leaving or left a position due to moral distress?

Clinical Practice setting

- Institutional Type (e.g., public, private)
- % of patients who are uninsured
- % of patients who are from racially or ethnically minoritized backgrounds

Outcomes of Interest

1) Overall Severity of Moral Distress

2) Are you considering leaving your position now due to moral distress?

Measuring Moral Distress

Original MMD-HP (Epstein *et al.* 2019[1])

- 27 questions
  - Potential causes of moral distress at the patient, team, and intra-organizational level

- Composite item score based on
  - Frequency
    - Never to Very frequently
  - Level of distress
    - None to Very distressing

Measure of Moral Distress – Healthcare Professionals (MMD-HP)

	Frequency					Level of Distress				
	Never				Very frequently	None				Very distressing
	0	1	2	3	4	0	1	2	3	4
1. Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs.				X						X
2. Be required to care for more patients than I can safely care for.				X					X	
3. Work within power hierarchies in teams, units, and my institution that compromise patient care.			X					X		

Measuring Moral Distress

- 8 original MMD-HP questions
- 3 physician focus groups (14 doctors) to identify healthcare system-wide contributors to moral distress
- 14 new questions
  - “Work within a system that prioritizes financial goals over best patient care.”
  - “Have excessive administrative burdens because of insurance prior authorizations and denials of care.”
  - “Make recommendations to patients that I know they will not be able to pursue because of their financial constraints.”

“

“The health system’s goals are lots of volume, more specialty volume. Less important is patient-centered care.”

“Institutions cut resources and staff, and then milk docs for more labor.”

“I fear I have pushed more people into medical debt than [the number of] lives saved.”

Survey Respondent Characteristics

- 1,886 overall responses

Profession	Number of Respondents	Percentage
Board Eligible/Certified Physician	1330	70.5%
Physician Trainee - Resident or Fellow	135	7.2%
Medical Student	75	4.0%
Nurse	84	4.5%
Advanced Practice Provider	16	0.8%
Healthcare Advocate	27	1.4%
Patient	46	2.4%
Other Healthcare Professional	157	8.3%
Non-Healthcare Professional	16	0.8%

- Of 1,465 physicians
  - 257 retired
  - 1,208 currently practicing
    - 135 physician trainees
    - 1,073 BE/BC physicians

Demographics of Practicing Physicians (n=1,208)

Characteristic of Residents, Fellows, and Currently Practicing BE/BC Physician	Number of Respondents	Percentage
Gender		
Men	456	37.7%
Women	733	60.7%
Transgender	2	0.2%
Non-binary / no gender	10	0.8%
Prefer not to say	7	0.6%
Race and/or Ethnicity		
American Indian or Alaska Native	0	0.0%
Asian	181	15.0%
Black or African American	41	3.4%
Hispanic or Latino	45	3.7%
Middle Eastern or North African	32	2.6%
Mixed Race	59	4.9%
Native Hawaiian or Pacific Islander	7	0.6%
White/Caucasian	798	66.1%
Prefer Not to Say	17	1.4%
Other	28	2.3%
Underrepresented in Medicine		
Under-represented in Medicine	131	10.8%
non-URIM	1077	89.2%

Professional Characteristics of Practicing Physician Respondents (n=1,208)

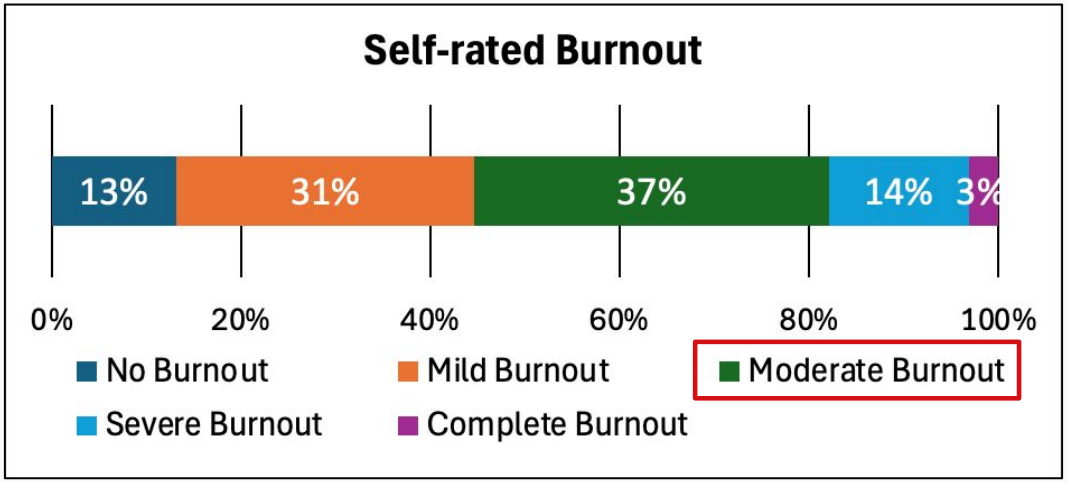
Characteristics of Residents, Fellows, and Practicing BE/BC Physicians	Number of Respondents	Percentage
Specialty		
Anesthesiology	9	0.7%
General Adult Outpatient Medicine	443	36.7%
General Adult Inpatient Medicine	35	2.9%
Adult Medicine Subspecialty	91	7.5%
Dermatology	1	0.1%
Emergency Medicine	62	5.1%
General Pediatrics	75	6.2%
Pediatrics Subspecialty	15	1.2%
Internal Medicine & Pediatrics	12	1.0%
Neurology	20	1.7%
Obstetrics & Gynecology	35	2.9%
Other	6	0.5%
General Psychiatry	117	9.7%
Psychiatry Subspecialty	15	1.2%
Pathology	5	0.4%
Physical Medicine & Rehabilitation	8	0.7%
Radiology	4	0.3%
Radiation Oncology	4	0.3%
General Surgery	9	0.7%
Surgery Subspecialty	23	1.9%
Unknown specialty	219	18.1%
Primary Care		
Primary Care	527	43.6%
Non-Primary Care	681	56.4%

Characteristics of Residents, Fellows, and Practicing BE/BC Physicians	Number of Respondents	Percentage
Years of Practice as a Physician		
less than 3 years	149	12.3%
3-5 years	124	10.3%
6-10 years	175	14.5%
11-20 years	214	17.7%
Over 20 years	545	45.2%

Practice Characteristics of Practicing Physician Respondents (n=1,208)

Characteristics of Residents, Fellows, and Practicing BE/BC Physicians	Number of Respondents	Percentage
Practice Setting		
Public Institutions	449	37.2%
Private Institutions	375	31.0%
Mixed Public and Private	352	29.1%
Other/Undetermined	32	2.6%
Proportion of Patients who are Uninsured		
less than 25%	826	68.4%
26-50%	180	14.9%
51-75%	83	6.9%
over 75%	59	4.9%
unknown	60	5.0%
Proportion of Patients who are Racially or Ethnically Minoritized		
less than 25%	292	24.2%
26-50%	394	32.6%
51-75%	223	18.5%
over 75%	280	23.2%
unknown	19	1.6%

Self-rated Burnout among Practicing Physicians (n=1,208)

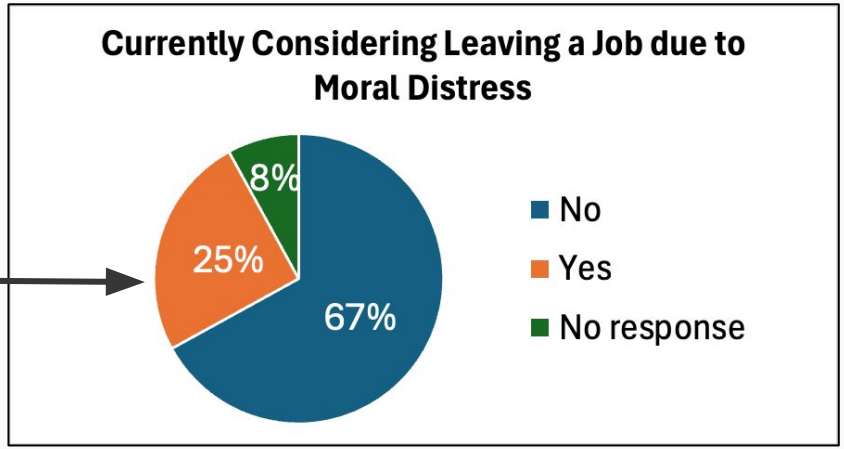


- On average, moderately burnt out
- No significant difference in average burnout between residents/fellows and BE/BC physicians

Consideration to Leave due to Moral Distress (n=1,208)

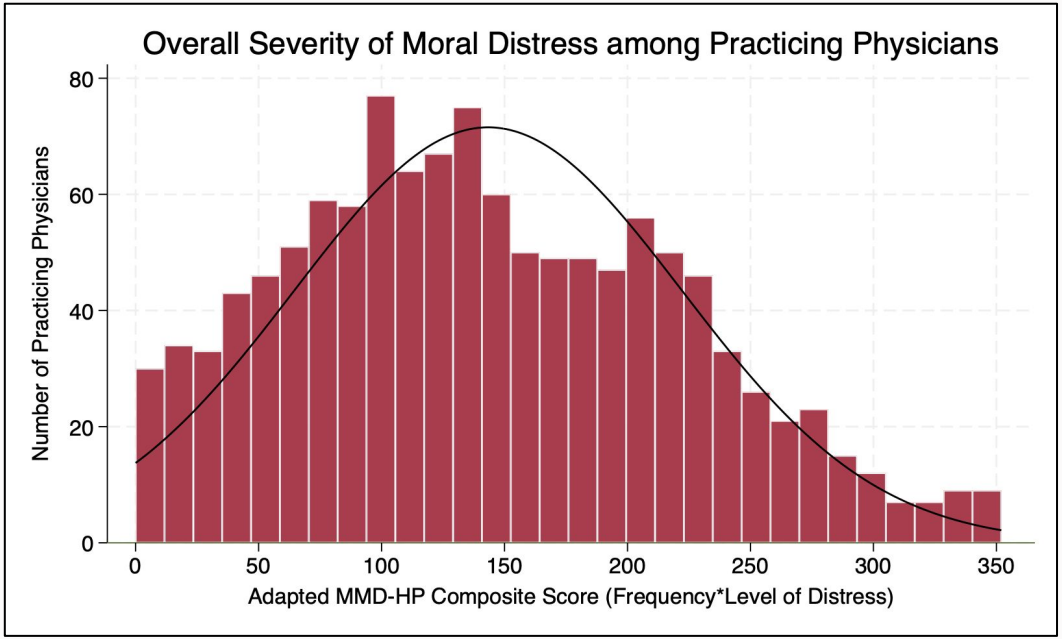
- 72% of BE/BC physicians
- 47% of residents/fellows

- 29% of BE/BC physicians
- 11% of residents/fellows



Overall Severity of Moral Distress (n=1,208)

- 19 of 22 situations experienced at least *sometimes* (2 out of 4)
- For 18 of 22 questions, the most common level of distress was *very distressing* (4 out of 4)
- Overall moral distress scores
  - Mean 143, Median 136
  - Physicians in original MMD-HP study: mean 96



What contributes to the greatest moral distress among practicing physicians?

1. Having excessive documentation requirements that compromise patient care & interfere with work-life balance.

2. Feeling betrayed by a healthcare system that hinders one's ability to provide good patient care and feeling unable to provide patients with the best possible care.

3. Having excessive administrative burdens because of insurance prior authorization and denials of care.

4. Making diagnostic or treatment recommendations to patients that one knows that patients will not be able to pursue because of healthcare system limitations.

5. Feeling the financial goals of one's organization conflict with one's own goals of best patient care.

Who is experiencing more severe moral distress?

- Women
  - Mean moral distress score 156 vs. 122 for men
- Physician trainees
  - Mean moral distress score 160 vs. 142 for BE/BC physicians
- Those caring for increasing % of uninsured patients
- Those caring for increasing % of racially/ethnically minoritized patients
- Those with greater self-rated burnout

For the 25% of physicians currently considering leaving their job, moral distress was 55% greater than their counterparts
(mean moral distress score 190 vs. 123 for those not considering leaving)

Aim for One-on-One Interviews

- Uncover narrative themes around how financialization has contributed to moral injury among physicians, and exacerbated systemic racism affecting patients, physicians and communities

Interview Participants and Interview Domains

- 30 practicing physicians who had completed the survey and indicated openness to being interviewed
  - 28 BE/BC physicians (1 resident, 1 fellow)
  - Various clinical specialties
    - 9 family medicine
    - 8 general IM
    - 3 psychiatry
    - 3 emergency medicine
    - 2 general pediatrics
    - 2 pulmonary/critical care
    - 1 pathology
    - 1 surgery

Interview Domains

- Professional trajectory
- Physician autonomy
- Financialization in healthcare
- Healthcare equity and care of marginalized populations
- Moral injury
- Coping strategies
- Future outlook
- Recommendations

Analyzing the Interview Data

- Deductive and inductive coding
  - 45 unique codes

- Most frequent codes
  - Impact of the business of medicine (323 instances)
  - Professional trajectory (207 instances)
  - Professional autonomy (152 instances)
  - Moral Injury (95 instances)
  - Role of health insurance (72 instances)

Code Cloud

Emphasis on billing and documentation detract from patient care

“I think that the mainstream business of medicine in this country is evil. It's just awful. I mean, patients are not the center, and they don't even at this point lie about it. It's all about the chart. It's all about the codes. I didn't realize I became an ICD-10-ologist. But apparently I'm that, and I'm a CPT-ologist and an E&M-codeologist. In the military, we never used any of those. Suddenly I had to be an expert on all of that and it was just like, that's not what I got into medicine for, to learn all this nonsense... Let me do the diagnosing and treating...”

Insurance utilization review impedes patient-centered care

"I'd rather just make the decisions based on the medical care I'm providing and the patient in front of me. So the prior authorizations, these peer-to-peer requests too…I did a peer-to-peer recently but to get the peer-to-peer started took me like 20 min on the phone, and it turns out that the number I had been given was actually not right. And there was a third-party group managing the peer-to-peer requests … I mean, I spoke to 3 different operators… and then, when I finally was able to access the other physician to do the peer-to-peer request, it was cursory and useless, and did not inspire confidence… It was clear to me that the entire peer-to-peer exercise was administrative burden to alienate my patients from medical care that they were entitled to."

Corporatized systems take advantage of physicians' professionalism

"[The patient] may not be able to afford the bandaid that [they] have to go and buy out of pocket from the drugstore. So, trying to find ways to help patients do that. I was expected to do all that in 15 min. It's undoable … Myself and every other provider end up working 2 hours over. Then you document after that, and it's exhausting, it's unsustainable. I would often not be able to go to the bathroom. I was eating and charting when I had a baby. I was calling patients while pumping, and they would be like, "What's that noise in the background?" I was like, "Oh, it's nothing. It's a machine in the background. Don't worry about it." It was unsustainable, and I really do think … the system takes advantage of the professionalism of the docs."

Feelings of guilt and complicity from 'overfunctioning'

"I almost feel this sense of complicity in taking part in the system that … doesn't feel very patient-centered … Rather than pushing back and saying, "I can't see this many patients, or I need to have ample time" … I feel I'm becoming the face of this healthcare system that's not providing adequate time to these patients … But am I complicit in this by participating in and helping support that kind of system? And on the days that I do get through every patient in 20 min, is that just signaling to them, "Hey, 20 min is enough time. They can go down to 15?" And so there's this lingering sense of almost guilt."

Initial High-Level Interview Themes

Physicians with a career calling focused on being of service to others are struggling to deliver compassionate and evidence-based care within a system that is increasingly undermining their professional autonomy.

The growing influence of insurance companies and private equity—driven by profit—has eroded physicians' ability to deliver optimal care.

Physicians are experiencing overwhelming demoralization, frustration, and disillusionment. The emotional and physical toll has led to psychological distress, hopelessness, and existential anguish, leaving them searching for ways to cope and preserve their sense of purpose.

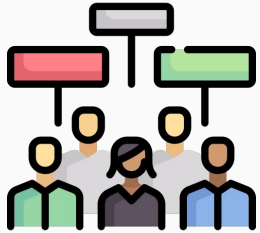
The financialization of healthcare has made it even harder for marginalized patients to receive the care they need, when they need it.

Summary of Preliminary Project Findings

- Of 1,208 practicing physicians, plurality (37%) of physicians reported moderate burnout
- Mean moral distress was greater than that previously reported in the literature
  - Level of distress >> frequency with which morally distressing situations were encountered
- Excessive documentation requirements, insurance-imposed administrative burdens, and conflicting financial goals contribute to physicians' moral distress
- ~70% of physicians (including ~50% of residents/fellows) have considered leaving or left their jobs due to moral distress
- 25% of physicians are currently considering leaving a job due to moral distress
- The business of medicine is undermining physicians' ability to provide evidence-based, compassionate care, provoking psychological distress, and leaving them searching for how to cope and to preserve a sense of purpose in their day-to-day clinical practice

Takeaways

- You are NOT alone – Moral distress among physicians is strikingly common.
- Moral distress should NOT be seen as an occupational hazard of practicing medicine.
- Sharing our stories can help us build our movement and agitate for change!



Thank you!

- Funding support
  - Robert Wood Johnson Foundation

- Project team
  - Dr. Diljeet Singh
  - Dr. Carol Paris
  - Rebecca Delay
  - Anika Thota
  - Dr. Dharma Cortes
  - Donald Bourne

- Healthcare for All Oregon
  - Dr. Rebecca Schoon
  - Dr. Lisset Dumet
  - Audrey Fleming

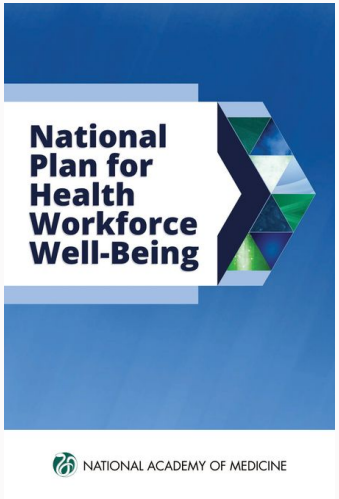
- Focus group, survey, and interview participants

- Research advisory team
  - Dr. Camara Jones
  - Dr. Linda Rae Murray
  - Dr. Danny McCormick
  - Hayden Rooke-Ley
  - Priya Patel
  - Chiamaka Okonkwo

- PNHP staff and board members

Appendix

Burnout: Misdiagnosing the Problem



Health systems do not exist in isolation. Political, market, professional, and cultural forces heavily influence health care delivery, workplace stress, and health worker professional well-being. For decades, health workers have been reporting a loss of meaning in work due to overwhelming job demands and limited supportive resources in the environments in which they operate (Maslach, 2018). In the United States, up to 54 percent of nurses and physicians, 60 percent of medical students and residents, and 61 to 75 percent of pharmacists have symptoms of burnout—high emotional exhaustion, depersonalization (e.g., cynicism), or a low sense of personal accomplishment from work (Jones et al., 2017; NASEM, 2019; Patel et al., 2021). Burnout is a longstanding issue and a fundamental barrier to professional well-being. It was further exacerbated by the coron-

- **Burnout**
  - "Prolonged response to chronic emotional and interpersonal stressors." (Maslach 2001)
  - Often arising from operational demands (i.e., long work hours, staffing)
  - Individual failure of resourcefulness and resilience → wellness programs

Moral Distress and Moral Injury

- **Moral Distress**
  - "When one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984)
  - Key elements (Epstein *et al*. 2019)
    - Feeling complicit in wrongdoing associated with transgressions of professional values
    - Lack of voice (i.e., agency)
    - Repeated experiences with morally stressful situations

- **Moral Injury**
  - When moral distress persists (crescendo effect) → moral injury
  - Experienced as a loss of trust in oneself, authority, and systems (Epstein & Hamric 2009; Shay 2014)

Knowledge Gaps

- **Moral injury scales**
  - Largely focused on care of veterans
  - The psychological sequelae and functioning of those affected
- **Moral distress studies**
  - Single institution, single specialty (e.g., academic radiologists), or setting-specific (e.g., ICU)
  - Examine specific clinical situations or focus on interpersonal or intra-institutional dynamics

Amidst growing corporatization and financialization of health care, what are the systemic causes, incidence, and severity of moral distress and injury across a national cohort of clinicians?

Phase 1	*Phase 2*	*Phase 3*
Focus Groups	National Survey	1-on-1 Interviews